California
HealthCare
Foundation

California Health Care Market Report 2005

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California Health Care Market Report 2005

BY
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About the Foundation

The California HealthCare Foundation, based in Oakland, is an independent philanthropy committed to improving California's healthcare delivery and financing systems. Formed in 1996, our goal is to ensure that all Californians have access to affordable, quality health care. For more information about CHCF, visit us online at www.chcf.org.

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About This Report

In the conventional sense, California was not a battleground state in the 2004 elections. In fact, both major presidential candidates largely ignored the state. But on matters of health care, California was the site for some hard-fought battles in 2004 — at the ballot box, in the Assembly, and in the marketplace. After an extended and expensive campaign, voters narrowly overturned a new law that would have required many employers to offer health insurance to their employees or pay the state. In the health care marketplace, a large health care purchaser challenged one of the largest hospital systems in the state by cutting many of its hospitals out of a key provider network. The state is also the locus for a very closely watched experiment in collaboration and performance measurement by health plans and provider organizations.

The California HealthCare Foundation commissioned this report, *California Health Care Market Report 2005*, to provide a resource for health policymakers in understanding the latest activities and trends in the state's health care industry. This is the fourth annual edition of this report, first published in 2001 as *California Managed Care Review*. The report is intended to provide an objective analysis of health care market trends and comprehensive data on health care organizations.

This report is based on two kinds of research. First, it analyzes data on health plans, hospital systems, and physician organizations to evaluate financial performance, health plan enrollment trends, measures of utilization and effectiveness of care, and patient satisfaction. Most of these data are drawn from public sources, including the annual and quarterly statements that HMOs file with the California Department of Managed Health Care and the annual surveys that hospitals submit to the Office of Statewide Health Planning and Development. Data on utilization of care and patient satisfaction are licensed from the Quality Compass® data set prepared by NCQA (the National Committee on Quality Assurance).

Second, the author conducted interviews with 35 leaders in key health care organizations and government agencies and other knowledgeable observers on health care market issues. These are in addition to 130 interviews conducted in preparing three previous editions of this report. Most of the new interviews were conducted in person between June and November 2004. These interviews provided very helpful perspectives and a complementary context for the data. Rather than quoting the interviewees directly, the author gleaned their insights and placed them in the report as unattributed comments.

Report Organization

This report is organized into four major sections.

Section 1.0, Overview of Findings, summarizes the findings of the report on key issues in the market.

Section 2.0, Market Review: Key Organizations, provides an overview of the health plans, provider systems, and other organizations involved in purchasing health benefits, providing health care services, and administering health benefit plans. The connections that link those organizations and the evolution of these connections are key to this analysis.

Section 3.0, Trend Review, presents a competitive analysis of health plans in the state, examining trends in enrollment and profitability, and comparing large commercial HMOs on measures of utilization and effectiveness of care. Several sidebars in this section compare California health plans with health plans in the eight other states where the author prepares similar market analyses: Colorado, Florida, Illinois, Michigan, Minnesota, Ohio, Texas, and Wisconsin.

Section 4.0, Regional Sub-Markets and Provider Systems, focuses on provider systems and health market issues in the largest regional sub-markets in the state: the San Francisco Bay Area, Sacramento, the Central Valley (including Fresno and Bakersfield), Los Angeles/Orange County, the Inland Empire of Riverside and San Bernardino Counties, and San Diego. Each regional analysis includes exhibits with information about major physician organizations and the finances, inpatient occupancy, and payer mix of hospitals and hospital systems. Some of the regional pieces also include graphics showing the local market share of health plans.

What is Managed Care?

Managed care systems are plans or organizations that integrate the financing and delivery of appropriate health care services to covered individuals using the following basic elements:

- Arrangements with selected providers to furnish a comprehensive set of health care services to members
- Explicit standards for the selection of health care providers
- Formal programs for ongoing quality assurance and utilization review, and
- Significant financial incentives for members to use providers and procedures associated with the plan.

Managed care has evolved, and health plans have reduced their use of medical management tools to control utilization and costs. They have also expanded their provider networks to offer broader choices. A U.S. Supreme Court decision upheld the right of states to enact "any willing provider" laws and limited health plans' ability to be selective in contracting with providers. And health plans are less likely to pay providers using capitation contracts that create incentives for the providers to hold down utilization of care.

The term "managed care" has acquired some negative baggage in recent years, and the industry's association rarely uses the term anymore, preferring terms like "comprehensive" or "coordinated care."

Source: America's Health Insurance Plans

1.0 Overview of Findings

With regard to health care, the population of California can be divided into four broad segments:

1) **The world of Kaiser,** where more than 6 million Californians get their health care in a largely self-contained system of clinics and hospitals.
2) **The delegated model HMO world,** where about 12 million people get their care from doctors who practice in groups and through independent clinics linked through IPAs (Independent Practice Associations). Most of the physicians practicing in these settings still receive the bulk of their revenue in the form of capitation payments.
3) **The fee-for-service world,** a growing segment of people whose health benefit plans pay physicians and hospitals for each unit of service provided. It includes an unknown number of people who have migrated from an HMO to a PPO (preferred provider arrangement) benefit plan, which does not require them to select a primary care clinic or physician. As shown in Section 3.2, enrollment in commercial HMO plans dropped by more than half a million in 2003 (4 percent), and it is generally believed that most of them moved to PPO plans.
4) **The uninsured,** which includes six to seven million Californians who often rely on a system of safety net community health centers and county hospitals for medical care.

Relationships are key to the working of health care markets: between purchasers (both employers and the state for Medi-Cal and other programs) and health plans; between health plans and providers; and between physicians and hospitals and their patients. In the early years of managed care, consumers were encouraged to utilize care so long as they stayed with the providers under contract with the health plan. Now employers would like their employees to be more judicious in their consumption of care, and are experimenting with benefit plan designs that make consumers more responsible for the cost of their choices.

1.1 Key Findings

1 Hospitals and medical groups are redefining relationships and risk-sharing models.

Under the classic version of the California delegated model of health plan and provider relations of the 1990s, physician groups and hospitals shared risk with health plans. Both physicians and the hospitals to which they admitted patients benefited when physicians held down hospital utilization. (Health plans benefited as well.) The physicians and hospitals shared the dollars left in the payment pools at the end of the year. However, health plans did not raise premiums much during the late 1990s. The payment pools stopped growing and there was little money left to divide. Consolidated hospital systems, enjoying and exercising their new economic power, exited those risk-sharing contracts and negotiated higher payments for themselves. In the process, less money remained for the physicians. As a result, hospitals and physicians no longer saw themselves as having common economic interests.

However, the continued growth of new premium dollars in the system has prompted some physician groups, hospitals and health plans to experiment with new versions of

risk-sharing. Health plans and physician groups negotiate utilization and per-member-per-month spending targets and agree on opportunities to share in surpluses at the end of the year if the targets are met.

The relationship between hospitals and medical groups is discussed in Section 2.5.

2 Medical groups face a variety of challenges going forward.

As was described in last year's report, the number of capitated patients in HMOs has been declining by between 2 and 5 percent in each of the last few years. California medical groups built their systems for medical management and administration around receiving monthly capitation payments, controlling hospital admissions and keeping those patients within their systems as much as possible. Many medical groups have not been able to re-position themselves to capture part of the growing number of PPO enrollees. Their investments in information systems and care management have been premised on managing monthly capitation payments, not on trying to maximize revenues from patients who have more provider choices. And while some medical groups expect (or wish for) a public backlash when people realize that they receive skimpier benefits in their PPOs, that has not materialized.

The migration away from the delegated model is likely to accelerate with the introduction of new plan designs that provide consumers with spending accounts and additional responsibility for making choices about providers and care. For the most part, these new plans are being introduced outside of HMOs and are not suited for provider capitation. While health plans may still prefer the delegated model and do not want to take back responsibility for medical management and claims administration, they also can see that growth opportunities are mostly found outside the current model.

Furthermore, medical groups increasingly face demands from health plans aiming to link compensation to performance and to the use of more sophisticated administrative systems. While today only a small proportion of payments from health plans is tied to clinical and administrative performance, that proportion is likely to grow. Well-managed and well-financed groups will prosper in that environment, but groups that are smaller and lack management savvy and systems will fall further behind. Some observers expect a new wave of closures by small IPAs in something of a Darwinian thinning out of weaker species.

Issues related to medical groups are discussed in Section 2.4.

3 Despite initial skepticism, payment systems that link some portion of payments to contract criteria are taking hold and are likely to have secondary impacts.

The most prominent example is the Pay for Performance initiative launched by the Integrated Healthcare Association, which ties a portion of physician group compensation to achievement of certain clinical measures, enrollee satisfaction rates, and use of information technology. The participating health plans wrote the first bonus checks in 2004, based on data from 2003 operations. Blue Cross, which has its own incentive arrangements, had already introduced incentive payments to doctors in both its HMO and PPO plans.

Pay for Performance is one approach to the issue of wide variation in how providers perform. Previous approaches, such as efforts to separate hospitals or physicians into tiers based on performance or pricing, have largely stalled here and in other parts of the country. In California, those approaches were relatively unsophisticated, distinguishing hospitals from one another primarily based on pricing differences. Hospitals responded angrily and employers were not enthusiastic about the approach. Still, these efforts took another form when CalPERS announced that it would exclude some "expensive" hospitals from its Blue Shield HMO network.

As will be discussed below, Pay for Performance programs will have an impact on how medical groups collect and report data. They are also likely to have secondary impacts. For example, some doctors may switch IPAs in order to participate in one that has more sophisticated data collection and reporting abilities.

Some (especially employers) question the Pay for Performance approach, wondering why physicians should be paid extra for meeting a standard of care. In their view, bonuses should be reserved for superior performance, well above average. Performance that is below average should be paid at a lower rate.

The issue of variation in practice and performance is discussed in Section 2.4.

4 Hospital capacity has declined in recent years, while utilization has crept upward. This has further strengthened the bargaining position of hospitals.

As recently as 2001, inpatient hospital capacity was seen as excessive in many parts of the state. Since then hospitals have closed, reducing inpatient capacity. In other cases, newly rebuilt hospitals are constructed with less inpatient bed capacity.

Some experts believe that a hospital system that owns 30 percent or more of the hospital capacity in a certain geographic area has a controlling position. When negotiating with health plans, these hospital systems can demand higher

prices, pointing to their geographic dominance or popular brand name. In the past, HMOs could threaten to move their business to other hospitals, but it is harder to make that threat today. Certain specialties are also in short supply and they will also demand higher prices.

Issues affecting hospital organizations are discussed in Section 2.3.

5 Size is an issue for health plans, provider systems and purchasers.

The market continues to be most responsive to the largest purchasers, health plans, and provider systems. CalPERS, the agency that purchases health benefits for 1.2 million people, has enjoyed some better results in negotiating rates for 2005, apparently vindicating its strategy to reduce the number of health plan options and to cut some hospitals from its Blue Shield network. Sutter and the other large hospital systems can absorb the loss of some CalPERS members because these members comprise only a small percentage of these hospitals' total business in most parts of the state. And not all CalPERS members have moved away from those hospitals.

Kaiser Foundation, the largest HMO in the state, continues to add new hospitals and medical offices, although its enrollment growth has leveled off. It has invested in electronic medical records and points to improved efficiency and quality in describing the return on its investment. By many accounts, Kaiser is able to recruit excellent new doctors to practice in its system, while other practices are having difficulty with physician recruitment. Blue Cross and its parent WellPoint Health Network are now combining with Anthem, Inc. The early returns suggest that WellPoint's leaders will play a large role in the combined company (known as WellPoint, Inc.) even if its headquarters are in Indianapolis.

Purchasers are discussed in Section 2.1 and health plans are discussed in Section 2.2.

Data tables and analysis are included in Section 3.0.

2.0 Market Review: Key Organizations

This section of the report provides an overview of the major organizations that finance, deliver, and organize health care and health benefits for most Californians. Organizationally, this summary "follows the money," starting with purchasers, going to health plans, and then to hospital systems and physician organizations.

2.1 Purchasers

Private employers and government agencies face enormous challenges in continuing to provide health insurance benefits to their employees and beneficiaries. Prices continue to rise, with only moderate relief in sight.

In 2003, the Legislature passed SB 2, creating a "pay or play" system of health coverage for many employers. Beginning in 2006, those employers would either pay fees into a state fund to cover the cost of health insurance for their employees (and dependents, for some) or could secure the coverage directly. The SB 2 law was challenged and overturned in a closely watched and hard-fought referendum in November 2004. Although SB 2 was overturned, the debate over the law and the referendum focused attention on the role that purchasers play in a system built around employer-sponsored health insurance.

For many employers, the system of employer-sponsored health insurance imposes a role that they accept reluctantly. Many employers would prefer not to shoulder responsibility for decisions about who is eligible for coverage, which health plan options are offered, and what kind of benefits are included in the plans. In the last few years employers have also faced the challenge of ever-increasing health coverage costs. So far, employers have absorbed most of the annual increases, but many do not believe they can continue to cover the perennially rising costs.

Employers talk increasingly about strategies and benefit plans designed to get consumers more "engaged" in their health care. To quote a frequently voiced complaint: "Consumers don't understand the cost of health care. They think that a prescription costs only the $10 co-payment or that outpatient surgery can be had for a few hundred dollars." If, the logic goes, consumers were more financially engaged in their health care decisions, those decisions would be more efficient, saving money for employers. Following this logic, some employers have tinkered with cost-sharing and implemented small increases for enrollees, either in premiums or in co-payments at the time of care.

A variety of new plans have emerged and are being tested by employers and consumers alike. Many of these plans are built around the notion of a health savings or spending account, which got a big boost from the Medical Modernization Act of 2003. These plans usually involve a spending account for each employee that covers the first $500 or $1,000 of health care received. Once that fund is exhausted, the consumer has to satisfy a deductible — say $2,000 of services. After the deductible is paid, a comprehensive insurance policy typically applies with relatively little cost-sharing. A growing number of employers are offering these plans as a benefit option. Early experience shows that about 5 percent of employees in those companies choose that plan option.

Employers' growing interest in experimenting with cost-sharing increases for employees contributed to a shift away from HMOs, which historically have been limited in their ability to offer plans that incorporate significant cost-sharing. The notion was

Types of Managed Care Plans

Health Maintenance Organizations (HMOs): Prepaid plans that provide comprehensive care to enrollees. Historically, HMO plans have not included significant consumer cost sharing, although that is changing with the introduction of plans with higher deductibles and health savings accounts. An HMO employs or contracts with health care providers. Through those contracts, providers may assume some financial risk for the utilization of care by given enrollees.

Preferred Provider Arrangements or Organizations (PPOs): Used by insurance companies and self-funded employers as a vehicle to contract with a limited panel of providers who agree to a fee schedule (discounted) in anticipation of receiving an increased volume of patients. In self-funded plans, the employer assumes the risk for the costs of medical care, rather than paying an insurer a premium to assume the risk. Those plans are generally not subject to state laws on mandated benefits and allow employers more flexibility in plan design.

The term point-of-service is used differently in different markets. In the context of HMOs, point-of-service plans provide full coverage when using the HMO's provider panel and indemnity coverage, with additional enrollee cost sharing, for services received from providers outside the HMO network. In the context of PPOs or insurance carriers, it also refers to a two-tiered plan for coverage — in and out of network — and usually includes a requirement that enrollees select a primary care physician to coordinate their care and referrals to specialists.

that HMOs provided comprehensive care, and that significant cost-sharing created barriers to access. As a result, much of what is considered innovative in plan design in the past few years has taken place outside of HMOs, and has targeted larger employers that self-fund their employee health benefits. New companies such as Definity Health and Vivius emerged to serve this niche. The Pacific Business Group on Health began to offer Definity's plans to companies in its purchasing coalition in 2003. UnitedHealthcare recently acquired Definity Health. Vivius initiated arrangements with Health Net to market its products in the northwest United States.

Recognizing this trend, HMOs are responding by developing their own plans with innovative cost-sharing arrangements. Kaiser recently won state approval in California to offer plans with $1,000 deductibles that would be marketed with health savings accounts. Other companies are preparing similar offerings, and these new plan designs may well reduce the migration of HMO customers to other plans. However, many of these companies have decided to underwrite these plans through affiliated insurance companies and not through their HMOs. This is done to avoid regulatory complications associated with HMOs.

Purchasing Coalitions: CalPERS and PBGH

The two largest employer purchasers of health care in the state are the California Public Employees' Retirement System (CalPERS) and the Pacific Business Group on Health (PBGH). Both have built coalitions of employers that sponsor benefit plans, for purposes of negotiating health benefit plans with managed care companies. Both organizations are widely recognized not only as innovators in health benefit administration, but also as bellwethers for trends in the health care industry.

Both CalPERS and PBGH represent employers that in the aggregate have very large numbers of employees. These large numbers have given both of them significant power in negotiating with health plans. For much of the 1990s, they consistently had more success than the rest of the market in holding down annual price increases. However, in recent years they have been less successful in fending off the high premium increases that have frustrated other purchasers.

California Public Employees' Retirement System (CalPERS)

CalPERS' primary responsibilities are administration of pension benefits for California state employees and investment of about $171.6 billion in 2004 used to pay those benefits. (That amount is up from about $136 billion in 2002.) The CalPERS board of directors has been in the news over the past year for voting in opposition to the management of certain companies and for challenging executive compensation and other corporate practices.

Of primary interest for purposes of this report is CalPERS' role in administering health benefit plans for state employees and for the employees of about 1,300 local government units. CalPERS spends about $3.3 billion to purchase health benefits on behalf of those government units, making it one of the largest purchasers in the United States.

Exhibit 1 shows enrollment in the CalPERS health plans from 1996 through June of 2004. Total enrollment in all plans has hovered around 1.1 million in the past three years. In 2004, enrollment began to decline, dropping by about 45,000 enrollees. Some 35 local government units dropped out of the purchasing coalition at the end of 2003 over concern about increasing premiums. As of June 2004, about 75 percent of enrollees were in HMOs, 21 percent in PPOs, and 4.7 percent in the association plans.

HMOs. CalPERS was an early proponent of HMOs for its members and offered a dozen or more HMO options for many years. In 2000, however, it began strategically to reduce the number of HMO options and by 2003 offered only two plans statewide: Kaiser and Blue Shield. It also offered Western Health Advantage, a provider-owned plan, in the Sacramento area. Blue Shield surpassed Kaiser in 2003 and now covers 40 percent of the group. Besides the HMOs, which are not available in all counties of the state, CalPERS offers two self-funded PPO plans, for which Blue Cross provides administrative services. CalPERS also administers association plans for about 40,000 law enforcement personnel.

PPOs. Enrollment in CalPERS' PPOs grew steadily through 2003, but has since declined. There were about 100,000 CalPERS enrollees in PPOs in 1996, comprising about 11 percent of the total group. By 2003, PPO enrollment was 224,000, amounting to 21 percent of total enrollment. This number has since dropped to 208,400. Much of the initial growth seemed to result from favorable pricing that made the PPO plans a particularly good deal for enrollees. However, the low prices combined with higher utilization led to dangerously low reserves. In a self-funded arrangement, the employer must maintain reserves that are adequate to pay claims as they are submitted. To make up deficits in the self-funded plans and to build up their reserves, the CalPERS board increased the price of the PPO plans significantly.

EXHIBIT 1. Enrollment in CalPERS Health Plan Options, 1996 to 2004: Active and Retiree Enrollment in Basic Plans

Health Plan	1996	2000	2001	2002	June 2003	June 2004	Change 2004/2003	Share
HMOs	**739,981**	**796,081**	**878,063**	**849,797**	**813,431**	**781,873**	**– 3.90%**	**74.70%**
Aetna Health	23,609	31,124	36,003	0	0	0	NA	NA
Blue Shield HMO*	31,267	44,766	59,478	118,566	435,164	412,042	– 5.30%	40.00%
CIGNA	35,023	27,709	29,232	0	0	0	NA	NA
Health Net	201,886	215,544	223,344	162,924	0	0	NA	NA
Health Plan of the Redwoods	7,738	7,255	7,322	0	0	0	NA	NA
Kaiser Permanente	294,460	324,649	347,866	368,417	373,544	360,996	– 3.40%	34.30%
Maxicare	8,980	8,606	9,546	0	0	0	NA	NA
National	2,696	0	0	0	0	0	NA	NA
PacifiCare	103,014	107,164	130,936	175,574	0	0	NA	NA
Universal Care	0	1,327	5,822	19,135	0	0	NA	NA
Western Health Advantage	0	0	0	5,181	4,723	8,835	87.10%	0.40%
PPOs	**99,538**	**157,486**	**166,243**	**217,372**	**223,745**	**208,400**	**– 6.90%**	**20.60%**
PERS Care	63,359	51,942	39,180	34,874	30,032	25,395	–15.40%	2.80%
PERS Choice	36,179	105,544	127,063	182,498	193,713	183,005	– 5.50%	17.80%
Association Plans	**41,922**	**34,161**	**38,166**	**41,943**	**51,038**	**53,116**	**4.10%**	**4.70%**
California Association of Highway Patrolmen	15,240	18,638	20,401	21,852	22,879	23,002	0.50%	2.10%
California Correction and Peace Officers Association	17,933	9,695	9,426	9,637	17,121	19,459	13.70%	1.60%
Peace Officers Retirement Association of California	4,630	5,828	8,339	10,454	11,038	10,655	– 3.50%	1.00%
TOTAL	**881,441**	**987,728**	**1,082,472**	**1,109,112**	**1,088,214**	**1,043,389**	**– 4.10%**	**100.00%**

NA: Not applicable
*Blue Shield's internal enrollment reports consistently show a higher number of CalPERS lives than CalPERS' own reports.
Source: Author's analysis of CalPERS enrollment reports.

Enrollment in CalPERS PPOs also grew because not all service areas in the state offer an HMO option. In areas where PPOs are the only option, the employers participating in CalPERS had to subsidize enrollees so they would not be at a disadvantage relative to enrollees in other areas. In other words, the different government units agreed to make PPO plans available in those parts of the state at rates comparable to what the employees would contribute for HMO plans.

Although the cost trend for the CalPERS PPOs has been high, PPOs do provide purchasers with an alternative to contracting with providers and managing benefits. In the past, CalPERS considered dropping the rest of its HMOs and moving all enrollees into PPO plans.

Strategic Issues. In 2004, CalPERS decided that it needed to reduce the size of the Blue Shield hospital network. It targeted high-cost hospitals in some parts of the state for removal from the network. Most of these were Sutter Health hospitals, although hospitals from some other systems are also being considered for exclusion, including Cedar-Sinai in Beverly Hills, two Catholic Healthcare West hospitals, and two of the Daughters of Charity hospitals. On its Web site, CalPERS explained: "These hospitals represent the highest-cost providers in the network, which results in increased costs to everyone in the CalPERS Health Program." The network reduction plan was reviewed and largely approved by the Department of Managed Health Care, and is to take effect in January 2005.

CalPERS officials say that the move to a more restrictive hospital network reduced premium increases between 2004 and 2005 by about three percentage points. The CalPERS board approved some modest increases in enrollee cost-sharing for the 2004 plan year in order to mitigate projected premium increases. For 2005, CalPERS employers face average annual premium increases of 10 to 15 percent, down from 16 to 18 percent for 2004.

Coalitions can be difficult to maintain, especially when members believe that they can secure better deals by going out

California Government Agencies Involved with Managed Care

The **Business, Transportation and Housing Agency (BTH)** (www.bth.ca.gov) is responsible for regulating managed care plans, among other duties. Among the agency's 13 departments are the Department of Corporations and the **Department of Managed Health Care (DMHC)** (www.dmhc.ca.gov), which was created as part of a broad, managed care reform package enacted January 1, 2000. The department formally began its responsibilities July 1, 2000. In addition to general regulatory and licensing powers, the DMHC's mandates and responsibilities include prevention rights, advisory boards, public education campaigns, new lines of communications with health plans, safeguards for financial solvency, and an Office of the Patient Advocate.

The **California Department of Insurance** (www.insurance.ca.gov) regulates insurers and licenses insurance agents and brokers. The department also provides consumer information and assistance concerning insurance issues.

The **California Health and Human Service Agency** (www.chhs.ca.gov) administers state and federal programs for health care and social services. Programs are administered through the agency's 15 boards and departments including the **Department of Health Services and the Office of Statewide Health Planning and Development (DHS)** (www.dhs.ca.gov). The DHS operates California's Medicaid program, Medi-Cal, and is responsible for coordination and direction of its eligibility, benefit and reimbursement components as well as for developing partnerships with providers and medical service organizations to encourage organized health care delivery systems.

on their own. In particular, regional price issues have become a concern to local governments. Local governments in southern California have argued that since health care costs, particularly for hospital care, are lower in their region than in the north, they are, in effect, unfairly subsidizing government units in northern California.

In March 2004, the CalPERS board approved the concept of setting regional rates for as many as five different regions in the state. For the 2005 plan year, CalPERS moved forward and adopted five regional rates for contracting agencies, resulting in a wide range of premiums. For example, family coverage for Blue Shield in the Bay Area and Sacramento will cost $1,014 per month. The same coverage will cost only $748 per month in Los Angeles and some nearby counties. Yet units of state government will continue to pay a uniform rate statewide. Public employee unions strongly opposed the pricing change, but others view it as a necessary measure to stem the outflow of participating local governments.

Looking forward, the CalPERS board has set a number of goals for the health plans, including an increased emphasis on disease management and quality initiatives. Health plans have sought to justify large premium increases by showing that CalPERS enrollees are relatively high utilizers of care. CalPERS will seek to moderate annual premium increases by entering into multi-year contracts with Blue Shield. At this point, CalPERS expects to continue working with HMOs, although it is unlikely to add new plan options.

Pacific Business Group on Health (PBGH)

Nearly 50 large companies are members of PBGH and many, though not all, purchase their employee health benefits through PBGH. PBGH disseminates comparative information on health plans—and now provider groups—through its HealthScope Web site at www.healthscope.org. To extend the benefits of its purchasing expertise to smaller employers, PBGH successfully bid to take over administration of the state's health insurance purchasing pool, renamed it PacAdvantage, and now markets to small and medium-sized employers.

PBGH is a founding member of several collaboratives that collect quality data on health plans, and survey enrollees on their satisfaction with health plans and medical groups in the state. For example, almost all of the California hospital systems participated in the Leapfrog survey in its first year, in part because PBGH threw its considerable weight behind the initiative. (Leapfrog is a coalition of 145 private and public health benefit purchasers that joined together to improve patient safety and quality of care in hospitals. See www.leapfroggroup.org.) Since then Leapfrog has teamed up with the National Quality Forum and has surveyed hospitals on their compliance with 30 safety improvement standards. PBGH reported the results of that survey in November 2004, and some health plans are making the results available to enrollees to help them compare hospitals. Similarly, PBGH was an early proponent of the Pay for Performance initiative developed by the Integrated Healthcare Association.

The Pay for Performance initiative is described in Section 2.4.

2.2 Health Plans

More than in other states, health insurance offerings in California have moved to a point where most of the insured population is covered by plans in which enrollees have incentives to use specific providers. Few continue to have a cost-free choice of seeing any provider under indemnity coverage. Employers that provide health insurance usually contract with health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

See the sidebar, "Types of Managed Care Plans" on page 7, for a description of these two types of plans.

California employers use HMOs more than their counterparts in other states. About 13 million Californians, or 37 percent of the state's population, are enrolled in commercial HMO

plans. HMO penetration in the state is also relatively high for seniors and for beneficiaries of state assistance programs.

Even so, a growing number of employers and consumers have migrated from HMOs to PPO plans. National data from the 2004 Kaiser Family Foundation/HRET survey show that 55 percent of employees were enrolled in PPO plans, a significant increase from 46 percent in 2001. The percentage of California workers in PPO plans increased from 29 percent in 2003 to 36 percent in 2004. That shift has occurred steadily over the past three years. In 2001, only 25 percent of California workers were in PPOs and 54 percent were in HMOs. (Kaiser/HRET California Employer Health Benefits Survey, 2003.)

Regulatory Agencies

Oversight of health insurance in California is divided between two state agencies.

1) **The California Department of Managed Health Care (DMHC)** is the state's regulator of HMOs. (The Knox-Keene Act, California's primary law governing HMOs, uses the term "health care service plans.") The DMHC was created in 1999 and took over HMO regulation from the Department of Corporations in 2000. Advisory boards work with the DMHC on issues such as quality and health plan solvency.
2) **The Department of Insurance** regulates some California PPOs and indemnity insurance plans.

While the Department of Insurance's jurisdiction is somewhat limited, it had a significant impact on the final details of Anthem's acquisition of WellPoint Health Networks. After Anthem had secured approvals from all other federal and state regulators, including the California Department of Managed Health Care, the Department of Insurance announced that it would not approve the transaction, saying that it was too costly to California consumers. Anthem sued to overturn that decision, but eventually reached an agreement with the Department of Insurance that allowed the deal to be completed. The combined company is called WellPoint, Inc.

From time to time legislators and others have proposed that all health insurance regulation be combined in a single agency, so that state government would provide consistent oversight and speak with one voice. So far, those proposals have not prevailed. The California Performance Review (http://cpr.ca.gov), a massive proposal for state government reorganization, proposed that the state reduce its oversight of managed care plans and rely more on the work of outside accreditation bodies like NCQA (the National Committee for Quality Assurance). In response, the Department of Managed Health Care began a preliminary assessment of large commercial HMO plans, using the results of NCQA surveys in place of state surveys. It determined that there is overlap between NCQA standards and the Department's own regulations. To proponents of streamlining, this is evidence that the state should accept the results of the NCQA surveys and redirect state resources to areas of problematic performance or unique California requirements.

California regulators have historically limited the ability of provider groups to accept capitation risk for services that they did not provide. During the 1990s, however, California issued health plan licenses to provider organizations that wanted to take full capitation risk. These were called Knox-Keene licenses with waivers. While a handful of those plans are still operating, several of them failed spectacularly in 1998 and 1999, resulting in significant disruption for patients and providers alike. Some others later decided to go out of business, but five of those licensed plans are still in active operation. The still-active plans in this group are listed in the exhibits in this report as "Limited License Health Plans."

State Government Agencies, cont.

The **Managed Risk Medical Insurance Board (MRMIB)** (www.mrmib.ca.gov) administers programs that help to fill the uninsured gap. Its original program is a risk pool for persons turned down in the private insurance market. It now administers the Healthy Families program of subsidized health insurance; previously it managed the Health Insurance Plan of California, a small-business insurance purchasing initiative.

The **Office of Statewide Health Planning and Development** (www.oshpd.state.ca.us), also under the jurisdiction of the California Health and Human Services Agency, plans and supports the development of health care systems to meet current and future needs of the state. In addition to collecting and analyzing data about hospitals, clinics, and other health-related facilities, the office has a hospital building safety program, a loan insurance program for not-for-profit facilities, and a program to support health professional training.

The **California Public Employees Retirement Association (CalPERS)** (www.calpers.ca.gov) manages a health benefits program with more than one million members. It is the second-largest purchaser of health care benefits in the nation, after the Federal Employees' Health Benefits Program. The Public Employees' Medical and Hospital Care Act governs the benefit program. CalPERS is administered by a board of directors. The program was established in 1962 for employees of the state. In 1967, other public employers were allowed to join the program on a contract basis and about 1,200 other public employers now participate in the program.

State Government Agencies, cont.

The **California State Teachers Retirement System (CALSTRS)** (www.calstrs.ca.gov) contracts for health insurance and other benefits for active and retired teachers. The state **Department of Personnel Administration** (www.dpa.ca.gov) manages the benefits for state employees.

In California, counties have been providing health care services for almost 150 years. Several counties own and operate hospitals that serve as a safety net for uninsured people seeking medical care. A handful of county health departments also administer publicly funded health care plans and provide health plan benefits for county employees. Counties that contract with the state to manage services for Medi-Cal include:

- San Mateo (Health Plan of San Mateo)
- Solano and Napa (Partnership Health Plan of California)
- Santa Cruz (Santa Cruz County Health Options)
- Santa Barbara (Santa Barbara Health Authority), and
- Orange (CalOPTIMA).

HMOs

Exhibit 2 presents an overview of California HMOs, grouped into three categories: standard plans, county-sponsored plans, and limited license health plans. The table includes basic financial and enrollment information about these health plans and, when available, their Web site addresses.

1) The first group, **standard plans,** includes a variety of plans, some national and others doing business in California only. Four of the largest managed care companies in the United States are based in California: Blue Cross (part of WellPoint, Inc.), Health Net, Kaiser Permanente, and PacifiCare. Most of these HMOs are investor-owned, but a few — notably Kaiser and Blue Shield — are organized as nonprofit organizations. While almost all of these HMOs serve commercial groups, a few do not contract with employers but only with the state for its Medi-Cal and Healthy Families programs.
2) The second category, **county-sponsored health plans,** includes 13 HMOs that are organized by county governments to serve enrollees in Medi-Cal managed care and in Healthy Families. Some of them are County Operated Health Systems, which operate all Medi-Cal managed care in those counties. The others are local initiative county plans that compete with plans run by commercial HMOs in their respective counties.

   Additional details about HMOs serving the Medi-Cal population are found below, and in Section 3.
3) Finally, the third category of HMOs in Exhibit 2, **limited license health plans,** comprises the provider-sponsored organizations that have a Knox-Keene license with waivers. Some of those are small or inactive. Only five still had enrollees in 2003, including three large groups operating in southern California: Heritage Provider Network, PrimeCare Medical Network, and Scripps Health Plan Services in San Diego. The Cedars-Sinai Provider Plan reported no enrollment in 2004.

The number of plans doing commercial business in the state has decreased for a variety of reasons including insolvency, acquisition and changes in core business strategies, which was the case for UnitedHealthcare. United gave up its HMO license four years ago and has focused on its PPO plans for self-funded employers.

California has experienced several major health plan insolvencies so far in this decade. Four plans were liquidated or closed their doors: Health Plan of the Redwoods, Lifeguard, Maxicare of California, and Tower Health are out of business. WATTSHealth has recovered, although it no longer operates in Orange County.

As of December 2003, 19.1 million Californians, or about 56 percent of the population, were enrolled in insured HMO plans through full-service health plans. Other sources may cite a different number for total HMO enrollment in the state, depending on their treatment of PPO or self-funded employer plans operated by companies like Blue Cross and CIGNA. The analysis in this report focuses on insured enrollment in HMOs and generally does not include enrollment in other kinds of managed care arrangements, such as PPOs. Still, the overlap of health plan product lines is important, and many of the HMOs discussed here are also administering benefit plans with PPO networks.

EXHIBIT 2. California HMOs at a Glance, 2003 to 2004

Health Plan (Web site)	Headquarters	Owner/Manager/ Other Affiliation	Year Begun as an HMO	HMO Enrollment in June 2004	2003 Net Income/Loss Margin	Historical Notes
Standard Plans						
Aetna Health of California www.aetna.com	San Ramon	Aetna Health, Inc. Hartford, CT	1981	319,527	$56,974,515 5.50%	Acquired Prudential Health Care in 1999.
Blue Cross of California www.bluecrossca.com	Woodland Hills	WellPoint Health Networks Thousand Oaks, CA	1993	2,931,016	780,898,100 7.80%	Acquired membership of Omni Healthcare (Sacramento) in 1999.
Blue Shield of California www.blueshieldca.com	San Francisco	California Physicians' Service	1978	2,691,562	100,817,649 1.70%	Organized as California Physicians' Service; acquired CareAmerica in 1998.
Care 1st Health Plan www.care1st.com	Alhambra		1995	159,725	5,860,684 2.60%	
CareMore Insurance Services www.caremoremedical.com	Cerritos	CareMore Medical Group	2002	1,538	NA	Doing business as California Medical Advantage.
Chinese Community Health Plan www.cchphmo.com	San Francisco		1987	11,280	862,495 1.80%	
CIGNA HealthCare of California www.cigna.com	Glendale	CIGNA Healthcare, Inc. Philadelphia, PA	1978	87,684	6,746,713 0.50%	Formerly Ross Loos Health Plan and Equicor.
Community Health Group www.chgsd.com	Chula Vista		1985	101,762	– 2,347,769 – 2.10%	
Community Health Plan www.ladhs.org/chp	Los Angeles	LA County Department of Health Services	1985	162,366	24,557,648 11.90%	
Great-West Health Care www.onehealthplan.com	San Jose	Great-West Life Assurance Co., Englewood, CO	1996	55,039	3,765,352 2.30%	
Health Net www.health.net	Woodland Hills	Health Net (formerly Foundation Health Systems)	1979	1,958,768	204,958,681 3.60%	Merged with Foundation Health of California.
Inter Valley Health Plan www.ivhp.com	Pomona		1979	14,360	866,379 0.70%	Only Medicare business
Kaiser Foundation Health Plan, Inc. www.kaiserpermanente.org	Oakland		1977*	6,414,145	995,566,000 3.90%	
Molina Healthcare of California www.molinahealthcare.com	Long Beach	Molina Healthcare, Inc.	1994	245,187	13,538,844 4.30%	
On Lok Senior Health Plan www.onlok.org	San Francisco		1999*	943	3,214,163 5.90%	
PacifiCare of California www.pacificare.com	Cypress	PacifiCare Health Systems	1975	1,736,142	196,193,678 3.40%	Acquired FHP, which had acquired TakeCare in 1994.
SCAN Health Plan www.scanhealthplan.com	Long Beach		1984	61,078	115,712,471 18.40%	
Sharp Health Plan www.sharp.com	San Diego		1992	124,559	– 138,768 – 0.10%	
Sistemas Medicos Nacionales, S.A. de C.V. www.simnsa.com/index2.htm	San Diego	Simnsa Health Care Tijuana, Mexico	2000	14,098	134,237 1.40%	
UC San Diego Health Plan	San Diego	Regents of the University of California	1997	0	– 3,173,818 –19.10%	Acquired Comp Care Health Plan, a Medi-Cal Primary Care Case Management arrangement, in 1998. Ended Medi-Cal HMO business in 2003.

NA: Not Available.
*On Lok Senior Health Services commenced business in 1971, Kaiser in 1955.

EXHIBIT 2. California HMOs at a Glance, 2003 to 2004, cont.

Health Plan (Web site)	Headquarters	Owner/Manager/ Other Affiliation	Year Begun as an HMO	HMO Enrollment in June 2004	2003 Net Income/Loss Margin	Historical Notes
Standard Plans, cont.						
Universal Care www.universalcare.com	Signal Hill	Howard E. Davis	1985	285,940	$– 4,257,198 – 0.9%	Includes enrollees absorbed from Great American Health Plan and Health Max America/HMO California.
Valley Health Plan http://claraweb.co.santa-clara.ca.us/vhp/	San Jose	Santa Clara County	1985	58,066	357,105 0.5%	Formed to serve Santa Clara County employees and retirees.
Ventura County Health Care Plan www.vchca.org/hcp/index.htm	Ventura	Ventura County	1996	10,638	271,237 1.8%	
WATTSHealth (UHP Healthcare) www.uhphealthcare.com	Los Angeles	WATTS Health Foundation	1978	80,419	26,728,000 11.7%	State regulators took control in August 2001. Conservatorship was terminated by court order in November 2003.
Western Health Advantage www.westernhealth.com	Sacramento	Sponsored by Mercy Healthcare Sacramento, NorthBay Healthcare System and the University of California Davis Health System	1997	71,664	603,849 0.5%	
County Organized Health Systems and Local Initiative Plans						
Alameda Alliance for Health www.alamedaalliance.com	Alameda	Alameda County	1995	98,887	$– 8,309,022 – 6.5%	
CalOptima www.caloptima.org	Orange	Orange County Organized Health System	2000	296,667	1,245,039 0.2%	Formal name is Orange Prevention and Treatment Integrated.
Central Coast Alliance for Health www.ccah-alliance.org	Santa Cruz	Santa Cruz-Monterey Managed Medical Commission	2000	83,547	1,481,373 0.7%	
Contra Costa Health Plan www.cchealth.org/health_plan/	Martinez	Contra Costa County Health Services Department	1973	58,939	3,772,129 3.1%	
Inland Empire Health Plan ww2.iehp.org/iehp	San Bernardino	Joint powers agreement agency created by San Bernardino and Riverside Counties	1996	278,642	5,362,826 1.8%	
Kern Health Systems	Bakersfield		1995	84,439	329,104 0.4%	
LA Care (Local Initiative Health Authority) www.lacare.org	Los Angeles	Local Initiative Health Authority for Los Angeles County	1997	30,141	23,960,307 2.4%	
Partnership Health Plan of California www.partnershiphp.org	Suisun City	Solano-Napa Commission on Medical Care	1994	81,506	NA	Also serves Medi-Cal recipients in Yolo County.
San Francisco Health Plan www.sfhp.org	San Francisco	San Francisco Health Authority	1996	46,981	3,020,508 4.9%	
San Joaquin County Health (Health Plan of San Joaquin) www.hpsj.com	Stockton	San Joaquin County Health Commission	1996	68,246	3,467,886 4.3%	
San Mateo Health Commission (Health Plan of San Mateo) www.hpsm.org	South San Francisco	San Mateo Health Commission	1998	54,334	0.00 0.0%	
Santa Barbara Health Initiative www.sbrha.org	Goleta	Santa Barbara County Special Healthcare Authority	2000	55,725	8,265,605 5.6%	

NA: Not Available.

EXHIBIT 2. California HMOs at a Glance, 2003 to 2004, cont.

Health Plan (Web site)	Headquarters	Owner/Manager/ Other Affiliation	Year Begun as an HMO	HMO Enrollment in June 2004	2003 Net Income/Loss Margin	Historical Notes
County Organized Health Systems and Local Initiative Plans, cont.						
Santa Clara Family Health Plan www.scfhp.com	San Jose	Santa Clara County Health Authority	1996	96,665	$4,271,758 3.7%	
Limited License Health Plans						
Cedars-Sinai Provider Plan, LLC www.csmc.edu	Los Angeles	Cedars-Sinai Medical Center, Los Angeles	1998	0	$62,853 14.3%	No enrollees as of June 2003
Heritage Provider Network www.heritageprovidernetwork.com	Reseda		1997	259,089	1,876,721 0.4%	
PrimeCare Medical Network www.nammcal.com	Ontario	North American Medical Management, California	1998	237,005	6,315,771 2.2%	
ProMed Health Care Administrators www.promedhealth.com	Upland	ProMed Health Services Company	1999	NA	1,530,549 11.1%	
Scripps Clinic Health Plan Services www.scrippshealth.org	La Jolla	Scripps Clinic	1999	39,525	22,264 0.0%	

NA: Not available.

Other full service plans terminated in the past three years: Tower Health, MaxiCare of California, Great American Health Plan (San Diego), Greater Pacific (San Francisco), HealthMax America, Health Plan of the Redwoods, National Med. Knox-Keene plans with waivers terminated in past three years: California Pacific Medical Group (San Francisco), Concentrated Care (Salinas), FPA Medical Management (San Diego), MedPartners Provider Network (Long Beach), Monarch Plan, Priority Plus, St. Joseph's Provider Network, THIPA Management Consultants (Torrance).

Source: Author's analysis of HMO annual and quarterly statements.

Exhibit 3 on the following page shows the market share of California HMOs as of June 2004. Kaiser Permanente remains the largest plan in the state, with 33.9 percent of enrollment. Blue Cross is second largest, with 15.5 percent. Blue Shield has grown by adding CalPERS members at the expense of PacifiCare and Health Net. Blue Shield now has 14.2 percent of the HMO market, while Health Net has 10.3 percent and PacifiCare is in fifth place with 9.2 percent.

Significantly, four of the ten largest HMOs in the state are serving public programs, including Medi-Cal and Healthy Families. While CalOptima and Inland Empire operate in only one or two counties, Molina Healthcare has public program enrollment in several counties. It has grown in California and in four other states through acquisitions. In December 2004 it announced that in 2005 it would take over the Medi-Cal and Healthy Families enrollment that Universal Care and Sharp Health Care have in San Diego County. This change would affect about 107,000 enrollees.

Medicare HMOs and Medi-Cal managed care plans are discussed in Sections 3.3 and 3.4.

At the end of 2003, the four largest HMOs had 73.7 percent of the HMO market. The sidebar on the following page, compares HMO market concentration in California and eight other states, measuring the proportion of HMO enrollees in the four largest plans in each state. HMO enrollment in California has become somewhat more concentrated in recent years so that it is now among the more highly concentrated states. Other states have become less concentrated on the HMO side (Ohio is an example) because their largest plans shifted their emphasis away from insured HMO plans and toward PPO arrangements.

Kaiser Permanente controls one-third of the HMO market in the state and continues to have an enormous impact on the market. It is the largest Medicare HMO in the state, but has only a small program for Medi-Cal. It had strong net income in 2003 and is investing in electronic medical records and construction of new hospitals and health centers. Kaiser is expanding its geographic reach and, in some cases, challenging locally dominant hospitals by building new hospitals nearby. As noted earlier, the organization is making changes to expand plan financing options for employers. It will offer plans with higher deductibles in an effort to retain or win accounts with employers who think that comprehensive HMO coverage is too broad and too costly.

WellPoint Health Networks, the parent of Blue Cross of California, has grown its California operations and continued its national expansion. It has now combined with Anthem Blue Cross Blue Shield to form WellPoint, Inc., a $21.8 billion company with 26 million enrollees that is based in Indianapolis.

HMO Market Concentration

Portion of HMO enrollees in each state enrolled in the four largest HMOs at the end of 2003 and 2002.

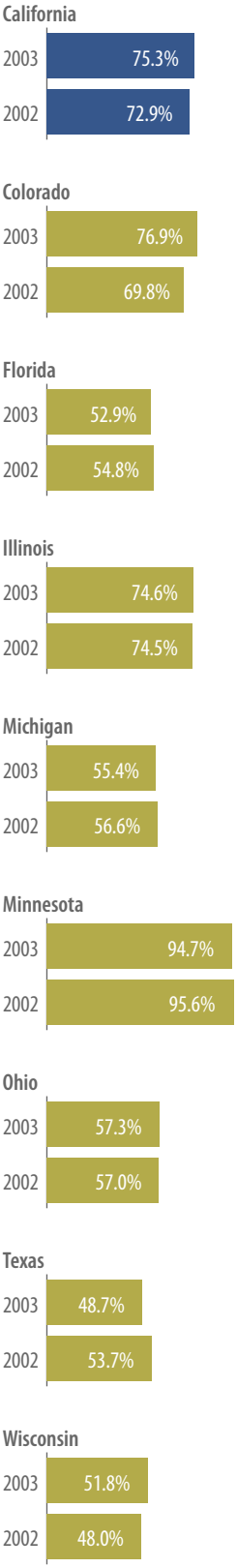
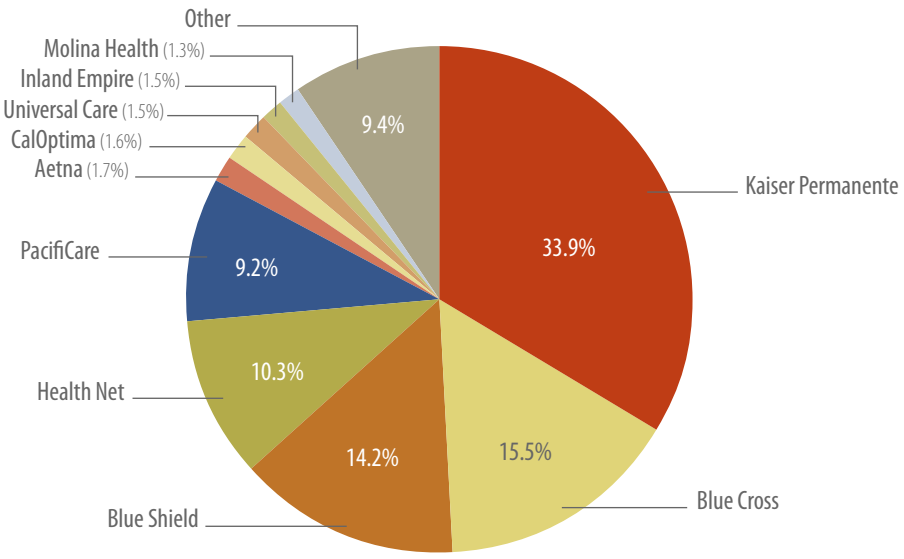


EXHIBIT 3. Market Share of California HMOs, June 2004



Source: Author's analysis of HMO quarterly statements, June 2004.

It has now become the largest health insurance company in the country, leaping over UnitedHealthcare. WellPoint has been acquiring Blue Cross and other plans aggressively for the past 10 years. After acquiring the Blue Cross Blue Shield plan of Georgia, it bought health plans in three contiguous states in the Midwest. First it acquired the Rush-Prudential HMO in Chicago, which it operates as UniCare Health Plans of the Midwest. Then it acquired Blue Cross Blue Shield of Missouri, known as RightCHOICE. In 2003 it acquired Cobalt, the Blue Cross Blue Shield United plan of Wisconsin. It operates as UniCare in Texas where it acquired the Methodist Care HMO, a provider-sponsored health plan based in Houston.

From its base in the east central part of the country (Blue Cross plans in Indiana, southern Ohio and Kentucky), Anthem added Blue Cross plans in three New England states and Trigon in Virginia. It was turned away by the state insurance commissioner (who was later elected governor) when it tried to convert and then acquire the Kansas Blue Cross plan.

What are some implications of the Anthem-WellPoint deal? The two companies do not overlap much in their HMO operations. In California, WellPoint has distinguished itself through its successful operations of Medicaid managed care (it is by far the largest plan here), and in designing and marketing plans to small businesses. Both of these market segments may provide opportunities in Anthem states like Ohio. When WellPoint made its acquisitions in the past, it usually retained much of the senior staff in its acquired health plans but centralized certain accounting activities and other functions. It would apply its California expertise in actuarial, product design, and marketing to the acquired plans.

The Anthem-WellPoint combination may also strengthen the company's position in marketing to large employers. UnitedHealthcare has been particularly successful in selling plan administration services to large employers that self-fund their benefits and that have employees in sites across the country. United offers them a chance to deal with a single plan administrator with national provider networks. It completed its acquisition of Oxford Health Plans in New York and Connecticut in July 2004, in part to improve its access to the many large companies with headquarters in those states.

The completion of the Anthem-WellPoint deal also means that the price of acquiring Blue Cross plans in other states has probably declined sharply. WellPoint and Anthem competed to acquire Blue Cross Blue Shield of Colorado (which includes the Blue Cross plan for Nevada) a few years ago and Anthem prevailed, but their competition helped drive up the price. Of course, it is not clear whether there will be more conversions or acquisitions in the near future. Besides the Blue Cross plans mentioned above, proposed Blue Cross conversions were blocked or dropped in places like Washington state and New Jersey in the past two years.

PPOs

PPO plans can be divided into insured and self-funded arrangements. An employer buying an insured PPO plan pays premiums to an insurance company. Employees receive the highest benefits within the preferred provider network, but can also receive benefits while using providers outside the network by paying additional co-payments and deductibles.

In a self-funded plan, the employer sets aside funds to pay claims for services received by the covered employees. These reserve funds are maintained based on estimates of future claims. An HMO, insurance company, or other plan administrator will provide certain administrative services including member enrollment, provider network management, and claims payment. The employer may buy insurance to protect against large claims or catastrophic cases. These arrangements are sometimes called Administrative Services Only (ASO).

A larger employer may find it advantageous to self-fund its plans for several reasons. It can benefit from the "float" of its benefit dollars, meaning that it can hold on to those funds and earn interest until it is time to pay the claims. In addition, the employer has more flexibility to design its benefit plans since self-funded plans are generally exempt from state laws mandating benefits (such as state laws mandating chemical dependency inpatient care coverage, dependent coverage, or mandating access to certain providers such as chiropractors). By self-funding its benefit plan, a company with locations in several states can also simplify plan administration. Some health plan companies, including UnitedHealthcare and some of the Blue Cross plans, focus on that market segment, competing for business from those large, self-funded employers that operate in more than one state.

Blue Cross of California is the largest administrator of PPO arrangements in California. National managed care companies like Aetna Health and UnitedHealthcare (through its Uniprise business group) have many employer groups in PPOs, many of them in self-funded arrangements. National PPO companies also have proprietary networks in California, including Private Healthcare Systems, Beech Street PPO, and ppoNEXT. Some California provider groups also operate PPO networks for use by plan administrators, including Southern California Preferred Physician Medical Group and the California Foundation for Medical Care.

2.3 Hospital Systems and Networks

A forest of construction cranes is a common sight at new and existing hospital campuses around California. As was described in the 2004 report, a significant amount of new hospital construction is underway. Much of it reflects the steady progress of the state's hospitals toward compliance with California's requirements that hospitals be able to withstand the next major earthquakes to hit the state. (California Senate Bill 1953, enacted in 1994.)

The extensive new construction also reflects a change in attitude about what constitutes an adequate (or surplus) supply of hospital facilities. After years of declining utilization rates for inpatient hospital care, those rates have been trending upward of late.

Increasing utilization, due partly to an aging population with more health care needs and changes in financial incentives facing physicians and hospitals, is discussed in more detail in Section 3.13.

But new construction also reflects market competition. A strong hospital system may add new specialty units to retain its star surgeons and cardiologists or to cement its dominant market position in a certain area. Or a hospital may want or need to challenge the locally dominant hospitals, as is the case with some of the facilities that Kaiser Foundation plans to build. Even within tightly integrated hospital systems, the individual hospitals and the doctors that practice in them still strongly influence clinical services at each hospital. Besides operating several hospitals, a hospital system might also add other lines of business by acquiring or operating physician clinics, home health agencies, skilled nursing facilities, and other services.

There is wide variation in how hospitals are connected, including types of governance, ownership, integration of administration and of clinical services, and so on. Hospital systems, as compared to hospital networks, are more tightly integrated in some aspects of operation, such as ownership and administrative governance. Administration is largely centralized — e.g., a single chief financial officer for the system instead of a CFO at every hospital. Some systems seek to promote a unified brand in their advertisements and signage. To the extent they can develop

Who Represents Providers in California?

The **California Medical Association (CMA)** (www.cmanet.org), representing more than 34,000 physicians, promotes the science and art of medicine and is dedicated to the care and well-being of patients. The CMA actively represents physicians in legislative and litigation matters.

The **Integrated Healthcare Association** (www.iha.org) is a leadership group with members from health plans, physician groups, and health systems, and at-large representation from academic, purchaser, pharmaceutical industry, and consumer interests. The group is involved in policy development and special projects around integrated health care and managed care. In recent years, it has been the driving force behind Pay for Performance initiatives.

The **California Association of Physician Groups** (www.capg.org) represents 149 integrated medical groups and independent practice associations. It was formed in 2001, bringing together associations that had previously represented physician organizations.

The **California Hospital Association (CHA)** (www.calhealth.org) based in Sacramento, represents the interests of nearly 600 hospital, health system, and physician group members, and more than 200 affiliate and personal members. CHA has three corporate members: the Hospital Council of Northern and Central California, the Healthcare Association of Southern California, and the Healthcare Association of San Diego and Imperial Counties. CHA provides state and federal representation in legislative and regulatory arenas.

a positive identification with the public, they can strengthen their hand in negotiations with managed care companies. In San Diego, the Sharp and Scripps hospitals are regarded as strongly integrated hospital systems.

A network of hospitals is more loosely affiliated than a hospital system, and usually maintains separate ownership and board governance for participating hospitals. Networked hospitals come together for specific administrative functions, which usually include negotiation of managed care contracts. It is not unusual for networks of hospitals to go their separate ways when the value of working together is not compelling.

Hospitals have come together, whether in integrated systems or loose networks, in order to regain economic power previously lost to HMOs. During the heyday of HMOs, hospitals and physicians worried that they would lose access to patients if they did not accept HMO contracts, even when they thought that payment was inadequate. Through system-building and more strategic negotiation, hospitals now send the message to managed care companies that the HMOs need those hospitals in order to sell insurance, either because of the hospitals' geographic dominance, their brand names, or sometimes both. Examples of regionally dominant hospital systems include the John Muir/Mt. Diablo hospitals in Contra Costa County and the St. Joseph hospitals in Orange County.

Hospital systems and networks have used their renewed economic power in a variety of ways. First, they have insisted that HMOs negotiate system-wide contracts and agree to use all hospitals and services in the system or network. This was a significant issue years ago when HMOs wanted to be more selective in their contracting. It has become less of an issue now, with HMOs wanting to offer broader networks and showing less interest in selective contracting. Today their employer customers want access to broad networks of physicians and hospitals, and HMOs rarely object to contracting with numerous hospitals. However, signing a contract is no guarantee that many members of an HMO will actually go to a certain hospital. Member use of hospitals is still largely steered by the admitting patterns of the physicians. It is in this context that the move by CalPERS to have hospitals excluded from the Blue Shield HMO was so significant.

Second, hospitals have used their economic power to change the terms of contracts. Most of the major hospital systems in California have limited their acceptance of risk by ending their participation in global capitation arrangements in which they and local medical groups had shared in health plan payments, downside risk and upside rewards.

The analysis in this report examines California's hospital systems based on affiliations during 2003. System affiliations change through acquisitions and through decisions to end affiliations. In last year's report it was noted that the Daughters of Charity had withdrawn seven hospitals from Catholic Healthcare West that were now operating as a separate system. In the last few years, the major for-profit hospitals systems have undergone significant changes. In 2002 and 2003, Tenet Health was still in acquisition mode and had acquired two Los Angeles area hospitals from the Carondolet system and announced plans to close one of them. In 2004, Tenet Health, facing declining earnings, federal investigations, and other issues, announced a plan to downsize its system and put several of its California hospitals up for sale.

More detailed information on the acute care hospitals, including their revenues, net income, occupancy, and payer mix, is presented in Section 4.0.

Dominant Hospital Systems

Exhibit 4 provides an overview of the largest hospital systems in California. The analysis in this section is based on data collected and disseminated by the state Office of Statewide Health Planning and Development (OSHPD). The data used were reported by the hospitals for their fiscal years ending between January

and December of 2003. (There is a lag before the data from each reporting year are submitted, reviewed, and then made available to the public.) This analysis is generally limited to acute care hospitals and does not include specialty hospitals for rehabilitation, long-term care, or mental health; state facilities for people with mental illness or developmental disabilities; or hospitals operated by the U.S. Department of Veterans Affairs or other federal agencies.

The size of hospital systems can be compared using several different measures. The analysis in this report uses a combination of three measures:

1) **inpatient hospital beds** (based on staffed beds as reported by the hospitals)
2) **inpatient hospital days,** and
3) **net patient revenues,** which is the amount that hospitals actually collected after discounts to Medicare, Medicaid, and insurers, and after allowances for uncompensated care provided.

Analysts use different measures or combinations of measures and will also use different definitions of the relevant local market, both in terms of geographic area or specialized products. For example, the geographic market for specialized pediatric care in children's hospitals might be different than the geographic market for other acute care services. For the most part, this analysis uses relatively broad geographic areas for the local market analysis and does not attempt to distinguish the market for specialty services.

As shown in Exhibit 4, the three largest hospital systems in California are Catholic Healthcare West, Kaiser Permanente, and Tenet Health. Sutter Health is close behind and the University of California hospitals, if combined, would round out the top five. Based on the 2003 data, Tenet has the most inpatient beds and the most inpatient hospital days. However, Kaiser Foundation reported the highest net patient revenues (billed charges less discounts): $6.4 billion, compared to $4.5 billion at Tenet and $3.5 billion for Catholic Healthcare West. All of the large hospital systems reported positive net income for 2003, though Tenet had the best results of the major systems. It had net income of $706.7 million on patient revenues of $4.5 billion.

Of the three largest systems, Catholic Healthcare West and Kaiser come closest to a statewide presence. Catholic Healthcare West (CHW) has its headquarters in San Francisco. It was formed by Catholic health organizations that retained ownership of their hospitals but created CHW to gain operating efficiencies and brand recognition. It now has about 35 hospitals in the state.

Kaiser provides most care, though not all, to its HMO members at its own facilities. Kaiser's 28 hospitals are mostly in the San Francisco Bay Area and Los Angeles, though it also has hospitals in other areas including Sacramento, Fresno, Santa Rosa, and San Diego. Where it doesn't have its own hospital, Kaiser contracts with community hospitals for inpatient care. For example, in northern San Diego County, it uses the Palomar Pomerado hospitals for inpatient care (though it has not ruled out adding its own hospital there in the future).

During a brief period in the late 1990s Kaiser reduced its investment in new facilities and contracted out for more member care. That strategy did not work; buying service from other providers at a time when Kaiser's health plan enrollment was growing proved to be very expensive. Kaiser has now launched very ambitious plans to construct new facilities in the state. It plans major expansions to several of its hospital locations including Sacramento, and will build new hospitals in some communities where it has had difficulty negotiating rates with a locally dominant hospital. In interviews last year, Kaiser leaders said that their analysis shows that building new facilities will offer a very quick payback compared with the cost of contracting with external hospitals.

In 2003, the Kaiser hospitals had net income of $673.2 million on patient revenues

Provider Representives, cont.

The **Hospital Council of Northern and Central California** (www.hcncc.org) is a nonprofit hospital and health system trade association representing more than 200 hospitals in 50 counties. Membership ranges from rural hospitals to large urban medical centers representing more than 38,000 licensed beds. Established in 1961, the organization provides legislative and regulatory advocacy.

Established in 1923, the **Healthcare Association of Southern California** (www.hasc.org) represents more than 170 hospitals in six counties. The association provides technical and information services, as well as advocacy. It has two affiliates: AllHealth, a for-profit subsidiary that provides business and consulting services, and the National Health Foundation, a charitable affiliate working to improve access to quality health care for the underserved.

EXHIBIT 4. Largest California Hospital Systems at a Glance, 2003

System and Locations	Staffed Beds	Inpatient Days	Inpatient Occupancy	Outpatient Visits	Net Patient Revenue	Net Income
Adventist www.adventisthealth.org	1,996	540,407	62.3%	1,716,752	$1,168,780,193	$23,477,910
15 Central Valley General Hospital (Hanford), Frank R. Howard Memorial Hospital (Willits), Glendale Adventist Medical Center, Hanford Community Hospital, Paradise Valley Hospital (National City), Redbud Community Hospital (Clearlake), Selma District Hospital, Simi Valley Hospital–Sycamore (Simi Valley), Sonora Community Hospital, South Coast Medical Center (South Laguna), St. Helena Hospital & Health Center (Deer Park), Ukiah Valley Medical Center, White Memorial Medical Center (Los Angeles), San Joaquin Community Hospital (Bakersfield)						
Catholic Healthcare West www.chwhealth.com	7,394	1,724,745	60.1%	3,774,135	$3,579,520,877	$23,647,941
35 Bakersfield Memorial Hospital, California Hospital Medical Center (Los Angeles), Community Hospital of San Bernardino, Dominican Santa Cruz Hospital–Soquel, Glendale Memorial Hospital, La Palma Intercommunity Hospital, Long Beach Community Medical Center, Marian Medical Center (Santa Maria), Mark Twain St. Joseph's Hospital (San Andreas), Martin Luther Hospital Medical Center (Anaheim), Mercy General Hospital, Mercy Hospital & Health Services (Merced), Mercy Hospitals (Bakersfield, Folsom and Mt. Shasta), Mercy Medical Center (Redding), Mercy San Juan Hospital (Carmichael), Mercy Westside Hospital (Taft), Methodist Hospital of Sacramento, Northridge Hospital Medical Center, Northridge Hospital Medical Center Sherman (Van Nuys), Oak Valley District Hospital (Oakdale), San Gabriel Valley Medical Center, Sequoia Hospital (Redwood City), Sierra Nevada Memorial Hospital (Grass Valley), St. Bernardine Medical Center (San Bernardino), St. Dominic's Hospital (Manteca), St. Elizabeth Community Hospital (Red Bluff), St. Francis Medical Center (Santa Barbara), St. Francis Memorial Hospital (San Francisco), St. John's Pleasant Valley Hospital (Camarillo), St. John's Regional Medical Center (Oxnard), St. Joseph's Behavioral Health Center (Stockton), St. Joseph's Medical Center of Stockton, St. Mary Medical Center (Long Beach), St. Mary's Medical Center (San Francisco), Woodland Memorial Hospital						
Daughters of Charity Health System www.dochs.org	1,523	396,406	62.4%	883,554	$810,724,919	$22,128,216
7 O'Connor Hospital (San Jose), Robert F. Kennedy Medical Center (Hawthorne), Seton Medical Center (Daly City), Seton Medical Center–Coastside (Moss Beach), St. Francis Medical Center (Lynwood), St. Louise Health Center (Gilroy), St. Vincent Medical Center (Los Angeles)						
HCA: The Healthcare Company www.hcahealthcare.com	807	284,199	60.2%	503,064	$806,254,037	$3,289,446
5 Good Samaritan Hospital (San Jose), West Hills Medical Center, Los Robles Regional Medical Center, Regional Medical Center (San Jose), San Jose Medical Center						
Kaiser Foundation www.kaiserpermanente.org/locations/california	5,661	1,338,298	64.8%	990,494	$6,385,330,568	$673,195,057
25 Anaheim, Baldwin Park, Bellflower, Chemical Dependency Program (Fontana), Fresno, Geary (San Francisco), Harbor City, Hayward, Oakland Campus, Panorama City, Redwood City, Riverside, Sacramento, San Diego, San Rafael, Santa Clara, Santa Rosa, Santa Teresa Community Hospital (San Jose), South Sacramento, South San Francisco, Sunset (Los Angeles), Vallejo, Walnut Creek, West Los Angeles, Woodland Hills						
St. Joseph www.stjhs.org	956	232,651	62.2%	642,584	$649,715,788	$30,148,316
10 Mission Hospital Regional Medical Center (Mission Viejo), North Coast Health Care Center-Sotoyom (Santa Rosa), Petaluma Valley Hospital (Petaluma), Queen of the Valley Hospital (Napa), Redwood Memorial Hospital (Fortuna) Santa Rosa Memorial Hospital, St. Joseph Hospital (Eureka), St. Joseph Hospital (Orange), St. Jude Medical Center (Fullerton), St. Mary Regional Medical Center (Apple Valley)						
Scripps www.scrippshealth.org	887	326,545	71.2%	454,374	$835,721,738	$32,111,221
5 Green Hospital of Scripps Clinic (La Jolla), Scripps Memorial Hospitals (Chula Vista, Encinitas and La Jolla), Scripps Mercy Hospital (San Diego)						
Sharp www.sharp.com	1,639	452,186	73.3%	778,815	$882,825,288	$28,305,155
7 Grossmont Hospital (La Mesa), Sharp Cabrillo Hospital (San Diego), Sharp Chula Vista Medical Center, Sharp Coronado Hospital & Healthcare Center, Sharp Healthcare Murrieta, Sharp Mary Birch Hospital For Women (San Diego), Sharp Memorial Hospital (San Diego)						
Sutter www.sutterhealth.org	4,552	1,243,780	69.4%	3,297,564	$3,889,864,925	$453,115,205
24 Alta Bates Medical Center (Berkeley), California Pacific Medical Center (San Francisco), Eden Medical Center (Castro Valley), Laurel Grove Hospital (Castro Valley), Marin General Hospital (San Rafael), Memorial Hospital Modesto, Mills-Peninsula Medical Center (Burlingame), Novato Community Hospital, St. Luke's (San Francisco), Sutter Amador Hospital (Jackson), Sutter Auburn Faith Hospital, Sutter Center For Psychiatry (Sacramento), Sutter Coast Hospital (Crescent City), Sutter Davis Hospital, Sutter Delta Medical Center (Antioch), Sutter General Hospital (Sacramento), Sutter Lakeside Hospital (Lakeport), Sutter Maternity & Surgery Center (Santa Cruz), Sutter Medical Center of Santa Rosa, Sutter Memorial Hospital (Sacramento), Sutter Merced Medical Center, Sutter Roseville Medical Center, Sutter Solano Medical Center (Vallejo), Sutter Tracy Community Hospital						

EXHIBIT 4. Largest California Hospital Systems at a Glance, 2003, cont.

System and Locations	Staffed Beds	Inpatient Days	Inpatient Occupancy	Outpatient Visits	Net Patient Revenue	Net Income
Tenet www.tenethealth.com	7,579	1,814,195	63.6%	3,180,321	$4,458,170,693	$706,710,017
39 Alvarado Hospital Medical Center (San Diego), Brotman Medical Center (Culver City), Centinela Hospital Medical Center (Inglewood), Century City Hospital (Los Angeles), Chapman Medical Center (Orange), Coastal Communities Hospital (Santa Ana), Community & Mission Hospitals (Huntington Park), Community Hospital of Los Gatos, Daniel Freeman Marina Hospital (Marina Del Ray), Daniel Freeman Memorial Hospital (Marina Del Ray), Desert Regional Medical Center (Palm Springs), Doctors Hospital of Manteca, Doctors Medical Center, Doctors Medical Center (Pinole and San Pablo), Encino Tarzana Regional Medical Center (Encino), Encino Tarzana Regional Medical Center (Tarzana), Fountain Valley Regional Hospital & Medical Center–Euclid (Fountain Valley), Garden Grove Hospital & Medical Center, Garden Grove Garfield Medical Center, Monterey Park Greater El Monte Community Hospital, South El Monte Irvine Medical Center (Irvine), John F. Kennedy Memorial Hospital (Indio), Lakewood Regional Medical Center–South, Los Alamitos Medical Center, Midway Hospital Medical Center (Los Angeles), Monterey Park Hospital, North Hollywood Medical Center, Placentia-Linda Community Hospital (Placentia), Queen of Angels-Hollywood Presbyterian Medical Center (Los Angeles), Rancho Springs Medical Center (Murrieta), Redding Medical Center, San Diego Rehabilitation Institute, San Dimas Community Hospital, San Ramon Regional Medical Center, Santa Ana Hospital Medical Center, Sierra Vista Regional Medical Center (San Luis Obispo), St. Luke Medical Center (Pasadena), Suburban Medical Center (Paramount) Tustin Rehabilitation Hospital, Twin Cities Community Hospital (Templeton), University of Southern California University Hospital (Los Angeles), Valley Community Hospital (Santa Maria), Western Medical Center (Anaheim), Western Medical Center (Santa Ana), Whittier Hospital Medical Center						
University of California	3,042	781,456	67.8%	3,257,337	$3,270,675,676	$123,621,512
8 Medical Center at the University of California (San Francisco), Langley Porter Psychiatric Institute (San Francisco), UCLA Medical Centers (Santa Monica and Los Angeles), UCLA Neuro-psychiatric Hospital (Los Angeles), University of California–San Diego Medical Center, University of California–Davis Medical Center (Sacramento), University of California Irvine Medical Center (Orange)						

Source: Author's analysis of annual financial report worksheet data prepared by office of Statewide Health Policy and Development. Data are for fiscal years ending between January 1 and December 30, 2003. System affiliations reflect arrangements in 2003.

of $6.4 billion. In its financial reports to the state, Kaiser combines the financial data for its hospitals into two reports, one for northern California and one for southern California. Using that data, it is not possible to compare the net income of individual Kaiser hospitals or even to isolate the Kaiser hospitals in the Bay Area or Los Angeles for analysis.

Most of Tenet's 39 California hospitals (as of 2003) are in Los Angeles County and Orange County, although Tenet also has a few locations in other parts of the state. Most Tenet hospitals are smaller community facilities, but it has acquired a few major teaching hospitals in California and in other states. In 2004 and 2005, Tenet announced the sale of several of its California hospitals as part of a national strategy of downsizing.

During 2003, Tenet's California hospitals had net income of $706.7 million on net patient revenue of $4.5 billion. In 2004, Tenet Health operated 85 hospitals in 14 states. That reflects the closure or sale of about 25 hospitals since 2002. The company had net patient revenue of $13.21 billion in 2003. Until 2002 and 2003 Tenet Health has been very successful and much loved by Wall Street analysts. However, it has been involved in a series of controversies and investigations about its business practices, including one involving its hospital in Redding, California. Questions were raised about its practices in billing Medicare and individuals who have no insurance coverage. That led to concerns about the company's ability to maintain its strong earnings in the future and consequently the price of its stock has declined.

Other Hospital Systems

Smaller hospital systems in the state have been able to exert significant power in local sub-markets where they control a large proportion of the hospital capacity or have developed brand recognition. For example, the Sutter system controls a high percentage of the hospital activity in Oakland in Berkeley. Further east, the two Muir/Mt. Diablo hospitals provide much of the hospital care in Walnut Creek and nearby communities.

After the top three dominant systems, the Sutter hospitals make up the next largest system in California, with almost all of their facilities in northern California. Sutter generated antitrust concerns a few years ago with its proposed acquisition of major hospitals in the East Bay area. In the end, those acquisitions were completed. Sutter is closely tied to some major physician groups in northern California, including the Palo Alto Medical Foundation and its affiliated medical groups. Sutter has 24 hospitals with 4,552 staffed beds. Sutter hospitals had net patient revenue in 2003 of $3.9 billion and net income of $453.1 million.

The other major investor-owned hospital system in the state is HCA: The Healthcare Company (formerly Columbia/HCA). HCA has 190 hospitals nationwide and $21.8 billion in net patient revenue. HCA has sold some of its properties in California and in other states. One result is that a new crop of investor-owned (for-profit) hospital companies is doing business in the state, including Pacific Health Corporation. HCA is now down to five California hospitals with about 800 staffed beds.

They reported net patient revenues of $806.3 million in 2003 and net income of $3.3 million. California has not been a strong state for the company and it plans to further reduce its presence here. HCA closed San Jose Medical Center in December 2004.

Exhibit 4 groups the eight University of California medical centers, including two specialty facilities. They are major providers of care to Medi-Cal recipients and patients without any coverage, and receive a large share of the state's special payments for hospitals serving poor patients. Combined, the hospitals reported net income of $123.6 million on $3.3 billion in net patient revenue.

2.4 Physician Organizations

How physicians organize themselves and how they are paid are two elements that distinguish health markets in California from those in other states. Both have evolved with the development and growth of managed care plans in the state. At times, the HMOs have made it clear how they wanted to buy physician services and the physicians responded favorably. At other times, the physicians have asserted themselves and put forth their own clear ideas about the type of relationship they want with health plans and how they want to be compensated.

A fundamental premise of managed care is that patients have incentives — and sometimes restrictions — to use certain providers. HMOs in California function as wholesalers of covered lives. They assemble the component parts (provider networks, administrative systems, marketing plans, and so on), market the plans to employers, and bring the enrollees to the contracted or employed providers.

HMOs in California organize their physician networks using two basic models as well as hybrids of the two:

1) **Kaiser Permanente Model.** First, there is the Kaiser Permanente model where the HMO contracts with the Permanente Medical Group (actually two separate groups in northern and southern California), and the group's physicians provide almost all medical services to Kaiser enrollees. In California, Kaiser does go outside the Permanente groups in some limited circumstances, such as to use certain specialists, for geographic access, or in cases where its capacity is inadequate. The Permanente Medical Groups are exclusive in the sense that they do not contract to serve enrollees in other HMOs or insurance plans. Kaiser is not interested in changing this exclusivity for now, but other classic HMOs around the country, such as HealthPartners in Minnesota and the Henry Ford Health System in Detroit, have for years "rented" their physicians to other health plans or plan administrators in order to have new sources of patients.

   Variations of the Kaiser model in California include combinations of employed physicians and contracted clinics. Molina Healthcare of California uses a combination of its own clinics and contracted physicians. Other health plans, including CIGNA in California and Florida, began with staff clinics, but later sold those clinics and switched to contracting for physician services. In a few states in the 1990s, Prudential Health tried a strategy of building group practices that ultimately failed.

2) **California Delegated Model.** In the world outside of Kaiser, a different model predominates. HMOs contract with medical groups or independent practice associations (IPAs) and delegate significant responsibilities to the physicians along with some financial risk. The HMO agrees to pay a capitated (fixed) monthly rate for every enrollee who chooses a primary care clinic within that group, retaining some percentage of the premium for administrative costs and profit.

   In this model, the responsibilities delegated by the HMO to the medical groups include functions like verifying physicians' credentials, claims administration, and medical management. The medical groups do not contract exclusively to any single health plan, although they may have at one time. By not being exclusive, the medical groups hope to receive more patients from many different health plans, thus assembling a better risk pool. The largest health plans in the state, including Blue Cross, Blue Shield, PacifiCare, and Health Net, use the delegated model to a greater or lesser extent. Blue Cross uses less capitation contracting than the others do and is more likely to pay discounted fee-for-service rates.

   Many medical groups are heavily dependent on the California delegated model. These groups have invested in medical management systems that keep specialty referrals within a limited network and control hospital admissions and lengths of stay. The disadvantage is that the number of patients in commercial HMO plans has been declining in recent years and many of these medical groups are getting fewer patients. Some have sought to attract or keep more patients who have coverage through a PPO arrangement, but find that their systems of medical management and billing don't work well for PPO patients.

   Others have found that patients switched to a PPO specifically because they wanted to get away from what

they saw as "HMO medicine" practiced in these medical groups. Note that physicians participating in IPAs usually contract directly with PPOs and don't use the IPA as an intermediary.

Physician Group Structures

Tables in Section 4.0, Regional Sub-Markets and Provider Systems, present information about the largest physician groups. According to various sources, there are between 250 and 350 organized physician groups in California, including many groups that are quite small. Data from the Cattaneo & Stroud consulting firm show that 10 organizations plus the two Permanente groups have contracts to provide care for almost 80 percent of managed care enrollees.

Physician groups in California tend to be organized into one of five different structures. Note that the lines separating medical groups from Independent Practice Associations (IPAs) have blurred, suggesting that the distinction is not always meaningful.

1) **Permanente Medical Groups.** While the Kaiser Permanente health plans in the state have generally combined their southern and northern California operations, there are still two Permanente Medical Groups. The Southern California Permanente Medical Group provides medical services to plan members in the southern part of the state while the Permanente Medical Group operates in the north. Southern California Permanente is organized as a partnership, while Northern California Permanente is a professional corporation, preferring to pay its doctors on a discounted fee-for-service basis.
2) **Medical Groups.** The integrated medical group is a traditional group practice structure. While many established groups in California include primary care physicians and numerous specialists, most new group practices are built around a single specialty. For a variety of reasons, many of them financial, few new multi-specialty groups have been created in recent years in California or elsewhere. Specialists generally feel that they bring more revenues to the practice than do primary care physicians, and want to be compensated in a way that reflects their contribution.

   Some of the established multi-specialty groups are growing and adding new primary care and specialty doctors. In some cases they are approached by doctors from smaller groups who are tired of trying to compete and who feel that they don't have adequate leverage with health plans. Other medical groups have cut back, spinning off their specialty physicians, therapists, and pharmacies.

   Physicians in integrated medical groups are either employees or partners of the group and may practice at one or more group sites. Some medical groups contract with IPAs (described below) to extend their geographic reach and to add a source of revenue. Medical group practices are very common in southern California but less so in the northern part of the state.

   Prominent medical groups include Healthcare Partners (www.healthcarepartners.com) in Los Angeles; Camino Medical Group (www.caminomedicalgroup.com), which is now affiliated with the Palo Alto Medical Foundation; San Jose Medical Group (www.sjgsmedgrp.com); Bright Medical Associates in the Los Angeles area; and Beaver Medical Group (www.beavermedgrp.com) in the Inland Empire of San Bernardino and Riverside Counties.
3) **Independent Practice Associations (IPAs).** An IPA is an administrative vehicle for independent physicians or clinics that practice in their own private offices in the community. These physicians contract with the IPA, and the IPA, acting on behalf of the physicians, signs network contracts with one or more health plans. Physicians typically contract with more than one IPA and each IPA may account for only a small percentage of their patients. IPAs are especially common in northern California.

   Prominent California IPAs include the Brown and Toland Medical Group (www.brownandtoland.com) in San Francisco; Alta Bates Medical Group (www.altabatesmedicalgroup.com) in Oakland; Affinity Medical Group, Inc. (www.affinitymd.com), a "super-IPA" in the East Bay that includes a number of smaller IPAs; and Hill Physicians Medical Group, Inc. (www.hillphysicians.com) in the East Bay area. In many instances, the IPA contracts with a management services organization, as described below. In these cases, the IPA is the publicly visible doctors group, and the management services organization (MSO) works in the background. For example, PriMed Management Consulting is the MSO for Hill Physicians in northern California.
4) **Foundation Model.** California law generally bars the corporate practice of medicine, so other structures have formed in which a hospital can have close ties to physicians. In the foundation model a hospital creates a foundation which in turn purchases a physician practice.

It is similar to a group practice in some respects, because the physicians are employed by the foundation and contract with health plans only through the foundation. The foundation is governed by a board with representatives of both the physicians and the hospital. The hospital may provide capital to the physicians through the foundation. Foundation model examples include John Muir/Mt. Diablo Health Network Foundation (www.jmmdhs.com) in the East Bay; Palo Alto Medical Foundation (www.pamf.org) in the South Bay; Scripps Clinic (www.scrippsclinic.com) in San Diego; and Adventist Health Southern California Medical Foundation.

5) **Management Service Organizations (MSOs).** An MSO is not a physician organization as such, but provides administrative services to participating groups. Many physician groups, especially IPAs, contract with a management service organization that handles services including billing, collection, and administrative support. Some MSOs offer a full menu of services, including health plan contracting, quality management, utilization management, provider relations, member services, and claims processing.

Management service organizations include PriMed Management Consulting, Inc. (the management company for the Hill Physicians IPA), and Brown and Toland Physician Services Organization. North American Medical Management of California (NAMM, www.pcsuncity.com/company_info.html) is the MSO for PrimeCare Medical Network (a Knox-Keene limited license HMO), the PrimeCare clinics, and Alta Bates Medical Group.

Physician Group Finances

The HMO delegated model requires physician groups to manage a significant amount of insurance risk, and their financial stability has been a matter of serious concern in recent years. Between 1998 and 2002, several dozen physician groups went out of business, including some well-known and well-established groups, causing significant disruption in patient-physician ties. In response to these physician group failures, the California Legislature passed several managed care bills in 1999, including SB 260, which addressed the financial solvency of physician groups. SB 260 established four criteria for physician groups, requiring them to maintain:

- Positive working capital;
- Positive tangible net equity;
- Calculated and documented IBNR (Incurred But Not Reported) claims; and
- Timely claims payment.

The Department of Managed Health Care (DMHC) was charged with financial oversight of physician groups and began to implement the solvency requirements of SB 260. Through an administrative rulemaking process, the DMHC adopted reporting requirements to address the criteria spelled out in the law. The DMHC also took the first steps to collect data from 250 physician groups and disseminate summary information on the Internet.

For a few months, the DMHC Web site provided a list of the 250 physician groups and noted whether they were in compliance or not with each of the four criteria. The DMHC wanted to go further and provide detailed information about the finances of those physician groups, including the actual ratio of working capital or a more specific measure of timely claims payment. However, the California Medical Association (CMA) sued the DMHC, claiming that the statute did not authorize the DMHC to disclose the financial details of physician groups. The CMA's concern was that disclosure of this information could undermine the position of the physician groups in negotiating contracts with managed care companies. The trial court sided generally with CMA and barred the DMHC from implementing portions of the reporting rules. The DMHC then pulled the information from its Web site.

In its 2003 session, the California legislature considered bills to clarify what was intended by SB 260. The DMHC and the different associations representing physicians still fundamentally disagree on how much data should be disclosed to the public.

Paying for Physician Performance

Variation in physician practice and how to address it in quality improvement measures, health plan payment systems, and organization of delivery networks has emerged as a key issue. Reports like the Dartmouth Atlas show that there is wide variation in, among other things, the cost of care and the rate at which certain procedures (such as C-section deliveries) are performed in different areas of the country.

A number of initiatives around the country focus on variation in practice. Some seek to improve the quality of patient care by reducing the extent of variation. Others seek to make the variation more transparent and to reward those physicians found to be better performers by some objective measures. Proponents of the latter approach hope that physicians would respond to financial incentives by improving their performance.

In the last two years a great deal of attention has been focused on the California Pay for Performance initiative launched by the Integrated Healthcare Association and endorsed by six large health plans in the state: Aetna, Blue Cross, Blue Shield, CIGNA, Health Net, and PacifiCare, which have nearly 7 million commercial enrollees. Under the initiative, medical groups in the state will be evaluated using an agreed-upon set of measures. Some of the measures are clinical and correspond to HEDIS measures. (HEDIS is the Health plan Employer Data Information Set, coordinated by NCQA, the National Committee for Quality Assurance.) Other measures are related to enrollee satisfaction as measured by the California Consumer Assessment Survey (CAS). In 2004 all six of the health plans began to pay performance bonuses to physician groups that meet the initiative's criteria.

Selected HEDIS measures on commercial HMOs are reported in Section 3.13.

Each health plan decides for itself the size of the bonuses and exactly how they are distributed. It appears that bonuses paid in 2004 were between 2 and 5 percent of the base payments. In 2004, Blue Cross paid $56.9 million in bonuses to 134 medical groups, using its own formulas to calculate the amount. In 2003, Blue Cross paid $28 million in performance bonuses to about 80 California medical groups, based on their 2002 performance. The involved parties have announced some changes to the criteria for medical group operations and payments in 2005. More emphasis will be placed on information technology capabilities of the medical groups and some new clinical measures will be added. NCQA was enlisted to aggregate the data across health plans and a report card with 2003 data is planned for release at the end of 2004.

Physicians have received the Pay for Performance initiative with enthusiasm mixed with a healthy dose of skepticism. How much money would be available for incentive payments and whether all of it would be "new money" are among the questions yet to be resolved. In seeking new money, physician groups don't want to collect bonuses paid from dollars they might have negotiated as base payment rates or that have been reassigned from previous incentive payment plans. While these questions remain unanswered, it appears that medical groups are beginning to diverge in their responses to the challenge posed by Pay for Performance. Some have embraced it, knowing that their performance scores will bring in a significant share of the available bonuses. Others are prepared to bypass it altogether and have passed on offers to "practice test" their data in enrollee satisfaction surveys. About 160 medical groups did participate in the enrollee satisfaction survey this year.

Pay for Performance illustrates the growing importance of focusing on variation in practice, whether by individual doctors or medical groups. Other projects around the country, including the Bridges to Excellence and Rewarding Results programs funded by the Robert Wood Johnson Foundation and the California HealthCare Foundation, are also trying to use financial incentives to encourage better performance by doctors. Some employers question whether they should have to pay extra for a level of physician performance that they feel they are already entitled to. The Consumer-Purchaser Disclosure project, also supported by Robert Wood Johnson Foundation and the Leapfrog Group, is intended to standardize the measures used to evaluate performance by doctors and physician groups.

A sidebar on page 28 lists Web sites where consumers can obtain comparative information about health plans and physician groups in California.

Future Challenges

Physician groups face a series of challenges going forward. First, many are seeing a decline in the number of capitated HMO patients. As will be seen in Section 3.2, HMO Enrollment, the number of HMO commercial enrollees is declining, with some of them apparently switching to PPO plans. Some medical groups are trying to make the transition to serving more PPO patients, but run into regulatory obstacles or inadequate administrative systems to process fee-for-service claims. For most physician groups, all their systems are invested in administering a capitated HMO business, a specific financial model in which a check arrives every month for the capitated HMO patients. IPA doctors may get paid more for the services provided to someone with a PPO card, but will receive nothing in months when those patients don't come in. Further, consumers who carry a PPO card may tend to avoid doctors that they regard as HMO or managed care doctors.

Note that some physician groups welcome this change. Some have used the situation to try to test their value to the health plans, in some cases threatening to terminate their contracts unless an HMO greatly improves its payments. In seeking to maximize their revenues, busy physician groups look at the relative revenues generated from their different payers and sometimes see an opportunity to replace lower-paying HMO patients with higher paying patients from other plans. If they have full waiting rooms and high demand for their physicians, they can risk losing lower-paying health plans and patients.

Medicare HMOs seem to be making a comeback, and it is likely that medical groups will see an increase in seniors coming to them on a capitated basis. This will help to offset the losses of

commercial patients. In southern California, Medicare payments were often used in previous years to offset lower payments for commercial patients. And a few medical groups are taking a second or third look at Medi-Cal and Healthy Families, thinking that their medical management skills might work with the populations served by those programs, while providing access to a new set of capitated patients.

IPAs continue to face uncertainty about their futures as viable organizations for physicians. In some ways, the Pay for Performance initiative encourages IPAs to operate more like medical groups. One piece of the initiative's formula for earning additional payments measures the ability of the group to fully report encounter data, something that many IPAs have struggled with in the past. IPAs also face questions about their ability to deliver higher quality medicine in a loose organization compared to an integrated medical group.

Many IPAs contract with Management Services Organizations (MSOs), so the challenge may be to the MSO to demonstrate its ability to serve the needs of the IPA. The result may be some consolidation at the MSO level, as IPAs switch to the MSOs best able to serve their needs.

Finally, there is the question of whether there is a threshold or optimal size for effective physician groups. Physician groups need to make ongoing investments in administrative systems and in quality improvements, and to spread those costs over a sizable base of patients. Some observers suggest that a physician group in southern California with fewer than 50,000 or even 100,000 patients will have a difficult time sustaining itself. The need to invest in infrastructure while establishing a broad geographic presence has led to some consolidation of physician groups seeking to associate with larger health plan organizations.

2.5 Health Plan/Provider Relations

The delegated model in California was constructed on a foundation of physician groups and hospitals working in partnership. Their financial interests were aligned, and in disputes with HMOs, hospitals and physicians usually lined up together. When physicians practiced conservatively, admitting fewer patients for inpatient care and holding down their lengths of stay, both physicians and hospitals prospered. They shared the surpluses in the institutional care pools—that is, the reserves of capitation dollars that pay for hospital care. These surpluses were especially important for medical groups, since the capitation rates for professional services would barely cover their costs, if at all.

The financial ties between hospitals and physician groups have unraveled in recent years, especially because hospitals have concluded that their financial interests are best served by not continuing to partner with physicians in the same way. As noted earlier, most hospital systems have used their increased leverage to negotiate with health plans for new payment rates and methods. While there may still be an institutional care pool, hospitals are paid at much improved rates, effectively emptying out those pools more quickly and putting hospitals in an advantageous position. Hospitals have said that these payment increases were needed to make up for years of inadequate payments. And while the premium dollars available for provider payments have grown steadily in the past two or three years, health plans and hospitals take their share first, leaving physician groups with whatever is left. The effect is to reduce the financial incentive for physician groups to practice conservatively. Interviewees for this report noted some irony in the fact that hospitals were eager to take capitation risk in years when premiums were flat, but do not want capitation in years when premiums are increasing by double-digit amounts. Given a choice, most hospitals now prefer to get payments without the risk associated with capitation.

This move away from hospital risk-bearing is not what the HMOs want. In fact, it was noted in interviews in 2003 that the major HMOs would be willing to pay higher capitation rates if hospitals and medical groups would again join together to take more risk. That is, HMOs would prefer not to manage inpatient risk and would put more dollars in the combined pools if hospitals would again participate in risk-sharing arrangements. Interviewees spoke of examples where physician groups and hospitals had partnered in risk-sharing arrangements to their mutual benefit, but suggested that this was a small number of cases. For the most part, hospitals have declined those offers and insisted on other terms, leaving the health plans with few options. In the past, health plans could take advantage of excess hospital capacity and threaten to move their patients away from hospitals that would not accept their terms. With less surplus capacity today, threats to move patients from one group of hospitals to another are seen as empty.

New forms of risk-sharing by physicians, hospitals, and HMOs are appearing in the state. A prominent medical group in southern California has begun to contract with health plans using a "cost" model. The medical group is managing the pools and paying the hospitals on a DRG (diagnostic related group) basis, and deploying its care managers and hospitalists to manage resource consumption. If there is a surplus in the pool, the medical group and hospital share it.

While the incentives have decreased for physician groups to practice conservatively, it is not clear whether this has resulted in changes in how they practice. For example, in the past, physician groups typically employed hospitalists to manage hospital care and to move patients efficiently through hospitals. Even though the financial incentive has diminished, the physician groups interviewed said that they continue to use hospitalists and the same kind of medical management, because those practices result in higher-quality care.

In both instances, physician groups extend the additional services equally to PPO patients. For the most part, though, they can't bill the PPOs for these additional services, no matter how much they improve quality or patient satisfaction or reduce care utilization.

Sources of Comparative Information on Health Plan and Provider Quality

California Cooperative Healthcare Reporting Initiative (CCHRI)
www.cchri.org

California HealthScope (Pacific Business Group on Health)
www.healthscope.org

California Institute for Health System Performance
PEP-C survey, the Patients' Evaluation of Performance in California
www.calhospitals.org

Office of Public Advocate
2004 Quality of Care Report Card
www.opa.ca.gov/report_card/

3.0 Trend Review

This section of the report presents an analysis of enrollment and financial trends for California health plans. HMOs enroll more than half of the population of California, and trends in their enrollment profitability, pricing, and utilization are reflective of what is happening in the state as a whole.

Unfortunately, there is no comparable body of data on the finances, enrollment, or care utilization for other kinds of health plans such as PPOs (preferred provider arrangements) and point of service plans that are not subject to the same regulatory and reporting requirements as HMOs. As a result, this section of the report focuses on HMOs and generally does not analyze comparable trends affecting PPO plans. Some changes can be inferred; the decline of commercial HMO enrollment is most likely reflected in an increase in PPO activity.

Sidebars in this report — HMO Market Concentration, HMO Enrollment Growth, HMO Net Income, HMO Premium Trend, HMO Capitation, and HMO Net Worth — compare California health plans with their counterparts in the states where the author prepares market analyses.

3.1 About This Analysis

The data used in the following subsections are generally from public sources, except that the HEDIS data are licensed through NCQA. The analysis of HMO enrollment and finances is based on the annual and quarterly statements that licensed health plans submit to the Department of Managed Health Care. The tables in this section report data for health plan fiscal years ending in 2003 and update enrollment and profitability for the first half of 2004.

Commercial HMOs generally have fiscal years ending December 31of each year, but almost all of the limited license and county-sponsored plans have June 30 year-ends. California HMOs file annual and quarterly statements on forms prescribed by the DMHC. These statements are different from the ones used by HMO regulators in other states and the forms prescribed by the National Association of Insurance Commissioners (NAIC). California health plans also complete certain supplementary reports. One is used to calculate tangible net equity (TNE), a measure of the adequacy of a health plan's net worth that is tied to, among other things, its sharing of risk with provider organizations.

Enrollment data in the annual statements were supplemented by other sources, particularly in preparing Exhibits 12 and 13 showing enrollment by region and health plan. One source was responses to surveys submitted by the author to California HMOs for information on their 2002 enrollment by county and line of business (commercial, Medicare, Medi-Cal, and Healthy Families). If the plans did not respond to the survey, the author's estimates of commercial enrollment by region and plan were compared to March 2004 survey results reported by the Cattaneo and Stroud consulting firm. For Medi-Cal enrollment, monthly reports from the California Department of Health Services (DHS) were used to supplement the data in the HMO's annual statements. The DHS reports list enrollment by plan and county. For Medicare enrollment, quarterly reports from the federal Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration) on enrollment in Medicare HMOs by county and by plan were used.

To make the exhibits more useful, data on the six largest plans in the state are presented at the top of the tables. Data on the smaller plans follow in alphabetical order. The county-sponsored Medi-Cal health plans appear in a separate group. Finally, data on the limited license plans are shown at the bottom of the table.

Limited license plans are described under Physician Organizations in Section 2.4. Specific issues regarding data sources or methodology are addressed within individual sections.

3.2 HMO Enrollment

Before presenting HMO enrollment data for 2003 and 2004, it is useful to review and update from previous editions a discussion of methodology issues that affect this specific analysis. Analyzing HMO enrollment data in California presents several challenges.

First, there are several opportunities to double-count health plan enrollees, especially those in Medi-Cal plans. For example, LA Care Health Plan, the local initiative plan run by Los Angeles County, subcontracts all its 720,000 Medi-Cal enrollees ("lives") to "health plan partners," namely these HMOs: Blue Cross, Care 1st, Community Health Plan, Kaiser Permanente, and WATTSHealth/United Health Plan. However, it does manage full risk for a much smaller number of Healthy Families enrollees. For that reason, LA Care is listed separately in some of the enrollment tables in this section, and its Medi-Cal enrollees are not included in the total row of those tables. In this report, enrollment was adjusted based on information that the health plans gave about their subcontracting arrangements.

Second, health plan enrollees that are reported by the limited license plans (Knox-Keene license with waivers health plans) could also be double counted. For example, PacifiCare can contract out 100 percent of the care for a group of enrollees to a limited license plan. Both PacifiCare and the limited license plan will report the number of enrollees and the revenues and expenses associated with those enrollees. To avoid double counting, enrollment figures for those limited license plans are reported after the total enrollment line.

Third, HMOs are not consistent about how they report enrollment on their annual statements for preferred provider plans or self-funded groups where the HMO provides administrative services only (ASO). Some large HMOs include enrollment in PPO plans or by self-funded groups in their annual statements, but others do not. Blue Cross used to include self-funded enrollment on its HMO statements on a separate line, then stopped, and now has resumed reporting that way. The enrollment tables in this section do not include the self-funded groups in 2003 and 2004 and the 2002 figures were revised downward. Similarly, CIGNA's enrollment report includes enrollees in its FlexCare product, most of whom are in self-funded groups. In this report, FlexCare enrollees are not included as HMO enrollees. CIGNA's enrollment data from 2002 were restated to reflect that change.

As shown in Exhibit 6, enrollment in California HMOs grew steadily between 1995 and 2001, when it reached its peak. Some of the decrease in 2002 is because of how this analysis excluded self-funded business for Blue Cross and CIGNA. Still, an overall decline in enrollment began that year.

Exhibit 5 shows that total enrollment in California HMOs, including commercial, Medicare, Medi-Cal, and Healthy Families, declined by 2.0 percent in 2003, dropping by 385,000 to 19.1 million. This was the second consecutive year that HMO enrollment in California did not increase. Enrollment in commercial plans dropped by 4.0 percent or 556,000 lives. There are no comparably reported data on enrollment in PPO arrangements, so it is not possible to say conclusively what health benefit plan these groups and members migrate to when they leave HMOs. The annual Mercer surveys, discussed above, support the notion that enrollment in PPO plans in California is increasing.

HMO Enrollment Growth

HMO enrollment by state and percentage change from the previous year.

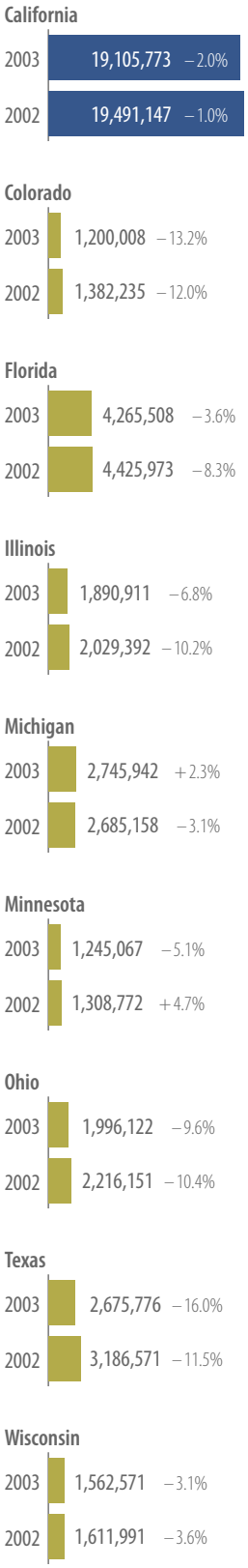


EXHIBIT 5. Enrollment in California HMOs, 2002 and 2003

HMO	Commercial	Medicare	Medi-Cal/ Healthy Families*	2003 TOTAL	2002 TOTAL	2002 to 2003 Change	2002 to 2003 Percent Change
Largest HMOs							
Aetna Health	346,129	31,589	0	377,718	523,099	– 145,381	– 27.8%
Blue Cross of California	1,572,298	265,304	1,133,443	2,971,045	2,979,288	-8,243	– 0.3%
Blue Shield of California	2,604,921	70,090	0	2,675,011	2,298,399	376,612	16.4%
Health Net†	1,436,888	99,403	445,104	1,981,395	2,116,364	– 134,969	– 6.4%
Kaiser Foundation	5,615,319	678,406	160,181	6,453,906	6,567,050	– 113,144	– 1.7%
PacifiCare	1,333,000	348,389	0	1,681,389	1,929,076	– 247,687	– 12.8%
Smaller HMOs							
Care 1st Health Plan	0	0	179,457	179,457	196,616	– 17,159	– 8.7%
Chinese Community Health Plan	6,533	4,704	0	11,237	10,734	503	4.7%
CIGNA Healthcare	146,977	0	0	146,977	207,210	– 60,233	– 29.1%
Community Health Plan	33,333	0	150,015	183,348	162,089	21,259	13.1%
Community Health Group	9,037	0	94,377	103,414	95,817	7,597	7.9%
Great-West Health Care	53,123	0	0	53,123	59,015	– 5,892	– 10.0%
Inter Valley Health Plan	0	14,823	0	14,823	37,651	– 22,828	– 60.6%
Molina Medical Centers	0	0	254,393	254,393	286,180	– 31,787	– 11.1%
On Lok Senior Health Services	0	25	909	934	905	29	3.2%
Prudential Health Care	0	0	0	0	62,678	– 62,678	– 100.0%
SCAN Health Plan	0	50,369	2,576	52,945	54,245	– 1,300	– 2.4%
Sharp Health Plan	51,802	0	71,631	123,433	119,036	4,397	3.7%
Sistemas Medicos Nacionales	11,994	0	0	11,994	11,764	230	2.0%
UC San Diego	0	0	12,920	12,920	12,151	769	6.3%
Universal Care	104,324	1,616	200,735	306,675	355,204	– 48,529	– 13.7%
Ventura County	7,189	0	3,466	10,655	10,612	43	0.4%
WATTSHealth Plan	8,282	14,961	70,132	93,375	108,482	– 15,107	– 13.9%
Western Health Advantage	46,035	2,907	15,607	64,549	60,347	4,202	7.0%
County Health Systems and Local Initiatives							
Alameda Alliance for Health	10,682	0	81,898	92,580	85,271	7,309	8.6%
CalOptima†	0	0	300,349	300,349	240,045	60,304	25.1%
Central Coast Alliance	0	0	81,901	81,901	85,098	– 3,197	– 3.8%
Contra Costa Health Plan	18,326	763	41,831	60,920	59,187	1,733	2.9%
Inland Empire Health Plan	3,825	0	261,323	265,148	241,258	23,890	9.9%
Kern Health Systems	0	0	79,791	79,791	74,712	5,079	6.8%
LA Care‡	0	0	17,494	17,494	19,268	– 1,774	– 9.2%
Partnership Health Plan	0	0	81,506	81,506	74,656	6,850	9.2%
San Francisco Health Plan	5,348	0	37,008	42,356	38,264	4,092	10.7%
San Joaquin County Health	0	0	64,418	64,418	61,544	2,874	4.7%
San Mateo Health Commission	5,397	0	47,547	52,944	46,784	6,160	13.2%
Santa Barbara Regional Health	0	0	54,024	54,024	62,565	– 8,541	– 13.7%
Santa Clara Family Health†	12,979	0	78,904	91,883	74,524	17,359	23.3%
2003 TOTAL	13,453,007	1,583,499	4,069,267	19,105,773	19,491,147	– 385,374	– 2.0%
2002 TOTAL	14,009,351	1,609,396	3,872,400				
Change	– 4.0%	– 1.6%	5.1%	– 2.0%			
2003 Program Share	70.4%	8.3%	21.3%	100%			
2002 Program Share	72.4%	8.3%	19.3%	100%			

EXHIBIT 5. Enrollment in California HMOs, 2002 and 2003, cont.

HMO	Commercial	Medicare	Medi-Cal/ Healthy Families*	2003 TOTAL	2002 TOTAL	2002 to 2003 Change	2002 to 2003 Percent Change
Limited License Plans and Other							
Cedars Sinai	1	0	0	1	6,873	– 6,872	– 100.0%
Heritage Provider Network	191,183	53,796	12,210	257,189	194,574	62,615	32.2%
LA Care‡	0	0	795,114	795,114	799,271	– 4,157	– 0.5%
PrimeCare Health Network	218,972	21,364	0	240,336	262,401	– 22,065	– 8.4%
ProMed Health Care Administrators	0	0	0	0	9,179	– 9,179	– 100.0%
Scripps Clinics	55,355	15,838	0	71,193	151,755	– 80,562	– 53.1%

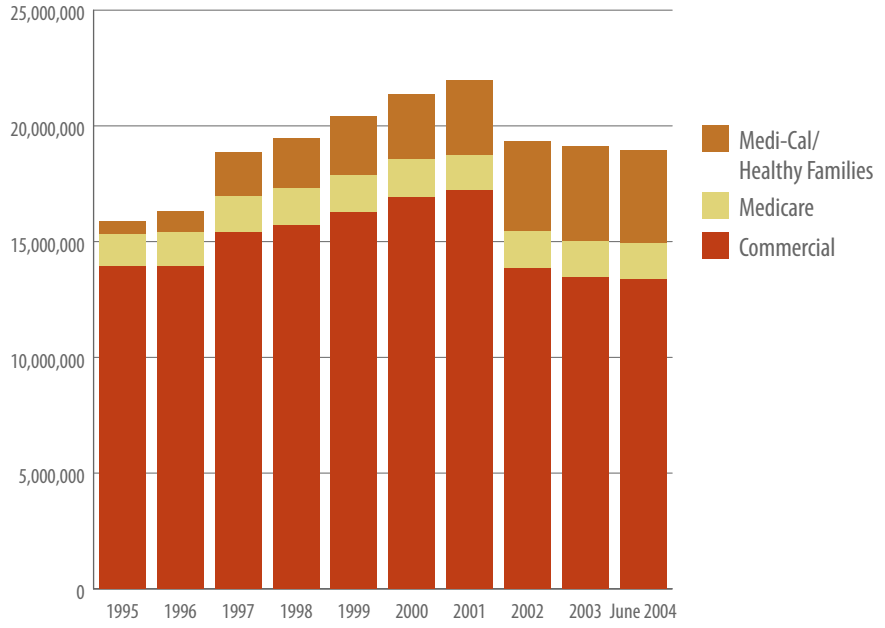
*Column includes Medi-Cal, Healthy Families, Healthy Children, AIM, and similar programs.

†Health Net's enrollment is adjusted downward to reflect Medi-Cal enrollees in Los Angeles County that are subcontracted to Molina Healthcare (125,000) and Universal Care (131,000) as of December 2003. CalOptima subcontracts 25,100 of its Medi-Cal lives to Kaiser Permanente and Universal Health. Santa Clara Family Health Plan subcontracts most of its lives to Valley Health Plan or Kaiser Permanente.

‡LA Care subcontracts its 795,000 Medi-Cal lives to other HMOs, so that is shown below the line. It does not subcontract for its Healthy Family enrollees, which are shown in the upper part of the table.

Source: Author's analysis of HMO annual statements, Report No. 4, Enrollment and Utilization Table. Based on fiscal years ending during 2002 and 2003.

EXHIBIT 6. Enrollment Trends in California HMOs, 1995 to 2004



Source: Author's analysis of HMO annual statements, Report No. 4.

There is also reason to believe that some employers have given up on providing health benefits and that some of their employees are joining the ranks of the uninsured. However, data from the Current Population Survey show a slight decrease in the percentage of the state population without health insurance. The two-year average for 2002 and 2003 was 18.3 percent, down from an average of 18.9 percent for 2001 and 2002.

The decline in commercial enrollment for California HMOs in 2003 was partly offset by significant growth in Medi-Cal and Healthy Families HMO plans, which increased by 5.6 percent to 4.069 million.

Of the largest health plans, most reported enrollment declines. Only Blue Shield reported enrollment growth in 2003. It grew by 376,600 enrollees, almost all of them in commercial plans. In turn, almost all of that growth can be attributed to the gain that Blue Shield made with CalPERS, adding almost all of the covered lives that had been in PacifiCare and Health Net in 2002. PacifiCare's enrollment declined by 247,700 lives, 210,000 in its commercial plans and 38,000 in Medicare enrollees. While Blue Cross lost only 8,200 enrollees, Kaiser Permanente lost 113,000. Kaiser had gained enrollees every previous year since 1995. Aetna Health continued to see its HMO enrollment decline as it pursued strategies outside of its HMOs. It has marketed to self-funded employer groups with national operations and has introduced consumer choice model plans.

Many of the smaller plans also lost enrollees during 2003. Prudential Health, acquired several years ago by Aetna, phased out its last member during the year. Molina Health lost about 11 percent of its membership, and Inter Valley Health Plan dropped its commercial members. Care 1st and Universal Care were also among the HMOs losing a significant number of members.

At the same time, a few of the smaller plans gained members in 2003. Community Health Plan in Los Angeles

Health Premium Revenues for Major Insurance Companies

Aetna Life
2003 $415,731,580
2002 $595,453,282

BC Life & Health
2003 $1,393,452,053
2002 $1,072,069,355

CIGNA (Connecticut General)
2003 $587,680,722
2002 $547,348,397

Fortis Benefits
2003 $115,841,442
2002 $116,714,952

Fortis Insurance Company
2003 $22,546,756
2002 $19,913,423

Great-West Life & Annuity
2003 $90,956,774
2002 $89,576,582

Guardian Life Insurance Company
2003 $313,001,626
2002 $313,547,440

Humana Insurance Company
2003 $37,140,089
2002 $65,127,519

Mutual of Omaha
2003 $56,311,983
2002 $52,628,769

New England Life Insurance
2003 $2,506,148
2002 $3,903,940

Principal Life Insurance
2003 $193,537,255
2002 $204,424,315

Prudential
2003 $71,446,633
2002 $82,569,710

UniCare Life & Health Insurance Co.
2003 $44,459,625
2002 $38,803,500

UnitedHealthcare Insurance Co.
2003 $435,220,849
2002 $393,167,055

Unum
2003 $360,385,115
2002 $333,851,643

TOTAL
2003 $4,140,218,650
2002 $3,934,877,458

added 21,300 lives mostly in public programs, and Community Health Group in San Diego also added enrollment in its public programs. At the beginning of 2004, Community Health Group added Medi-Cal members from the UC San Diego plan, which ended its contract.

All but three of the county Medi-Cal and Healthy Families HMOs gained enrollment in 2003. CalOptima, adding 60,300 net new lives and Inland Empire, which gained 23,900 lives, showed the largest gains. Six of the county plans have branched out in recent years to offer "commercial" plans, usually pilot programs to help small businesses or individuals to get affordable access to coverage. Some of those pilots were started when the county HMOs were posting strong net income, which has generally not been the case in the past two years.

The sidebar on this page shows the premiums collected by major health insurers for plans outside of their HMOs in California in 2002 and 2003. Collecting the largest amount of premiums by far is BC Life & Health, which is the Blue Cross-owned insurance company that the Commissioner of Insurance has jurisdiction over. Other companies with significant health insurance premiums are CIGNA (Connecticut General), Aetna Life, and UnitedHealthcare's insurance company.

Enrollment in California HMOs continued to decline in the first half of 2004, as shown in Exhibit 7. During the first part of 2004, enrollment decreased by 0.9 percent, or about 170,000 lives. While Medicare enrollment was flat, enrollment continued to decline in commercial plans. And, for the first time in since the 1990s, enrollment in the public program HMOs declined.

3.3 Medicare HMO Plans

The Medicare Modernization Act of 2003 (MMA) gave a new name to Medicare HMO plans. They are now called Medicare Advantage, replacing the name Medicare+Choice which had in turn replaced Medicare Risk HMO plans. As with the Medicare+Choice program, the idea behind Medicare Advantage is to give seniors private market options that mirror the kind of options that are available to commercial groups: HMO, PPO, fee-for-service, and so on. In enacting the 2003 law, Congress and the Bush Administration expressed a clear preference for moving seniors into private plans and backed that with a commitment of significant new dollars for participating health plans. (Still, there is a concern that budget deficits may lead Congress to take back some of this new money.)

When Medicare Risk HMO plans began in the 1980s, HMOs contracted to provide comprehensive health care for seniors in exchange for a payment rate that was about 95 percent of the average cost of care for seniors in that state or county. In 1997, Congress enacted the Balanced Budget Act, which, among other things, replaced the Medicare Risk program with the Medicare+Choice program. While Medicare Risk had been limited to HMOs, Medicare+Choice was intended to expand the insurance options open to seniors to include PPOs and private fee-for-service options.

HMOs embraced the new Medicare+Choice program and began Medicare plans in numerous states. By 1999, there were about 20 HMOs offering Medicare+Choice plans in California. HMOs competed vigorously, offering plans with significant benefits not offered by traditional Medicare, including prescription drugs, hearing aids, and transportation to appointments. The federal payment rates were generous enough that the HMOs at first charged only a small amount or even zero in enrollee co-premiums.

California seniors responded to the promise of good benefits and joined Medicare+Choice plans in large numbers in the late 1990s. In some parts of the state, almost half of all seniors were in Medicare HMOs. That was not the case in other states where the penetration rate barely broke 10 percent. In Michigan, for example, few seniors were interested in Medicare plans, even though six or seven HMOs started up. Many retirees from the automobile industry had rich retirement

EXHIBIT 7. Enrollment in California HMOs, June 2004

HMO	2003	June 2004	Change
Large HMOs			
Aetna Health	377,718	319,527	– 15.4%
Blue Cross of California	2,971,045	2,931,016	– 1.3%
Blue Shield of California	2,675,011	2,691,562	0.6%
Health Net*	1,981,395	1,958,768	– 1.1%
Kaiser Foundation	6,453,906	6,414,145	– 0.6%
PacifiCare	1,681,389	1,736,142	3.3%
Smaller HMOs			
Care 1st Health Plan	179,457	159,725	– 11.0%
CareMore Insurance Services	0	1,538	NA
Chinese Community Health Plan	11,237	11,280	0.4%
CIGNA Healthcare	146,977	87,684	– 40.3%
Community Health Group	103,414	101,762	– 1.6%
Community Health Plan	183,348	162,366	– 11.4%
Great-West Health Care	53,123	55,039	3.6%
Inter Valley Health Plan	14,823	14,360	– 3.1%
Molina Medical Centers	254,393	245,187	– 3.6%
On Lok Senior Health Services	934	943	1.0%
SCAN Health Plan	52,945	61,078	15.4%
Sharp Health Plan	123,433	124,559	0.9%
Sistemas Medicos Nacionales	11,994	14,098	17.5%
UC San Diego	12,920	0	– 100.0%
Universal Care	306,675	285,940	– 6.8%
Valley Health Plan	55,743	58,066	4.2%
Ventura County	10,655	10,638	– 0.2%
WATTSHealth Plan	93,375	80,419	– 13.9%
Western Health Advantage	64,549	71,664	11.0%
County Health Systems and Local Initiatives			
Alameda Alliance for Health	92,580	98,887	6.8%
CalOptima*	300,349	296,667	– 1.2%
Central Coast Alliance	81,901	83,547	2.0%
Contra Costa Health Plan	60,920	58,939	– 3.3%
Inland Empire Health Plan	265,148	278,642	5.1%
Kern Health Systems	79,791	84,439	5.8%
LA Care†	17,494	30,141	72.3%
Partnership Health Plan	81,506	81,506	0.0%
San Francisco Health Plan	42,356	46,981	10.9%
San Joaquin County Health	64,418	68,246	5.9%
San Mateo Health Commission	52,944	54,334	2.6%
Santa Barbara Regional Health	54,024	55,725	3.1%
Santa Clara Family Health Plan*	91,883	96,665	5.2%
TOTAL	**19,105,773**	**18,932,225**	**– 0.9%**

*Health Net's enrollment is adjusted downward to reflect Medi-Cal enrollees in Los Angeles County that are subcontracted to Molina Healthcare (119,000) and Universal Care (122,000) as of June 2004. CalOptima subcontracts 25,100 of its Medi-Cal lives to Kaiser Permanente and Universal Health. Santa Clara Family Health Plan subcontracts most of its lives to Valley Health Plan or Kaiser Permanente.

†LA Care subcontracts its 720,000 Medi-Cal lives to other HMOs, so that is shown below the line. It does not subcontract for its Healthy Family enrollees, which are shown in the upper part of the table.

Source: Author's analysis of HMO quarterly statements, Report No. 4, Enrollment and Utilization Table.

benefits, including full prescription drugs coverage, and had no financial incentive to choose a Medicare HMO.

As the 1990s came to a close, HMOs' enthusiasm for Medicare+Choice waned, both in California and in other states. As federal payment rate increases lagged behind inflation in medical costs, HMOs' profitability declined. Provider systems that had accepted capitation for comprehensive care saw that they were losing money and ended their contracts.

Many HMOs dropped out of the Medicare+Choice program as their provider networks began to fray or their plans began to lose money. These changes were less drastic in California than in other states. Still, the number of participating HMOs declined. Those HMOs that stayed generally reduced the supplemental benefits and sharply increased enrollee premiums. For example, a prescription drug benefit with few limits in 1999 might by 2005 provide an annual benefit limited to $1,250 worth of generic drugs. Many Medicare HMOs in California and other states also reduced their service areas, particularly when hospital systems decided that they would no longer accept capitation risk from Medicare HMOs.

According to data from the California Department of Finance, about 3.6 million Californians were 65 or older in 2000, or 10.7 percent of the population. In 2003, about 36 percent of them were enrolled in a Medicare HMO. As shown in Exhibit 8, enrollment in Medicare HMOs grew through 1999 but then began to decrease. Enrollment went from 1.4 million in 1995 to a peak of more than 1.6 million in 1999. Since then, enrollment has declined to 1.3 million in 2003.

Exhibit 9 shows that out of 24 counties selected for analysis in 2005, four counties show a penetration of Medicare HMO plans above 40 percent: Contra Costa, Placer, Riverside, and San Bernardino. Even with the withdrawals of plans in recent years, there are still three or four Medicare HMOs competing in most of the Bay Area, and eight to ten plans in much of southern California.

Kaiser Permanente has been the largest Medicare HMO in California since it surpassed PacifiCare in 2000. Kaiser grew its Medicare Risk plan from 440,000 seniors in 1995 to 658,000 in 2003. (Kaiser has another 20,000 seniors in other Medicare plans.) PacifiCare used to have 600,000 seniors in its California Medicare plans, but that dropped to 348,000 by the end of 2003. See Exhibit 5 for 2003 data for the other HMOs. Data from previous years come from the same annual statements used for Exhibit 5.

The enrollment decrease has apparently stopped in 2004 and some observers expect to see a comeback in senior enrollment in HMOs. In the other states studied by the author, Medicare HMOs that had remained in the business were very profitable in both 2003 and 2002. (The annual statements submitted by HMOs in those states include a table allocating revenue, expenses, and net income to different lines of business. California has such a table in its annual statements but allows HMOs to classify that as non-public information.)

In addition, the federal government has infused significant new dollars into Medicare HMO payment rates. For example, the base rate in Alameda County went up by only 2.2 percent between 2003 and 2004, to $676. But in March, as a result of the Medicare Modernization Act, the rates were increased again for the rest of 2004, this time by 6.2 percent. On top of that, the rates for 2005 will increase by 6.6 percent, up to $765. That is almost $90 more per-member per-month in a two-year period.

HMOs have responded to the new federal dollars by improving (or restoring) some of the supplemental benefits and reducing enrollee co-premiums. For example, PacifiCare increased the coverage limit on brand-name drugs from $1,000 to $1,300 in Los Angeles County. It reduced office visit co-pays in some counties and eliminated monthly premiums in others.

In the first half of 2004, Kaiser, PacifiCare, and SCAN all increased their Medicare Advantage enrollment. HMOs in California and other states announced plans to extend their service areas, in some cases expanding into counties that they had previously served and then abandoned. And in another sign of life for the Medicare HMO business, there have been some recent acquisitions of Medicare plans by companies like Humana, which are showing renewed interest in Medicare as a business opportunity. Still, it remains a somewhat risky proposition. Depending on Medicare as a key customer means relying on the federal government and how much or how little it chooses to increase payments each year. Whether the payment increases can or will be sustained into the future is a debatable proposition, especially given the pressure to contain the growth of the Medicare budget and to do so without directly cutting provider payments.

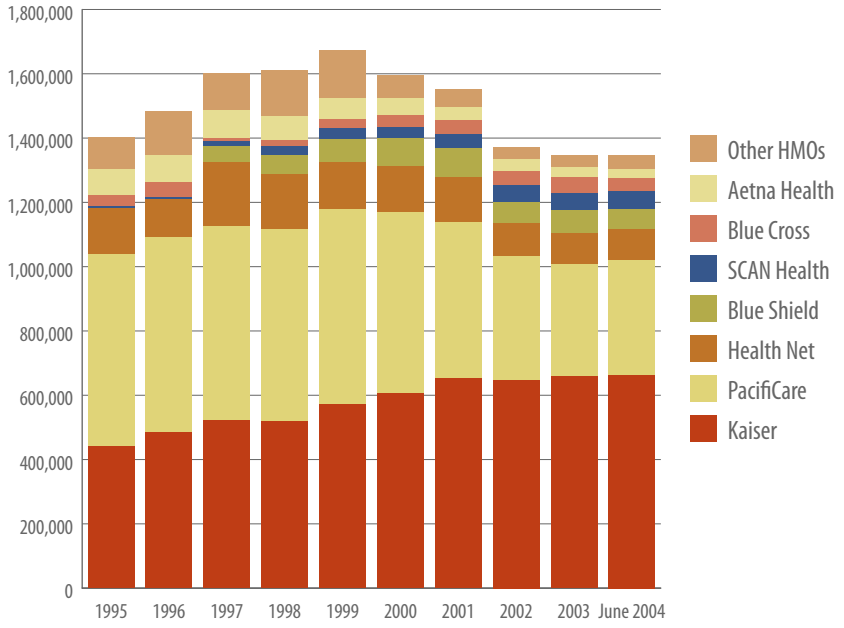
Blue Cross and some other HMOs sell Medicare Supplement products, which are generally used to cover co-payments and deductibles that are the responsibility of seniors in traditional Medicare. These products vary in their benefits and price. As PacifiCare has withdrawn its Secure Horizons Medicare plan from some service areas, it has begun to market Medicare Supplement plans to those seniors. Kaiser Permanente has a few different Medicare plans, including a cost contract in which the HMO manages patient care to some extent but is not at risk for inpatient care.

There is a good deal of uncertainty about the future of the three kinds of plans outlined under the Medicare Modernization Act:

- Medicare Advantage HMO plans, where the HMO takes risk for medical management and can limit its geographic service area.
- New PPOs that are envisioned as operating and competing in multi-state regions. The boundaries of those regions were announced in November 2004.
- Part D plans that will be selling prescription drug benefits beginning in 2006.

Some analysts believe that the business opportunities will generally be strongest

EXHIBIT 8. Enrollment in California Medicare+Choice HMOs, 1995 to 2004



Source: Author's analysis of HMO annual statements, Report No. 4.

EXHIBIT 9. Medicare+Choice Payment Rates, Plans and Penetration in Selected Counties, 2004 and 2005

County	2005 AAPCC	Increase Over 2004	Number of HMOs in 2005	Number of HMOs in 2004	Seniors in HMOs June 2004	Eligible Seniors	Penetration Rate
Northern and Central California							
Alameda	$765.40	6.6%	3	3	60,884	166,747	36.5%
Contra Costa	780.58	7.1%	4	4	52,248	128,445	40.7%
Fresno	654.22	6.6%	2	2	19,776	99,345	19.9%
Marin	709.32	6.6%	1	1	12,299	37,679	32.6%
Monterey	709.50	6.6%	0	0	307	45,454	0.7%
Napa	756.67	6.6%	1	1	7,119	22,823	31.2%
Placer	654.22	6.6%	4	4	18,816	43,381	43.4%
Sacramento	664.30	6.6%	4	4	67,433	169,511	39.8%
San Francisco	723.98	6.6%	4	3	35,930	124,176	28.9%
San Joaquin	654.22	6.6%	1	2	14,299	75,303	19.0%
San Mateo	681.30	6.6%	3	3	32,327	96,422	33.5%
Santa Clara	699.18	6.6%	3	4	63,734	183,339	34.8%
Santa Cruz	670.33	6.6%	1	1	3,827	29,491	13.0%
Solano	702.81	6.6%	2	2	16,313	45,727	35.7%
Sonoma	672.82	6.6%	1	2	18,947	66,719	28.4%
Stanislaus	712.79	12.8%	2	2	21,417	61,227	35.0%
Southern California							
Kern	$704.49	7.9%	5	5	26,481	83,890	31.6%
Los Angeles	813.25	8.1%	11	10	361,173	1,076,328	33.6%
Orange	769.39	7.9%	10	9	117,147	323,018	36.3%
Riverside	749.94	7.0%	8	7	99,453	232,418	42.8%
San Bernardino	748.24	7.8%	9	8	80,414	188,401	42.7%
San Diego	684.40	6.6%	4	4	141,113	363,260	38.8%
Santa Barbara	654.22	6.6%	2	3	10,476	58,108	18.0%
Ventura	739.51	6.7%	2	3	21,594	95,600	22.6%

Note: Some HMOs may offer more than one plan option or network arrangement in all or part of the county.

Source: Author's analysis of reports and Web site information from Centers for Medicare and Medicaid Services, www.cms.gov and www.medicare.gov.

for the Medicare Advantage HMO plans, since they will have control over their service areas and will be rewarded for effective medical management. There is less interest in the PPO plans and concern that the prescription drug plans will not be able to create incentives and rewards for effective medical management.

3.4 Medi-Cal Managed Care

The California Department of Health Services, working with county agencies, administers the Medi-Cal and Medi-Cal managed care programs. A separate program offering subsidized health insurance to low-income families is the Healthy Families plan, which is administered by a different state agency, the Managed Risk Medical Insurance Board.

Most of the data and discussion that follow are limited to Medi-Cal managed care enrollment, as opposed to the Healthy Families plan which offers subsidized health insurance to low-income families.

Background

States introduced managed care arrangements for Medicaid to achieve several goals: to improve access to physicians, to improve continuity of care by emphasizing primary care, and to save money to the Medicaid program, or at least set limits on the state's obligation. When patients have a primary care home, they will use hospital emergency departments less often and will have fewer admissions to hospitals. That is especially important for children or adults with chronic conditions such as asthma. To save money, states take a discount on the payments they make to HMOs. They will usually set them at 5 to 10 percent below what they calculate the equivalent cost would be if providers were paid the state's fee-for-service rates.

California introduced managed care for Medi-Cal more than 10 years ago. As in other states, it focused on recipients that were also receiving cash assistance through AFDC (Aid to Families with Dependent Children, now called TANF, Temporary Aid to Needy Families). Medi-Cal recipients with disabilities or seniors in nursing homes have generally been exempt from any mandate to enroll in an HMO. However, proposals are offered from time to time to enroll aged and disabled Medi-Cal recipients into some form of managed care.

While persons with disabilities are a small percentage of Medi-Cal recipients, they consume a significant portion of the total budget. Of the 8.5 million persons who received Medi-Cal benefits in California in 2001 (the last year for which data are available), 11.3 percent were blind or disabled. But that segment of recipients accounts for 47.1 percent of benefits paid that year, which totaled $18.6 billion.

Evolution of Models

In the 1970s and 1980s, California began with two models of Medi-Cal managed care:

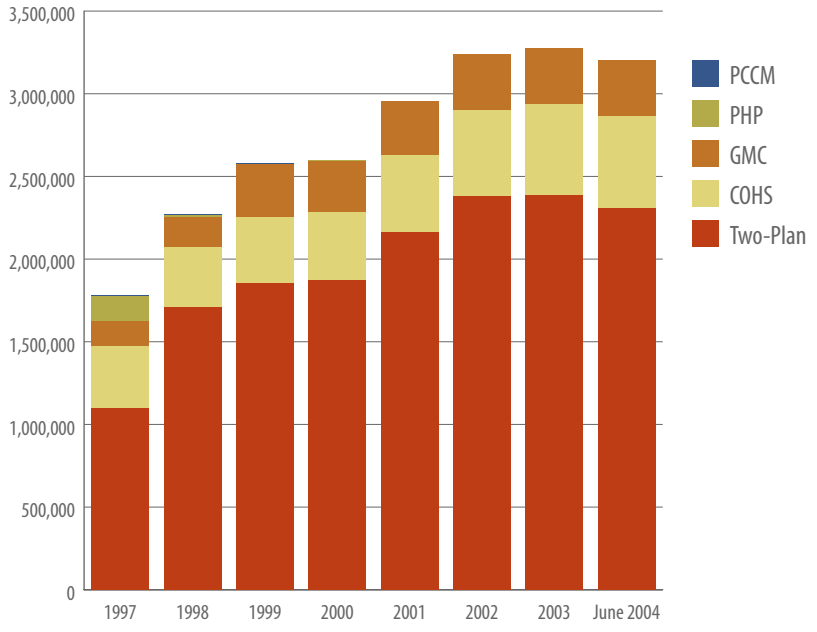
- **Prepaid health plan (PHP) arrangements,** first authorized by the California legislature in 1975, in which provider organizations did not accept significant risk for utilization.
- **Primary care case management (PCCM) model,** authorized in 1981, in which physicians and clinics would oversee patients' referrals to specialists and hospital admissions. They would usually be paid a few dollars extra per patient per month in exchange for that limited amount of care management.

As of November 2004, these two types of programs still existed in only a handful of counties: In Marin and Sonoma Counties, there were just over 1,700 enrollees in PHP programs; in Los Angeles County, there were approximately 800 enrollees in PCCM arrangements. These include some special projects such as the AIDS Healthcare Foundation in Los Angeles County. The state and contracting health plans also operate other special managed care programs for seniors, such as the On Lok Senior Plan for seniors at risk of entering nursing homes.

Since the early 1990s, California has moved to three managed care models in which it contracts with HMOs or with county health authorities that have organized their own HMO. They are: the two-plan model, county-organized health systems (COHS), and geographic managed care (GMC). The two-plan model was first developed by DHS in 1992 and geographic managed care was authorized in Sacramento in that same year. The smallest of the three models, the county-organized health system model, has a longer history and was first authorized in 1982.

- In the **two-plan model,** a county-sponsored health plan and a commercial HMO compete for Medicaid enrollees. Los Angeles, Riverside, San Francisco, and Alameda are examples of two-plan counties, although these counties have each taken different approaches. In Alameda County, the Alameda Alliance for Health is the county plan and it competes with Blue Cross. In Los Angeles County both the county plan (LA Care) and the commercial plan (Health Net) contract out many or all of their Medi-Cal enrollees to other HMOs. Blue Cross and Health Net are the commercial plans in most two-plan counties. In the 12 counties that have a two-plan system, the county-sponsored plans have two-thirds of the enrollees.
- In a **county-organized health system,** a county authority, sometimes partnering with one or two nearby counties, manages a health plan-like arrangement. There are eight counties in five county-organized health systems. Orange, Santa Barbara, Monterey, and Napa counties are examples. Some of those county authorities also enroll aged and disabled Medicaid recipients. Federal rules limit the percentage of a state's Medicaid managed care enrollees that can be in the COHS.
- In the two counties with **geographic managed care,** competing health plans vie for enrollees within a county, but there is no designated county government plan. Geographic managed care arrangements

EXHIBIT 10. Enrollment in Medi-Cal Managed Care, 1997 to 2004



Source: Author's analysis of monthly enrollment reports from the Department of Health Services.

operate in Sacramento and San Diego Counties with five or six HMOs competing. San Diego will soon see the number of competitors drop to five. Molina Healthcare has agreed to take over the San Diego County Medi-Cal and Healthy Families enrollment of two of the HMOs there, Sharp Health Plan and Universal Care.

In 2003, there were about 2.4 million Medi-Cal recipients in two-plan arrangements. About 554,000 enrollees were in the five COHS arrangements at the end of 2003, and 335,000 were in the San Diego and Sacramento GMC arrangements.

Exhibit 10 on the previous page shows the growth of Medi-Cal recipients in managed care, reflecting enrollment in different managed care arrangements. As of December 2003, there were 3.372 million Medi-Cal beneficiaries in HMO plans, but that number dropped to 3.286 million by June 2004. Budget cuts enacted in 2003 and 2004 required recipients to re-qualify for their eligibility more often, resulting in people dropping out of Medi-Cal. For example, LA Care, the local initiative plan for Los Angeles County, saw its enrollment drop from 767,000 at the beginning of 2004 to 720,000 by the end of June. Exhibit 11 shows enrollment by county in two-plan, county-organized health system, and geographic managed care counties.

Exhibit 12 on the following page compares contracting HMOs on their Medi-Cal enrollment between 1995 and 2004, based on their annual statements to the Department of Managed Health Care. Six HMO plans have more than 200,000 Medi-Cal enrollees, and three others have between 100,000 and 200,000 enrollees. At the end of 2003, Blue Cross was the largest plan for these programs. It reported almost 845,000 enrollees

EXHIBIT 11. Enrollment in Medi-Cal Managed Care Plans for Counties, 2002 and 2003

County	Plan	December 2002	December 2003	2003 Share
Two-Plan Model				
Alameda	Alameda Alliance	70,220	76,285	72.5%
	Blue Cross	27,481	28,914	27.5%
	County Total	97,701	105,199	100.0%
Contra Costa	Contra Costa Health Plan	41,684	42,407	84.1%
	Blue Cross	6,735	8,025	15.9%
	County Total	48,419	50,432	100.0%
Fresno	Blue Cross	125,322	130,544	82.1%
	Health Net	29,222	28,554	17.9%
	County Total	154,544	159,098	100.0%
Kern	Kern Health Systems	67,950	71,923	67.4%
	Blue Cross	35,840	34,765	32.6%
	County Total	103,790	106,688	100.0%
Los Angeles	LA Care*	814,461	789,820	60.9%
	Health Net*	532,928	507,958	39.1%
	County Total	1,347,389	1,297,778	100.0%
Riverside	Inland Empire Health Plan	96,624	105,068	72.8%
	Molina Medical Centers	38,478	39,309	27.2%
	County Total	135,102	144,377	100.0%
San Bernardino	Inland Empire Health Plan	127,875	131,514	71.0%
	Molina Medical Center	50,300	53,739	29.0%
	County Total	178,175	185,253	100.0%
San Francisco	San Francisco Health Plan	27,955	30,010	68.0%
	Blue Cross	14,532	14,125	32.0%
	County Total	42,487	44,135	100.0%
San Joaquin	Health Plan of San Joaquin	55,872	56,593	73.2%
	Blue Cross	19,674	20,729	26.8%
	County Total	75,546	77,322	100.0%
Santa Clara	Santa Clara Family Health*	60,580	70,070	71.7%
	Blue Cross	23,996	27,620	28.3%
	County Total	84,576	97,690	100.0%
Stanislaus	Blue Cross	35,224	39,171	100.0%
Tulare	Blue Cross	60,863	61,560	80.2%
	Health Net	17,662	15,198	19.8%
	County Total	78,525	76,758	100.0%
Two-Plan Subtotals	**County Plans**	**1,584,630**	**1,604,965**	**67.3%**
	Commercial Plans	**796,848**	**778,936**	**32.7%**
	All Enrollees	**2,381,478**	**2,383,901**	**100.0%**
County Organized Health Systems				
Monterey and Santa Cruz	Central Coast Alliance	80,132	82,490	14.9%
Napa, Solano and Yolo	Partnership Health Plan	72,958	80,345	14.5%
Orange	CalOptima	270,670	292,059	52.7%
San Mateo	Health Plan of San Mateo	42,405	46,888	8.5%
Santa Barbara	Santa Barbara Regional Health Authority	48,558	52,178	9.4%
COHS Subtotals		**514,723**	**553,960**	**100%**

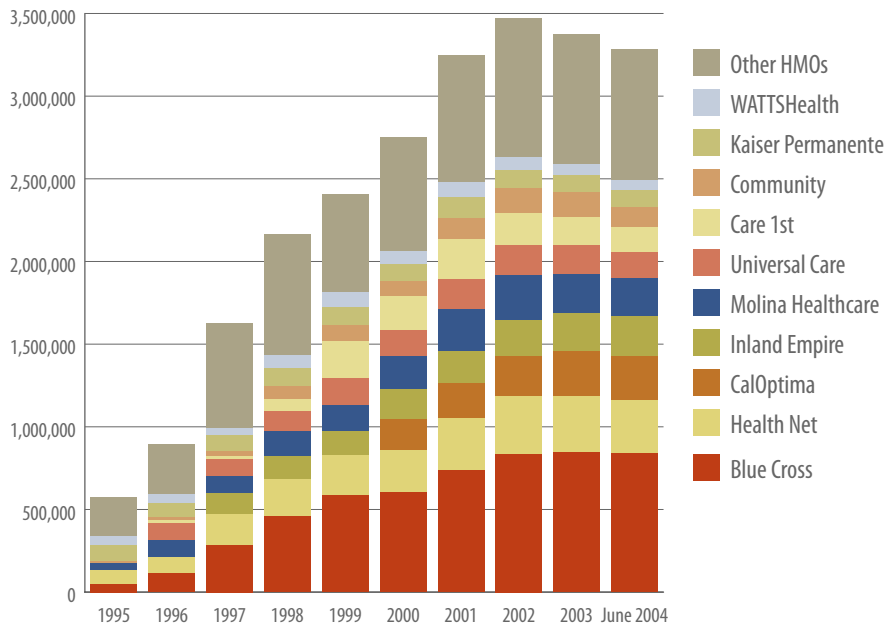
*In Los Angeles County, LA Care subcontracts all Medi-Cal enrollees to other HMO partners, including Blue Cross, Care 1st, Community Health Plan, and Kaiser Permanente. Health Net subcontracts a portion of its enrollees to Universal and Molina Healthcare. Santa Clara Family Health Plan contracts out many of its enrollees to Valley Health Plan and Kaiser Permanente.

EXHIBIT 11. Enrollment in Medi-Cal Managed Care Plans for Counties, 2002 and 2003, cont.

County	Plan	December 2002	December 2003	2003 Share
Geographic Managed Care				
Sacramento	Blue Cross	73,455	76,078	46.9%
	Health Net	30,655	30,497	18.8%
	Kaiser Foundation Health Plan	19,888	20,000	12.3%
	Molina Healthcare	21,533	20,108	12.4%
	Western Health Advantage	15,422	15,690	9.7%
	County Total	160,953	162,373	100.0%
San Diego	Blue Cross	15,658	15,737	9.0%
	Community Health Group	67,581	65,540	37.4%
	Health Net	8,882	8,903	5.1%
	Kaiser Foundation	9,437	8,906	5.1%
	Sharp Health Plan	49,047	50,016	28.5%
	UCSD Healthcare	12,986	13,336	7.6%
	Universal Care	11,979	12,850	7.3%
	County Total	175,570	175,288	100.0%
Geographic Managed Care Subtotals		336,523	337,661	
TOTAL ENROLLMENT		3,232,724	3,275,522	100.0%

Source: Author's analysis of Department of Health Services, Monthly Enrollment Reports for July and December 2002 and July and December 2003.

EXHIBIT 12. Enrollment in Medi-Cal HMO Plans, 1995 to 2004



Source: Author's analysis of monthly enrollment reports from the Department of Health Services.

in Medi-Cal plus 280,000 in Healthy Families.

WellPoint, Inc., the parent of Blue Cross of California, also operates Medicaid managed care plans in other states, including Oklahoma and Puerto Rico, and has looked at contracts or acquisitions in more states. It is one of the few Blue Cross plans around the country that has any significant amount of Medicaid business. As was noted earlier, the new WellPoint, Inc. may seek to contract for Medicaid in some of the former Anthem states.

If WellPoint, Inc., expands its state Medicaid operations in other states, it will run into competition from companies that have developed a niche of contracting for state programs. Four of them are now publicly traded companies that are exclusively contracting with states for Medicaid and children's health plans in managed care. They are AmeriGroup, based in Virginia; Centene Corp., based in St. Louis; Molina Healthcare, in Long Beach; and WellCare, based in Florida. Wall Street analysts have received these companies warmly and have been impressed by their ability to manage their state contracts. And while there is some risk in having a single customer in each state, federal law requires states to set actuarially sound payment rates for their Medicaid HMO contracts. In addition to those four, United HealthGroup has formed a Medicaid company within its company. It acquired AmeriChoice, a Medicaid HMO in New York and New Jersey, and has replicated that model in the other states where it has Medicaid HMOs.

While many states are beginning to recover from their budget problems of the past few years, many find that a growing economy is still weighed down by obligations for health care programs.

States addressing Medicaid shortfalls are largely limited to three approaches: reducing eligibility, reducing benefits, and reducing payments to providers. Under federal rules, there is very little room for states to do what private employers have done, namely increasing enrollee cost-sharing through co-payments and deductibles.

A California budget cut enacted in 2003 reduced fees to providers. A new requirement for Medi-Cal recipients to go through a re-qualification process twice a year (instead of just once under previous rules) caused some enrollees to fall off the rolls. California had planned expansions in eligibility for both Medi-Cal and Healthy Families. However, efforts to fix the state's budget deficit will slow or even reverse the growth of both the Medi-Cal and Healthy Families programs. California and other states were rescued in 2003 from needing to make more drastic cuts because they received a one-time infusion of federal funds, when Congress made an 18-month increase in federal matching dollars. However, that expired in 2004 and does not seem likely to be renewed.

California is one of the states that has looked at making major changes in its Medicaid program. The Bush administration proposed in its first term to cap the amount of money going to states in exchange for some additional flexibility to states in benefit design and program administration. (Many refer to this as a block grant, but not federal authorities.) The current administration in Sacramento has shown interest in making some kind of tradeoff to get more flexibility in how it operates Medi-Cal.

In addition, California has looked at steps that other states have taken to increase federal dollars for Medicaid. One method that has been employed in Michigan is to impose fees (the word "tax" is studiously avoided) on certain health care providers or on HMOs. It is usually referred to as a quality assurance fee. Those extra dollars are submitted for federal matching funds, and the state uses the additional dollars to increase payments to providers or HMOs.

3.5 HMO Enrollment by Region

Before examining regional HMO enrollment and penetration data for 2003, it is useful to review methodology issues that affect this analysis. California regulators do not collect data from HMOs on enrollment by geographic unit. Some states, including Minnesota, Wisconsin, and Florida, require that information as a supplement to their HMO annual statements. It would be helpful to researchers and others if supplemental reports with this information were submitted to the Department of Managed Health Care. Other researchers conduct surveys to gather that information from health plans, but do not disclose information on individual HMOs.

In 2003 the author surveyed California HMOs for information on their enrollment by county and line of business (commercial, Medicare, Medi-Cal, and Healthy Families). Many HMOs provided that information, but others did not. Where the HMOs did not respond, other sources were used to find enrollment in Medicare and Medi-Cal by plan and county. For Medi-Cal enrollment, monthly reports from the Department of Health Services were used to supplement the data found in the annual HMO statements. These reports list enrollment by county and health plan, but they do not address the question of enrollees that are in subcontract arrangements, such as Blue Cross and LA Care.

Another source of enrollment data is available through the federal Centers for Medicare and Medicaid Services (CMS). CMS's Web site offers monthly and quarterly reports on enrollment in Medicare HMO plans. Quarterly reports show enrollment by plan and by county. The CMS reports do not report enrollment in counties where a health plan has very few enrollees. The CMS reports do not exactly tie out to the state HMO filings, but the two reports come close.

The more difficult calculation was for enrollment in commercial plans. Because some HMOs have enrollment in only one region of the state, it was sufficient in those cases to transfer enrollment numbers from annual statements. Where HMOs do business in several regions or where there was an issue of double counting, enrollment in those regions was estimated based on the results of enrollment surveys conducted in past years. Those numbers were then compared to the results of a survey conducted by the Cattaneou & Stroud consulting firm.

Enrollment in limited license health plans is not included in this analysis because of the double counting problem described earlier in Section 3.2. Furthermore, this analysis does not include some small demonstration projects in California, which account for only a few thousand enrollees.

County population figures are taken from the 2003 county population estimates prepared by the Department of Finance. The counties are grouped into the 14 Health Service Areas (HSAs), the regions used for state health planning. To simplify the presentation, some of the county groups have been combined in the second half of the table. The far northern counties in the state, where there is very little managed care activity, are combined in this table with Sacramento and surrounding counties, where there is a good deal of managed care activity. Three HSAs in the Bay Area are also combined here,

as are Los Angeles and Orange Counties in the south.

Exhibit 13 presents two views of HMO health plan enrollment and market share in California. Part A examines total HMO enrollment and penetration in 14 regions of California. Part B looks at which HMOs, county systems, and local initiatives account for the enrollees in specific areas.

In four regions of the state, HMO penetration exceeds 60 percent: Sacramento, the Sonoma/Napa Valley areas, the East Bay area (Alameda and Contra Costa), and the Inland Empire of Riverside and San Bernardino Counties. The lowest penetration rates are found in the far north and the central coast, including the Santa Cruz and Monterey areas. The northern part of the state does not have HMOs for Medi-Cal, although there is some HMO activity for Healthy Families.

The central coast does use county-sponsored HMOs for Medi-Cal, but the hospitals and physician groups in the region have historically been inhospitable to managed care. Most HMOs have withdrawn from the area because of their inability to negotiate hospital discounts that would allow them to operate profitably.

Kaiser Permanente is the largest HMO in most of the state, including northern California, Los Angeles/Orange Counties, the Inland Empire, and San Diego. Blue Cross is the largest in central California and is second largest in Los Angeles and Orange Counties. The three HMOs that are next in size—Blue Shield, Health Net, and PacifiCare—all have many more enrollees in southern California and fewer in the north. For example, more than half of PacifiCare's enrollment is in Los Angeles/Orange and San Diego and only about one-sixth of its enrollees are in northern California. Only about 30 percent of Blue Shield's members are in northern California. Similarly, half of Health Net's enrollees are in Los Angeles/Orange and San Diego.

3.6 HMO Revenues and Net Income

HMO finances are the subject of endless speculation. Physicians and hospitals wonder why they can't secure an even bigger percentage of premium revenues. Employers ask why their premiums continue to increase by double-digits every year, especially when HMOs are profitable and have large reserves. Consumers ask questions about executive compensation and about what portion of revenues are returned to shareholders; could that money be used to improve access and quality?

The analysis in this section is based on the annual statements that HMOs file with the Department of Managed Health Care. Note that these reports are prepared according to statutory accounting rules, which may differ from generally accepted accounting principles (GAAP).

Reasonable questions can be raised about whether HMO statements present a fair and balanced picture of an HMO's financial condition, especially if the HMO has operations in multiple states, operates affiliated insurance companies, or is connected by ownership with hospitals or physician clinics.

EXHIBIT 13A. Estimated Health Plan Enrollment and Penetration by Region, 2003

	HSA	2003 Estimated HMO Enrollment	2003 Estimated Population	Estimated HMO Penetration
1	North	75,024	926,850	8.1%
2	Sacramento	1,410,550	2,217,820	63.6%
3	Sonoma / Napa	655,711	1,020,700	64.2%
4	San Francisco Bay West	995,454	1,750,000	56.9%
5	East Bay Area	1,609,272	2,499,200	64.4%
6	Sierra Nevada	634,539	1,484,510	42.7%
7	San Jose / South Bay	980,286	1,723,900	56.9%
8	Central Coast	244,794	992,100	24.7%
9	Central Valley	996,829	2,256,050	44.2%
10	Santa Barbara	499,439	1,211,300	41.2%
11	Los Angeles	5,259,555	10,047,300	52.3%
12	Inland Empire	2,332,380	3,659,950	63.7%
13	Orange	1,684,971	3,001,300	56.1%
14	San Diego	1,677,351	3,142,900	53.4%
	TOTAL	19,056,154	35,933,880	53.0%

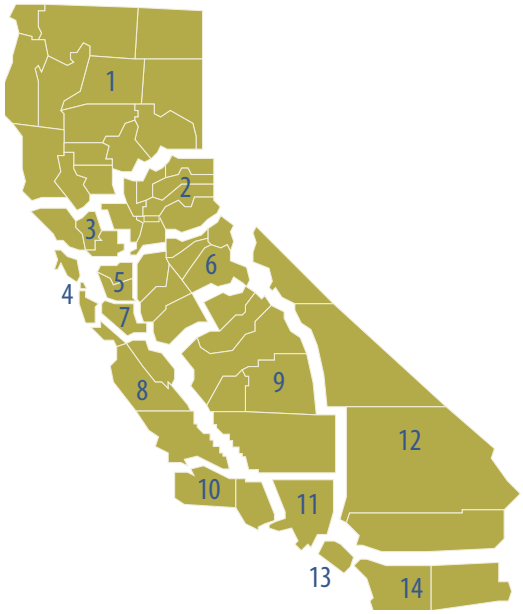


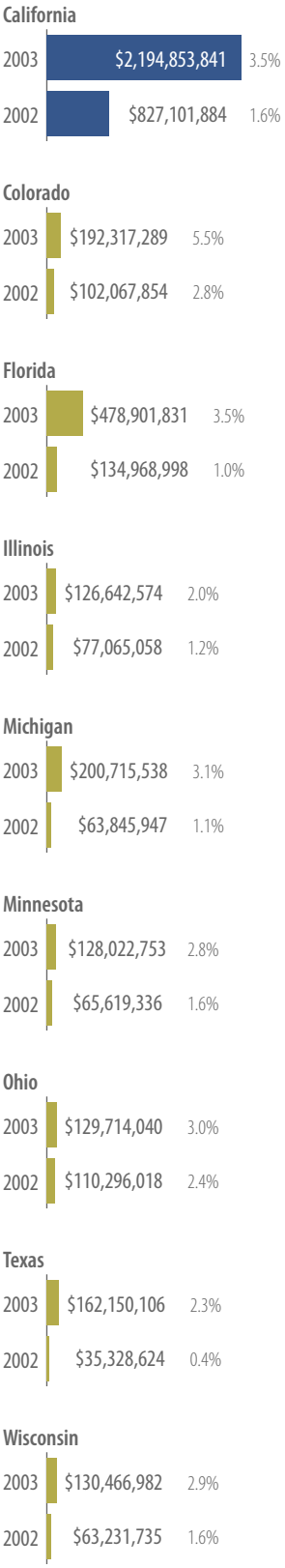
EXHIBIT 13B. Estimated Enrollment by HMO and Region, 2003

HMO	1, 2	3	4, 5, 7	6	8	9	10	11, 13	12	14	TOTAL
Larger HMOs											
Aetna Health	28	2,618	60,176	12,327	1,176	1,209	9,510	143,420	66,849	78,823	376,137
Blue Cross	162,091	17,204	270,125	117,789	43,074	305,559	124,266	1,390,023	365,657	162,437	2,958,226
Blue Shield	318,935	66,860	439,421	103,246	54,855	159,640	95,790	989,503	282,658	163,943	2,674,851
Health Net	172,103	78,571	376,746	74,226	26,390	135,197	75,288	752,807	155,126	154,783	2,001,236
Kaiser Foundation	633,994	376,338	1,813,686	238,255	12,057	215,326	68,907	1,871,324	621,639	501,362	6,352,888
PacifiCare	111,891	22,000	180,010	77,716	24,047	27,504	56,001	665,464	246,155	267,514	1,678,302
Smaller HMOs											
Care 1st Health Plan	0	0	0	0	0	0	0	179,457	0	0	179,457
Chinese Community Health Plan	0	0	11,220	0	0	0	0	0	0	0	11,220
CIGNA Healthcare	9,040	1,651	28,655	2,788	852	3,868	3,934	69,571	14,342	12,411	147,110
Community Health Group	0	0	0	0	0	0	0	0	0	103,414	103,414
Community Health Plan	0	0	0	0	0	0	0	33,333	150,015	0	183,348
Great-West Health Care	1,246	1,237	7,522	8,188	432	699	432	21,199	3,569	9,437	53,960
Inter Valley Health Plan	0	0	89	0	0	0	0	7,031	7,201	0	14,321
Molina Healthcare	20,217	0	0	0	0	0	0	138,422	97,340	53,704	309,683
On Lok Senior Health Services	0	0	934	0	0	0	0	0	0	0	934
SCAN Health Plan	0	0	0	0	0	0	0	38,617	13,176	55	51,848
Sharp Health Plan	0	0	0	0	0	0	0	0	0	123,433	123,433
Sistemas Medicos Nacionales	0	0	0	0	0	0	0	0	0	11,994	11,994
UC San Diego	0	0	0	0	0	0	0	0	0	12,920	12,920
Universal Care	10	13	4	3	10	3,618	633	233,670	40,106	21,106	299,173
Valley Health Plan	0	0	55,743	0	0	0	0	1,523	545	0	57,811
Ventura County	0	0	0	0	0	0	10,655	0	0	0	10,655
WATTSHealth Plan	0	0	0	0	0	0	0	91,319	2,855	13	94,187
Western Health Advantage	56,020	7,713	0	0	0	0	0	0	0	0	63,733
County Systems and Local Initiatives											
Alameda Alliance	0	0	92,580	0	0	0	0	0	0	0	92,580
CalOptima	0	0	0	0	0	0	0	300,349	0	0	300,349
Central Coast Alliance	0	0	0	0	81,901	0	0	0	0	0	81,901
Contra Costa Health Plan	0	0	60,920	0	0	0	0	0	0	0	60,920
Inland Empire Health Plan	0	0	0	0	0	0	0	0	265,148	0	265,148
Kern Health Systems	0	0	0	0	0	79,791	0	0	0	0	79,791
LA Care	0	0	0	0	0	0	0	17,494	0	0	17,494
Partnership Health Plan	0	81,506	0	0	0	0	0	0	0	0	81,506
San Francisco Health Plan	0	0	42,356	0	0	0	0	0	0	0	42,356
San Joaquin County Health	0	0	0	0	0	64,418	0	0	0	0	64,418
San Mateo Health Commission	0	0	52,944	0	0	0	0	0	0	0	52,944
Santa Barbara	0	0	0	0	0	0	54,024	0	0	0	54,024
Santa Clara Family Health	0	0	91,883	0	0	0	0	0	0	0	91,883
TOTAL	**1,485,574**	**655,711**	**3,585,012**	**634,538**	**244,794**	**996,829**	**499,439**	**6,944,526**	**2,332,380**	**1,677,351**	**19,056,154**

Sources: Based on HMO annual statements and author's surveys of health plans. Where health plan did not respond to survey, commercial enrollment is based on author's estimates compared to results of Cattaneo & Stroud annual survey of health plan enrollment; Medi-Cal enrollment based on monthly enrollment reports from the Department of Health Services; Medicare enrollment based on quarterly enrollment reports posted by Center for Medicare and Medicaid Services on www.hhs.cms.gov. Population estimates from California Department of Finance, Demographic Research Unit, www.dof.ca.gov/HTML/DEMOGRAP/repndat.htm.

HMO Net Income

State HMO net income from underwriting and investments and its share of total underwriting revenues.



In those cases, the company can shift certain revenues and expenses from the HMO to the insurance company, from state to state, from state plan to corporate operations, or from the health plan to the provider organization — and vice versa. Having raised these questions, this analysis relies on these statements simply because no other publicly available source of data is better.

Exhibit 14 on the following page shows net income for California HMOs in 2003. California HMOs had net income (after taxes and including investment income) of $2.195 billion, or 3.5 percent of revenues of $62.3 billion. That compares to net income of $827.1 million in 2002, or 1.6 percent of revenues of $51.5 billion, and represents the highest profits for California HMOs in at least the past decade. HMO profitability has improved for the past three years. In 2001 HMOs reported net income of $553 million, or 1.2 percent on revenues of $46.6 billion.

On average, the HMOs had net income of $9.04 per-member per-month in 2003. Among the largest health plans, Kaiser Foundation had net income of nearly $1 billion, or 3.9 percent of revenues. Blue Cross was second, with net income of $459.3 million, or 4.6 percent of revenues.

Blue Shield, Health Net, and PacifiCare all had strong net income in 2003. Blue Shield increased its net income from $41 million in 2001 to $87 million in 2002 and to $100.8 million in 2003. Health Net improved from $101 million in 2001 to $135 million in 2002 and $205 million in 2003. PacifiCare had net income of $196.2 million in 2003, which was 3.4 percent of revenues.

Among smaller HMOs, all but four reported positive net income in 2003. SCAN Health Plan in Long Beach, a special health plan for seniors, had 2003 net income of $115.7 million in 2003, or 18.4 percent of revenues. That comes out to a remarkable $187 per-member per-month. Community Health Plan, a unit of the Los Angeles County Department of Health serving Medi-Cal patients, had net income of $24.6 million, up from $17.1 million in 2002.

The county-sponsored Medi-Cal HMOs have seen their net income decline in the past two years. As a group they reported net income of almost $75 million in 2002. That decreased in 2003 to $46.9 million. LA Care had about half of that net income, with about $24 million in surplus. Inland Empire Health Plan had net income of $5.4 million in 2003. Santa Barbara lost $3.5 million in 2002 but turned that into a $8.3 million surplus in 2003. Alameda Alliance for Health reported a loss of $8.3 million, while San Mateo Health Plan literally broke even. San Mateo has lost almost $17 million in the past five years, and its future viability has been questioned. Kern Health System broke even for the year with net income of $329,104 after posting net income of $11.8 million in 2002. While LA Care reported nearly $24 million in net income in 2003, CalOptima saw its net income decrease from $20.8 million in 2002 to $1.2 million in 2003.

In the five years from 1999 through 2003, California HMOs had net income of $5.048 billion. As Exhibit 15 on page 44 shows, some of the large HMOs had consistently strong earnings from 1995 to 2003. Net income for the group declined in 2001, but has recovered strongly since then.

Exhibit 16 on page 45 updates HMO net income information through the first half of 2004. (For some HMOs whose year-end is June 30, this would be a 12-month result.) Based on unaudited figures, California HMOs as a group had net income of $2.564 billion, or 7.1 percent of their revenues. Several of the large plans, particularly Blue Cross, had very strong results.

3.7 Premium Revenue Trends

Setting prices is a risky activity for HMOs. For an employer group renewing in January 2005, the HMO will aim to develop a proposal by June of 2004. That proposal and its pricing will be based on claims experience for the previous

EXHIBIT 14. Net Income for California HMOs, 2003

HMO	Revenue	Net Income (Loss) Pre-Tax	Taxes Paid	Net Income (Loss) After Tax	Margin	Net Income (Loss) Per Member Per Month	Profits (Losses) 1999 to 2003
Largest HMOs							
Aetna Health	$1,039,095,647	$91,677,379	$34,702,864	$56,974,515	5.5%	$12.14	$49,661,017
Blue Cross	10,067,484,000	781,220,000	321,900,000	459,320,000	4.6%	12.85	1,454,348,000
Blue Shield	5,866,168,749	100,886,672	69,023,000	31,863,672	0.5%	1.00	248,497,672
Health Net	5,704,121,916	343,837,256	138,878,575	204,958,681	3.6%	7.61	692,836,276
Kaiser Foundation Health Plan	25,414,761,000	995,566,000	0	995,566,000	3.9%	12.71	1,228,501,000
PacifiCare	5,767,406,882	319,884,602	123,690,924	196,193,678	3.4%	9.63	735,203,273
Smaller HMOs							
Care 1st	$223,002,911	$10,545,028	$4,684,344	$5,860,684	2.6%	$2.61	$19,582,818
Chinese Community	47,621,671	1,409,139	546,644	862,495	1.8%	6.52	2,662,247
CIGNA Health	1,310,029,429	9,832,319	3,085,606	6,746,713	0.5%	4.18	46,343,734
Community Health Group	113,645,176	– 2,347,769	0	– 2,347,769	– 2.1%	– 2.08	4,881,328
Community Health Plan	206,781,126	24,557,648	0	24,557,648	11.9%	11.5	53,228,938
Great-West Health Plan	164,504,347	5,797,674	2,032,322	3,765,352	2.3%	5.68	46,490,981
Inter Valley Health Plan	127,136,839	866,379	0	866,379	0.7%	4.17	– 2,173,817
Molina	317,105,126	21,933,859	8,395,015	13,538,844	4.3%	4.84	66,527,912
On Lok Senior Health	54,195,958	3,214,163	0	3,214,163	5.9%	295.69	18,597,014
Valley Health	68,745,208	357,105	0	357,105	0.5%	0.58	2,345,853
SCAN Health Plan	629,711,260	115,712,471	0	115,712,471	18.4%	186.92	163,868,968
Sharp Health Plan	186,928,238	– 138,768	0	– 138,768	– 0.1%	– 0.09	– 9,791,824
SIMNSA	9,767,990	143,072	8,835	134,237	1.4%	3.7	982,028
UCSD Health Plan	16,582,009	– 3,173,818	0	– 3,173,818	– 19.1%	– 19.96	– 9,912,364
Universal Care	455,755,408	– 4,497,198	– 240,000	– 4,257,198	– 0.9%	– 0.68	– 9,841,893
Ventura County Health Care	15,346,525	271,237	0	271,237	1.8%	2.1	– 232,152
WATTSHealth	228,692,000	6,612,000	0	26,728,000	11.7%	18.91	24,411,000
Western Health Advantage	129,617,377	603,849	0	603,849	0.5%	0.81	– 1,669,222
County Health Systems and Local Initiatives							
Alameda Alliance for Health	$126,910,088	$– 8,309,022	0	$– 8,309,022	– 6.5%	$– 7.83	$12,083,987
CalOptima	761,869,705	1,245,039	0	1,245,039	0.2%	0.34	68,567,417
Central Coast Alliance	220,926,601	1,481,373	0	1,481,373	0.7%	5.9	25,283,076
Contra Costa Health Plan	121,879,326	3,772,129	0	3,772,129	3.1%	5.27	4,784,367
Inland Empire Health Plan	294,856,925	5,362,826	0	5,362,826	1.8%	1.76	23,364,842
Kern Health	92,467,798	2,045,424	0	329,104	0.4%	0.35	43,892,172
LA Care	990,206,629	23,960,307	0	23,960,307	2.4%	2.39	65,460,044
San Francisco Health Plan	62,010,519	3,020,508	0	3,020,508	4.9%	6.17	11,073,416
San Joaquin County Health	80,033,365	3,467,886	0	3,467,886	4.3%	4.53	24,767,259
San Mateo Health Plan	123,939,416	0	0	0	0.0%	0	– 16,866,230
Santa Barbara	147,043,996	8,265,605	0	8,265,605	5.6%	13.12	2,542,282
Santa Clara Family Health Plan	114,162,004	5,271,758	0	4,271,758	3.7%	4.23	13,105,440
Knox Keene Limited License Plans							
Cedars Sinai	$441,045	$62,853	0	$62,853	14.3%	NC	$407,513
Heritage Provider Network	533,588,870	2,248,528	371,807	1,876,721	0.4%	NC	2,549,032
PrimeCare Medical Network	289,692,972	8,331,927	2,016,156	6,315,771	2.2%	NC	7,808,095
ProMed	13,759,102	2,051,962	1,021,413	1,530,549	11.1%	NC	1,484,396
Scripps Clinic	193,009,297	23,064	800	22,264	0.0%	NC	603,308
TOTAL*	**$62,331,004,450**	**$2,887,072,466**	**$710,118,305**	**$2,194,853,841**	**3.5%**	**$9.04**	**$5,047,785,499**

*Total for 1999 to 2003 includes net income or losses for HMOs that have exited the field prior to 2003. NC: Per member per month not calculated for these entities because they do not assume full risk for care provided to enrollees.
Source: Author's analysis of HMO annual statements, Report No. 2, Statement of Revenues, Expenses and Net Worth.

HMO Premium Trend

State average HMO premium revenues per commercial member per month and its increase over the previous year.

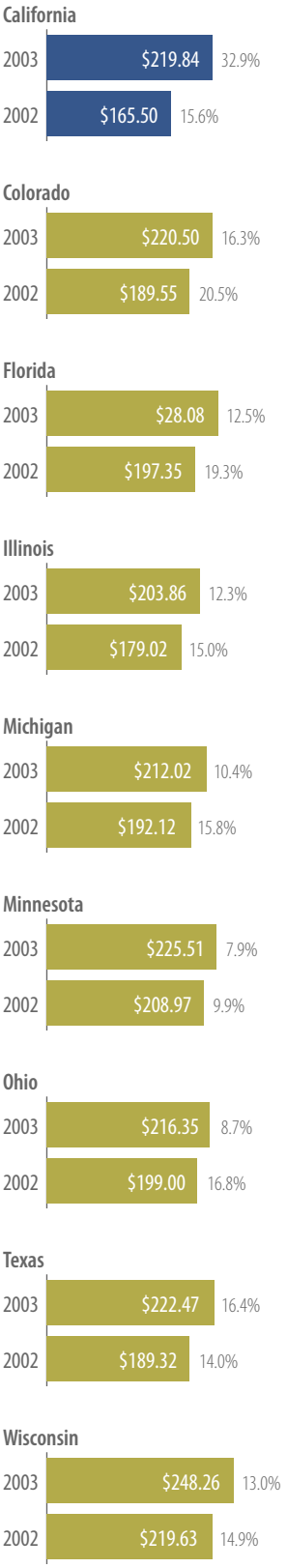
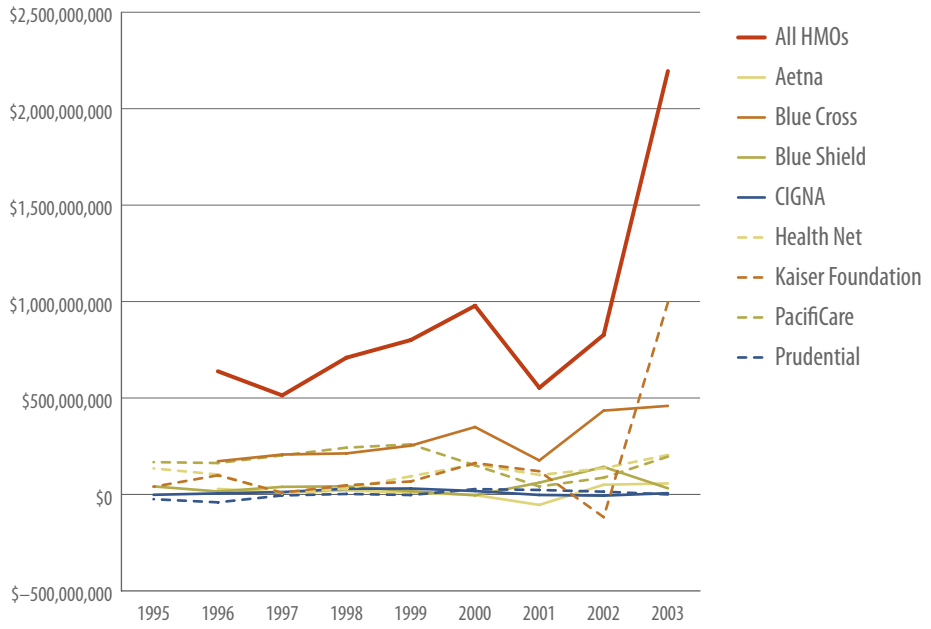


EXHIBIT 15. Net Income After Taxes for Largest California HMOs, 1995 to 2003



Source: Author's analysis of HMO annual statements, Report No. 2, Statement of Revenues, Expenses and Net Worth.

year. So the HMO has to make its best projection of health cost trend for 2005 based largely on the experience of 2003.

Inflation in health insurance premiums and in health care costs — two separate trends — is an important concern to employers and consumers alike. In some recent years, health care costs increased faster than premiums because health plans didn't anticipate that trend or because they decided to keep their premium increases low for strategic reasons. In other years, health plans raised their premiums faster than the anticipated increase in health care costs in order to improve profitability.

Premiums in California have historically been lower than in comparison states. (The most recent data from the Kaiser/HRET research shows that the average cost of HMO coverage in California in 2004 was $721 per month compared to a national average of $792.) That has occurred in part because of price competition by health plans wanting to gain or maintain market share. It is also because of the willingness of provider groups to accept capitation payments that often were lower than what their colleagues in other states might have received. And there are geographic differences within the state. HMOs in northern California have faced higher payment rates from dominant hospital systems, forcing their prices upward. HMOs and physician groups in southern California have been willing to use their Medicare revenues to cross-subsidize employer groups.

The analysis in this section approaches HMO premium revenue trends in three ways: First it looks at premium revenues collected for commercial HMOs in California. To show this trend, the amount of commercial premium revenue for each HMO is calculated, then converted to a per-member per-month (PMPM) basis. Second, California HMO premium revenues are compared to their counterparts in eight comparison states. Third, an exhibit presents data on premiums paid for commercial HMO and PPO plans organized through CalPERS. Note that CalPERS has now begun to use a regional pricing system that

EXHIBIT 16. HMO Revenue and Net Income, First Half of 2004

HMO	Revenue	After Tax Net	Share
Larger HMOs			
Aetna Health	$459,614,657	$19,908,490	4.3%
Blue Cross	6,298,907,000	1,261,733,000	20.0%
Blue Shield	3,356,122,000	233,572,000	7.0%
Health Net	3,115,229,708	41,033,751	1.3%
Kaiser Foundation	14,039,454,000	832,281,000	5.9%
PacifiCare	3,143,958,790	110,865,955	3.5%
Smaller HMOs			
Care 1st	$150,736,956	$5,692,256	3.8%
Chinese Community	26,190,356	388,289	1.5%
CIGNA Health	599,968,995	– 9,225,423	– 1.5%
Community Health Group	61,100,183	– 3,196,661	– 5.2%
Community Health Plan	200,024,911	9,294,840	4.6%
Great-West Health Plan	62,607,449	– 791,146	– 1.3%
Inter Valley Health Plan	27,854,066	641,075	2.3%
Molina Healthcare	135,636,618	4,595,974	3.4%
On Lok Senior Health	58,758,610	2,775,528	4.7%
SCAN Health Plan	372,031,946	57,679,003	15.5%
Sharp Health Plan	150,368,124	– 2,570,024	– 1.7%
SIMNSA	8,220,784	1,748,976	21.3%
Universal Care	444,166,946	5,969,295	1.3%
Valley Health Plan	80,738,285	312,817	0.4%
Ventura County	16,904,342	13,138	0.1%
WATTSHealth	104,780,000	1,085,000	1.0%
Western Health Advantage	160,982,097	2,689,064	1.7%
County Systems and Local Initiatives			
Alameda Alliance for Health	$138,101,340	$– 13,550,655	– 9.8%
CalOptima	782,886,322	– 20,799,186	– 2.7%
Central Coast Alliance	107,068,386	– 2,478,102	– 2.3%
Contra Costa Health Plan	137,159,379	473,141	0.3%
Inland Empire Health Plan	314,683,191	711,700	0.2%
Kern Health	48,036,589	3,385,842	7.0%
LA Care	695,972,974	6,886,040	1.0%
San Francisco Health Plan	71,133,085	3,441,335	4.8%
San Joaquin County Health	81,634,563	2,697,408	3.3%
San Mateo	63,423,019	– 2,318,665	– 3.7%
Santa Barbara	153,726,437	4,335,982	2.8%
Santa Clara Family Health Plan	128,458,862	1,193,951	0.9%
Knox-Keene Limited License Plans			
Heritage Provider Network	$312,256,495	$1,325,554	0.4%
PrimeCare Medical Network	131,590,478	2,251,700	1.7%
Scripps Clinic	105,316,740	33,606	0.0%
TOTAL	**$36,345,804,683**	**$2,564,085,848**	**7.1%**

Source: Author's analysis of HMO quarterly statements, Report No. 2, Statement of Revenues, Expenses and Net Worth.

makes very clear the differences in benefit prices between northern and southern California.

Premium revenue collected is a measure of revenue yield. That is different from a trend analysis in which employers are surveyed or rate filings are examined to determine the "sticker price" for health benefits. The format of the HMO annual statements in California requires making certain assumptions about the data. The composite statement does designate commercial premiums, but the correct number of member months is not always clear. For example, if an HMO has self-funded group enrollees, there may be a question about the number of member months to use in the denominator of the calculation. The best solution would be to make public the supplementary statement showing revenues and expenses by lines of business.

As shown in Exhibit 17 on the following page, the average commercial premium revenue, per-member per-month, increased sharply in 2003. It grew by an average of 32.8 percent, from $165.60 to $219.84. The average increase in 2002 was 15.7 percent. Among the largest HMOs, Kaiser Permanente showed a large per-member per-month increase of 58.2 percent and Health Net's increase in 2003 was 28.5 percent. Some of the smaller HMOs had large increases, including Sharp Health Plan (up by 65.3 percent) and Universal Care at 25.2 percent.

The most recent Kaiser Family Foundation/HRET California survey confirms a significant increase in HMO premiums in the state. According to that survey, the average cost for HMO family coverage in California increased by 12.3 percent in 2004 and 15.6 percent in 2003.

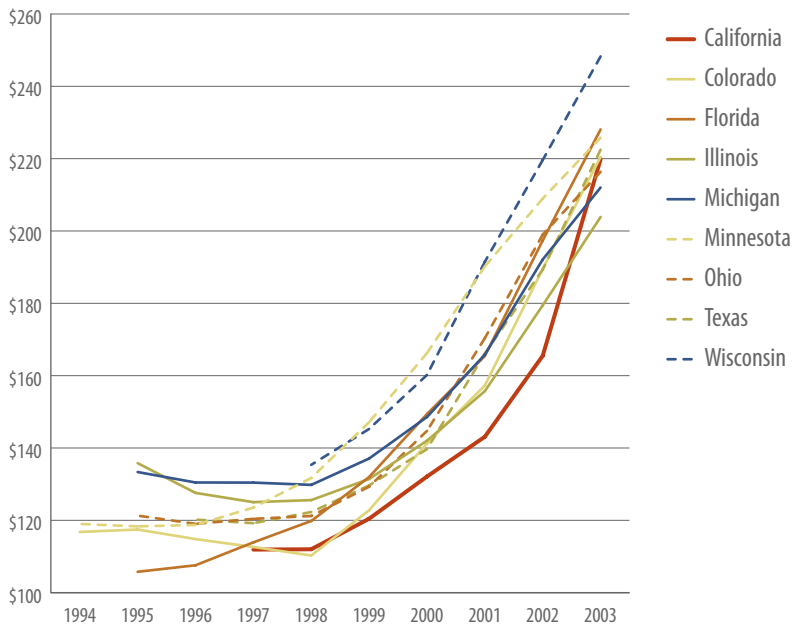
EXHIBIT 17. California HMO Commercial Premium Revenue, Per Member Per Month, 1997 to 2003

HMO	1997	1998	1999	2000	2001	2002	2003	Increase
Larger HMOs								
Aetna Health	$112.93	$112.53	$115.44	$124.36	$139.30	$152.42	$174.65	14.6%
Blue Cross of California	108.25	112.91	121.77	132.68	152.09	183.86	210.39	14.4%
Blue Shield of California	104.23	108.43	117.86	137.49	122.47	146.33	172.11	17.6%
Health Net	111.08	116.74	124.91	133.10	155.34	184.92	237.56	28.5%
Kaiser Permanente	112.54	112.61	122.07	133.96	144.78	163.44	258.59	58.2%
PacifiCare	135.37	109.99	116.74	123.58	135.29	149.92	171.95	14.7%
Smaller HMOs								
Chinese Community Health Plan	$125.66	$135.55	$117.44	$124.99	$127.05	$151.61	$175.97	16.1%
Great-West Health Plan	117.08	132.78	153.23	142.08	155.68	146.81	169.09	15.2%
Sharp Health Plan	133.88	103.85	107.49	107.53	82.63	119.41	197.38	65.3%
Universal Care	86.69	65.41	86.93	95.65	101.45	135.27	169.37	25.2%
Western Health Advantage	NA	149.19	103.36	111.84	141.86	139.41	164.50	18.0%
TOTAL	**$111.91**	**$112.00**	**$120.49**	**$132.11**	**$143.11**	**$165.60**	**$219.84**	**32.8%**
Change from previous year		0.10%	7.6%	9.6%	8.3%	15.7%	32.8%	

NA: Not applicable.

Source: Author's analysis of HMO annual statements, Reports No. 2 and No. 4.

EXHIBIT 18. HMO Commercial Premium Revenue Trends in California and Selected States, 1994 to 2003



Source: Author's analysis of HMO annual statements for these nine states, Statement of Revenues, Expenses and Net Worth.

Exhibit 18 compares the premium revenue trend in California with the PMPM trend in eight comparison states where the author publishes annual market analyses. Historically, PMPMs in California trailed behind those in other states. However, the large increase in 2003 propelled California HMOs into the upper tier of states for this analysis. This analysis does not adjust for differences in demographics or in benefit design. For example, in states where HMOs are permitted to market plans with significant enrollee cost-sharing, that might be reflected in a lower premium revenue trend. In those states, an HMO can offer a renewal quote of 14 percent, for example, then suggest that the employer adopt a plan design that includes an annual deductible or a co-payment for hospital admissions. In exchange for the additional enrollee cost-sharing, the HMO can offer the employer a smaller premium increase.

EXHIBIT 19. Family Premiums for Active CalPERS Participants in HMO and PPO Plans, 1996 to 2005

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005*	Increase 2005/2004
HMOs											
Kaiser Foundation†	$393.94	$376.87	$486.96	$428.57	$478.56	$525.75	$563.32	$673.95	$794.09	$872.64	9.9%
Blue Shield HMO	406.00	394.00	409.71	442.28	479.87	523.04	563.32	694.86	819.57	923.08	12.6%
Western Health Advantage	NA	NA	NA	NA	NA	NA	NA	543.14	729.07	838.42	15.0%
Health Net	384.80	384.80	403.66	427.48	469.67	512.88	534.25	NA	NA	NA	NA
PacifiCare	407.60	407.60	417.79	428.05	453.73	489.24	534.25	NA	NA	NA	NA
Universal Care	NA	NA	NA	NA	419.87	434.15	438.39	NA	NA	NA	NA
Aetna Health	406.80	406.80	420.14	436.11	464.46	504.40	NA	NA	NA	NA	NA
CIGNA	398.06	398.06	410.41	424.77	448.48	481.78	NA	NA	NA	NA	NA
Lifeguard	413.91	413.91	437.38	457.84	507.81	558.08	NA	NA	NA	NA	NA
Maxicare	390.00	390.00	391.74	415.24	431.60	460.33	NA	NA	NA	NA	NA
PPOs											
PERS Care	$666.00	$666.00	$705.00	$710.00	$764.00	$892.00	$1,167.00	$1,425.00	$1,416.40	$1,595.85	12.7%
PERS Choice	408.00	400.00	416.00	426.00	452.00	556.00	647.00	770.00	908.47	951.81	4.8%
Association Plans											
CCPOA – North	NA	NA	NA	NA	NA	NA	NA	$725.19	$834.25	$896.00	7.4%
CCPOA – South	NA	NA	NA	NA	NA	NA	NA	654.65	693.31	740.00	6.7%
California Association of Highway Patrolmen	469.88	469.88	469.88	469.88	488.68	579.60	671.17	798.02	909.00	990.81	9.0%
Peace Officers Retirement Association of California	489.62	489.62	499.00	518.00	549.00	599.00	699.00	847.00	931.00	950.00	2.0%
State Contribution	**$410.00**	**$410.00**	**$410.00**	**$432.00**	**$452.00**	**$452.00**	**$452.00**	**$589.00**	**$661.00**	**NA**	**NA**

NA: Not applicable.
*For 2005, CalPERS has adopted five regional rates for contracting agencies.
†Through 1997, Kaiser Permanente charged slightly different rates in northern California and in southern California.
Source: Author's analysis of CalPERS premium tables for 1996 through 2005.

During much of the 1990s, CalPERS had very good success in negotiating low rate increases (some would say forcing low increases), but that has not been the case recently. As Exhibit 19 shows, family premiums for CalPERS participants selecting HMO plans will again increase by double digits for 2005. Still, the increase of 10 to 15 percent is less than the increases for the two previous years: The increase for Kaiser Permanente and Blue Shield was about 18 percent for 2004, on top of increases in the 16 to 19 percent range for 2003. Premiums for the PERS Choice, the larger of the two PPO plans, will increase by 5 percent in 2005.

3.8 HMO Medical Loss Ratios

In their annual and quarterly statements, California HMOs divide their expenses into two main categories, Medical-Hospital and Administration. The medical loss ratio is calculated as the total amount of Medical-Hospital expenses (for the entire plan) divided by all premium revenues. Investment income and taxes are not included in the calculation. HMOs have a great deal of latitude in how they allocate expenses between those categories. For example, they might allocate certain expenses to administration in order to report lower health care costs, since that would appeal to stock analysts.

As was noted earlier, HMOs that are part of national corporations or affiliated with hospitals can allocate revenues and expenses to those organizations, again to make the HMO look better to certain audiences. These allocation practices sometimes lead researchers to question the usefulness of these ratios in

EXHIBIT 20. Medical Loss Ratios for California HMOs (Entire Plan), 1997 to 2003

HMO	1997	1998	1999	2000	2001	2002	2003
Larger HMOs							
Aetna Health	89.3%	86.4%	87.0%	88.5%	94.2%	86.8%	82.1%
Blue Cross of California	76.5%	77.9%	77.4%	76.4%	80.3%	80.8%	79.9%
Blue Shield of California	78.7%	81.5%	84.0%	84.5%	NA	83.5%	86.4%
Health Net	85.9%	87.9%	86.4%	84.6%	87.8%	86.3%	84.6%
Kaiser Foundation	96.3%	97.9%	96.4%	96.3%	96.0%	97.7%	93.2%
PacifiCare	84.5%	84.3%	84.7%	88.1%	91.1%	88.4%	84.2%
Smaller HMOs							
Care 1st Health Plan	75.5%	82.8%	84.6%	86.0%	83.9%	85.8%	85.9%
Chinese Community Health Plan	76.4%	80.0%	80.9%	81.0%	81.8%	84.6%	93.8%
Cigna HealthCare	85.4%	83.5%	82.5%	82.7%	83.3%	84.6%	85.1%
Community Health Group	78.1%	78.1%	86.1%	81.6%	84.4%	89.4%	84.4%
Community Health Plan	93.6%	93.6%	92.8%	89.5%	89.7%	81.0%	91.0%
Great-West Health Plan	73.9%	65.0%	54.5%	68.4%	88.6%	86.9%	82.4%
Inter Valley Health Plan	87.0%	88.6%	88.2%	87.8%	91.3%	NA	89.7%
Molina Medical Centers	93.2%	87.9%	80.5%	77.8%	80.7%	83.0%	83.3%
On Lok Senior Health	NA	NA	87.5%	83.2%	84.9%	84.9%	87.8%
SCAN Health Plan	79.6%	79.2%	81.2%	84.8%	88.5%	81.2%	73.8%
Sharp Health Plan	85.5%	87.3%	91.4%	92.1%	95.2%	95.0%	92.9%
SIMNSA	NA	NA	NA	61.5%	81.2%	81.2%	69.8%
UC San Diego Health Plan	NA	NA	85.5%	92.5%	89.9%	91.3%	105.7%
Universal Care	86.7%	88.9%	89.2%	88.2%	94.4%	91.9%	89.6%
Valley Health Plan	NA	NA	NA	87.6%	89.5%	89.7%	89.7%
Ventura County	95.3%	89.2%	89.3%	89.8%	90.3%	93.3%	87.8%
WATTSHealth	77.6%	82.1%	82.5%	86.3%	NA	84.3%	84.5%
Western Health Advantage	88.0%	86.1%	84.3%	84.7%	87.4%	88.0%	89.4%
County Systems and Local Initiatives							
Alameda Alliance for Health	71.7%	71.7%	79.3%	78.0%	102.4%	95.3%	99.3%
Central Coast Alliance	86.3%	NA	NA	90.8%	88.1%	92.4%	97.4%
Contra Costa Health Plan	93.3%	93.6%	NA	91.6%	95.8%	92.5%	89.1%
Inland Empire Health Plan	84.3%	85.8%	89.3%	90.4%	90.7%	89.5%	90.4%
Kern Health Systems	72.9%	72.8%	67.9%	76.9%	80.1%	79.3%	92.2%
LA Care	85.1%	93.9%	94.7%	95.2%	94.4%	94.2%	93.8%
San Francisco Health Plan	87.4%	84.0%	86.8%	88.4%	86.7%	86.1%	86.5%
San Joaquin County Health	79.4%	75.3%	79.4%	79.2%	84.0%	84.8%	85.6%
San Mateo Health Commission	NA	92.3%	81.5%	98.7%	102.0%	91.3%	92.7%
Santa Barbara Health Authority	NA	NA	NA	NA	95.1%	95.3%	87.4%
Santa Clara Family Health Plan	87.4%	84.1%	NA	75.2%	83.1%	82.6%	84.7%
Limited License Plans							
Heritage Provider Network	84.9%	93.7%	93.7%	96.7%	97.3%	99.1%	93.0%
PrimeCare Medical Network	97.5%	91.6%	NA	96.6%	95.3%	87.5%	86.6%
Scripps Clinic	NA	NA	NA	96.5%	97.5%	95.9%	94.6%
TOTAL	**87.6%**	**88.4%**	**87.8%**	**88.2%**	**90.5%**	**89.6%**	**88.0%**

NA: Not available.
Source: Author's analysis of HMO annual statements, Statement of Revenues and Expenses.

comparing HMOs. Still, medical loss ratios can be helpful because they give some indication of the ability of HMOs to control increases in their medical costs from year to year.

Exhibit 20 compares California HMOs on their medical loss ratios from 1997 to 2003. The average ratio in 2003 was 88.0 percent, down from 89.6 percent in 2002 and 90.5 percent in 2001. In the past few years, decreases in medical loss ratios have been reflected in higher net income and vice versa. In 2003, net income increased sharply as medical expenses decreased by almost two percentage points. Put another way, as revenues increased, the amount spent for medical expenses did not increase proportionately.

As in past years, Kaiser Permanente reports the highest loss ratio of the largest HMOs, although it too has seen its number decline in the last few years. This is partly the result of how it allocates expenses between the Medical-Hospital and Administration categories. For example, some HMOs say that clinic computer systems used for scheduling appointments or tracking laboratory tests are an expense of clinic operation and therefore a medical expense. HMOs that don't own their own clinics may assume that their payments to physicians and hospitals are all medical costs, even if they are used to cover the costs of clinical information systems.

Among the largest plans, Blue Cross has consistently shown the lowest medical loss ratio, below 80 percent almost every year. PacifiCare had medical loss ratios of 84 to 85 percent from 1997 to 1999, but then saw its ratio increase to 88 percent and 91 percent until 2003 when it declined by four percentage points.

The county-sponsored Medi-Cal plans have seen their medical ratios climb upward in the last three years. In 2000, four of the county-sponsored HMOs had medical loss ratios below 80 percent. In 2003, none of them had a ratio below 80 percent and only one had a ratio below 85 percent. Six of them had ratios of 90 percent or higher.

3.9 Capitation Payments

This year's report analyzes capitation payments using data from the revised revenue and expense statement that was introduced in 2002 for California HMOs. For that reason, the numbers may not be comparable to what we reported in previous years using a different method and data source. This statement created three new lines or subcategories in the revenue and expenses statement for reporting capitation payments for hospital care, ambulatory care, and prescription drugs. Those numbers were summed and compared to total Medical-Hospital expenses to calculate a capitation ratio.

The analysis of California HMO data in this report may also not be comparable to what is reported in comparison states. In other states that use NAIC forms, HMOs submit a separate exhibit to report the dollars paid through capitation to medical groups and other providers, and the amounts paid through other payment arrangements.

As was discussed earlier, payment arrangements between health plans and providers are key to their relationships. In California, a high but decreasing proportion of medical expenses are paid to providers through capitation arrangements. While most physician groups in the state are interested and invested in continuing to accept and manage capitation, hospitals have changed their contracts in the past three years.

Exhibit 21 on the following page shows that, on average, HMOs paid 28.9 percent of their medical payments through capitation in 2003. That is down from 37.3 percent of medical expenses in 2002. The rest presumably was paid through a variety of discounted fee-for-service methods, or methods such as case rates or per diems that shift a limited measure of risk to hospitals.

There is wide variation in the extent to which California HMOs use capitation. Health Net capitated almost half of its medical expenses in 2002 but that ratio dropped to 35.4 percent in 2003. Similarly, Kaiser Permanente went from 46.6 percent in 2002 to 28.1 percent capitated in 2003. Blue Cross is at the low end, capitating less than 15 percent of its medical expenses in 2002 and 2003.

Going forward, it will be interesting to compare the use of capitation among California HMOs. In interviews with executives at health plans and hospitals, it was clear that they see less use of capitation, particularly in hospital contracts. However, there is interest, even by hospitals, in exploring variations on capitation. As noted earlier, health plans are willing to pay more if hospitals and physicians are willing to play a significant role in managing inpatient utilization. And there is reason to expect growth in senior plan enrollment. In the 1990s, that growth was closely associated with increased use of capitation.

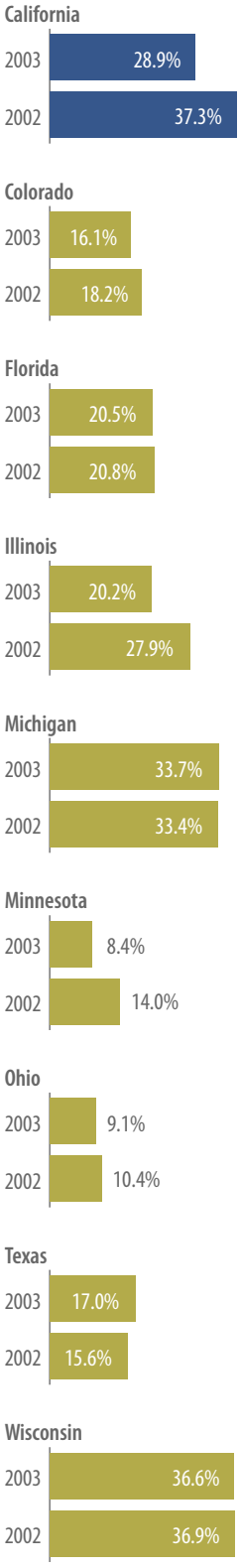
3.10 Prescription Drugs

Outpatient prescription drugs have been a key driver of overall health costs and insurance premiums in recent years. While still significant, they have been replaced by inpatient hospital care as the most significant cost driver. The cost of inpatient hospital care has increased sharply because of higher rates of utilization multiplied by higher unit prices negotiated by hospital systems.

On the other hand, cost increases for prescription drugs have moderated somewhat, partly because generic versions of some widely used drugs have now become available. In other cases, popular drugs are now available over the counter. These changes may have secondary impacts on physicians. According to a

HMO Capitation

Portion of dollars paid to providers through capitation arrangements.



*Methodology for calculating capitation use in California is different from other states.

What Is Capitation?

The goal of capitation is to provide a financial incentive for the provider to use care appropriately. Under capitation, the HMO pays a fixed amount to a network of physicians or other provider organization each month for each member that selects that network. The provider group, in turn, is responsible for managing that payment so that it covers the costs of care regardless of the level of utilization of those patients.

Depending on the size of the provider network and the inclination of the health plan, the capitation payment and the providers' risk may be limited to professional services, namely primary care and certain specialty referrals and outpatient procedures. In other cases, health plans and providers may choose to negotiate a global capitation, under which the provider organization receives a larger payment but accepts financial responsibility for almost all care, including inpatient hospitalizations, specialty referrals, and pharmacy benefits.

EXHIBIT 21. Use of Capitation by California HMOs, 2002 and 2003

HMO	Capitated Medical Expenses	Total Medical Expenses 2003	Portion in Capitation 2003	Portion in Capitation 2002
Large HMOs				
Aetna Health	$329,548,459	$841,132,751	39.2%	36.3%
Blue Cross of California	1,186,183,000	8,047,815,000	14.7%	14.9%
Blue Shield of California	1,076,356,000	5,012,147,077	21.5%	20.4%
Health Net	1,695,468,751	4,792,469,416	35.4%	47.0%
Kaiser Foundation	6,642,062,000	23,596,216,000	28.1%	46.6%
PacifiCare	1,921,532,029	4,834,294,194	39.7%	39.3%
Smaller HMOs				
Care 1st Health Plan	$71,408,575	$190,882,770	37.4%	41.5%
Chinese Community Health Plan	15,829,839	40,440,058	39.1%	40.4%
CIGNA Healthcare	344,556,798	1,102,376,817	31.3%	32.1%
Community Health Group	22,786,603	103,265,304	22.1%	18.3%
Community Health Plan	84,646,846	168,453,145	50.2%	50.2%
Great-West Health Plan	18,302,296	134,611,030	13.6%	13.1%
Molina Healthcare	90,746,755	263,806,854	34.4%	33.0%
On Lok Senior Health Services	31,189,422	47,244,233	66.0%	16.2%
SCAN Health Plan	170,919,184	464,812,088	36.8%	39.4%
Sharp Health Plan	47,149,990	173,339,137	27.2%	29.0%
Universal Care	128,329,266	407,802,436	31.5%	31.3%
Valley Health Plan	31,513,607	61,362,527	51.4%	63.0%
Ventura County	623,183	13,410,693	4.6%	4.5%
WATTSHealth Foundation	75,576,000	192,330,000	39.3%	31.7%
Western Health Advantage	48,808,110	115,778,693	42.2%	41.0%
County Systems and Local Initiatives				
Alameda Alliance for Health	$39,915,763	$124,051,263	32.2%	32.5%
CalOptima	156,773,287	728,617,226	21.5%	28.1%
Central Coast Alliance	8,892,488	206,270,585	4.3%	4.6%
Contra Costa Health Plan	6,465,939	108,354,736	6.0%	5.2%
Inland Empire Health Plan	146,090,437	265,740,730	55.0%	37.2%
Kern Health Systems	1,950,973	84,222,132	2.3%	0.0%
LA Care	916,443,898	926,293,071	98.9%	99.2%
San Francisco Health Plan	29,988,874	53,363,721	56.2%	44.0%
San Joaquin County Health	9,906,220	67,720,183	14.6%	15.6%
San Mateo Health Commission	6,160,852	114,512,618	5.4%	5.3%
Santa Barbara	4,249,350	128,028,137	3.3%	3.0%
Santa Clara Family Health Plan	46,151,169	96,062,991	48.0%	49.8%
TOTAL	**$15,796,036,200**	**$54,576,469,375**	**28.9%**	**37.3%**

Source: Author's analysis of HMO annual statements, Statement of Revenues and Expenses.

EXHIBIT 22A. Outpatient Prescription Drug Expenses for Health Plans, 2003 and 2002

HMO	Prescription Drug Expenses	2003 Expenses PMPM	2002 Expenses PMPM	2003 Increase over 2002
Large HMOs				
Aetna Health	$86,244,516	$18.38	$23.15	– 20.6%
Blue Cross of California	1,163,443,000	32.54	20.92	55.6%
Blue Shield of California	747,239,000	23.37	20.51	14.0%
Health Net	518,481,059	19.25	21.08	– 8.7%
Kaiser Foundation	2,928,331,000	37.27	24.61	51.5%
PacifiCare	387,357,107	19.02	20.48	– 7.1%
Smaller HMOs				
Care 1st Health Plan	$21,380,065	$9.54	$7.32	30.3%
Chinese Community Health Plan	3,345,906	25.28	23.38	8.1%
CIGNA Healthcare	112,091,785	69.46	15.63	344.4%
Community Health Group	16,744,572	14.82	14.03	5.6%
Community Health Plan	15,952,551	7.47	8.18	– 8.7%
Great West Health Plan	12,297,510	18.57	NA	NA
Molina Healthcare	31,708,570	9.58	9.57	0.1%
On Lok Senior Health Services	4,185,251	385.03	126.46	204.5%
SCAN Health Plan	34,118,190	55.11	79.69	– 30.8%
Sharp Health Plan	25,949,840	17.32	16.45	5.3%
Sistemas Medicos Nacionales	4,623,700	127.38	64.22	98.4%
UC San Diego	2,635,374	16.57	16.19	2.4%
Universal Care	50,851,854	12.50	13.31	– 6.1%
Ventura County	2,657,499	20.53	18.66	10.0%
WATTSHealth Foundation	17,816,000	14.72	11.22	31.2%
Western Health Advantage	20,278,301	27.05	24.28	11.4%
County Plans				
Alameda Alliance for Health	$15,655,191	$14.75	$11.70	26.1%
CalOptima	153,995,353	41.73	42.03	– 0.7%
Central Coast Alliance	45,915,125	47.53	44.70	6.3%
Contra Costa Health Plan	18,146,528	25.34	26.87	– 5.7%
Inland Empire Health Plan	44,479,746	14.60	6.86	112.8%
Kern Health Systems	16,277,913	17.53	15.32	14.4%
LA Care (Local Initiative Health Authority)	274,091	0.03	0.03	– 7.6%
San Francisco Health Plan	10,511,199	21.47	18.16	18.2%
San Joaquin County Health	12,134,855	15.86	16.52	– 4.0%
San Mateo Health Commission	39,741,201	63.73	63.37	0.6%
Santa Barbara	43,093,859	68.38	65.40	4.6%
Santa Clara County Health Authority (Santa Clara Family Health Plan)	10,150,481	10.06	8.61	16.8%
TOTAL	**$6,618,108,192**	**$24.34**	**$20.68**	**17.7%**

NA: Not applicable, meaning that the HMO did not have enough members in that cell to meet NCQA standards of statistical significance or to protect privacy of individual members.
Source: Author's analysis of HMO annual statements, Report No. 2, Statement of Revenues, Expenses and Net Worth.

Minnesota HMO executive, popular staff physicians are finding that they now have open appointments that they didn't have before. The reason is that some patients came in periodically just to get prescriptions renewed. If they can get the same product over the counter, there is no particular need for an office visit.

Exhibit 22 shows outpatient prescription drug expenses using two sources. Part A uses the Statement of Revenues, Expenses and Net Worth from the HMO annual and quarterly statements, which now have specific lines for prescription drugs paid by capitation and other methods. That data, for the entire health plan, shows that HMOs spent $6.6 billion on outpatient prescription drugs in 2003, which was $24.34 per-member per-month. That is about 18 percent higher than in 2002, when the average was $20.68 per-member per-month.

The range among plans is quite wide and may reflect inconsistency in reporting. Among the large health plans, Aetna and PacifiCare reported relatively low expenses, while Blue Cross's average expense was higher than the rest of the health plans in 2003.

Part B of the exhibit uses 2003 HEDIS data for commercial plans only and compares the PMPM calculated from that data with the PMPM for 2002 and 2001. This shows the two Kaiser plans spending a combined total of $1.4 billion on prescription drugs for their commercial enrollees. That equals $23 to $25 per-member per-month, lower than its competitors. Blue Shield showed the highest PMPM in this group at $35.11. These California HMOs were all below the U.S median of $43.61.

EXHIBIT 22B. Outpatient Prescription Drug Expenses for Commercial HMOs, 2001 to 2003 (HEDIS data)

HMO	Total Prescriptions	Prescriptions Per Member Year	Prescription Expenses	2003 Average Costs of Prescriptions PMPM	2002 Average Cost of Prescriptions PMPM	2001 Average Cost of Prescriptions PMPM
Aetna Health	2,082,815	6.93	NR	NR	NR	NR
Blue Cross of California	11,411,108	7.74	$536,467,308	$30.34	$38.85	$23.14
Blue Shield of California	10,961,458	9.54	484,345,659	35.11	30.08	NR
CIGNA HealthCare	3,532,678	7.43	NR	NR	24.57	21.59
Community Health Group	4,913,163	9.97	NR	NR	NR	NR
Health Net	11,835,547	9	549,102,358	34.78	33.01	28.78
Kaiser Foundation – Southern California	27,260,364	11.33	656,555,205	22.73	19.69	17.43
Kaiser Foundation – Northern California	30,752,928	12.47	735,766,745	24.87	21.58	18.82
PacifiCare	10,353,653	8.77	465,385,948	32.86	30.63	26.36
Sharp Health Plan	NR	NR	NR	NR	NR	NR
Universal Care	646,680	6.37	29,463,071	24.17	NR	NR
Western Health Advantage	NR	NR	NR	NR	NR	NR
U.S. Median	**NA**	**10.26**	**NA**	**$43.61**	**$38.41**	**$32.45**

NA: Not applicable. NR: Not reported.

Source: Author's analysis of HMO HEDIS reports found in NCQA Quality Compass® data files.

3.11 Administrative Expenses

HMO administrative expenses include compensation, marketing, and office expenses. Exhibit 23 that follows compares California HMOs on three measures of administrative costs: administration as a percentage of total revenues (including investment income), as a percentage of total expenses, and as a per-member per-month amount.

In 2003, HMOs reported spending $4.8 billion in administrative costs for all lines of business. On average, they spent 7.7 percent of their revenues on administration, and $19.20 per-member per-month. That is an increase from $15.37 per-member per-month in 2002. Kaiser continues to report very low administrative expenses, although its expense per-member per-month doubled in 2003. Both Blue Cross and PacifiCare reported large increases in their administrative expenses per-member per-month.

3.12 HMO Net Worth

Under California law, an HMO must maintain a certain level of tangible net equity, based on how much risk it shares with providers and how much it deals with providers not under contract. It must also maintain a restricted cash deposit of $300,000. These reserves are not to benefit consumers or providers directly, but would be available for the expenses of rehabilitating an HMO in distress or liquidating one that is insolvent. Tangible net equity is similar to the risk-based capital calculation of reserve adequacy that has been adopted by many state insurance departments.

Because of a change in reporting by Kaiser, we calculated measures of net worth including Kaiser Permanente and excluding Kaiser. As shown in Exhibit 24 on page 54, HMOs including Kaiser had an average of 11.30 weeks of net worth at the end of 2003. In other words, if no revenues were coming in but the HMO still was paying an average amount of claims and administrative costs, it could continue to operate for about 11 weeks. Viewed another way, HMOs had net worth averaging $667 per member.

However, if Kaiser is excluded from the calculation, HMOs had an average of 6.78 weeks of reserves and about $353 per member. That is still a significant increase over 2002, when HMOs had average reserves of 4.59 of operations and $201 per member.

Prior to 2003, Kaiser Permanente reported the assets and liabilities of its health plans in its annual statements. During 2003, Kaiser Permanente began, at the direction of the Department of Managed Health Care, to file combined balanced sheets including the health plan, the hospitals and clinics, and other subsidiaries. The result was that the table shows Kaiser increasing its net worth by $7.3 billion, obviously a huge amount. Consequently, Kaiser's weeks of reserves increased from 2.79 to 17.60 and its net worth per member increased from $166 to $1,280.

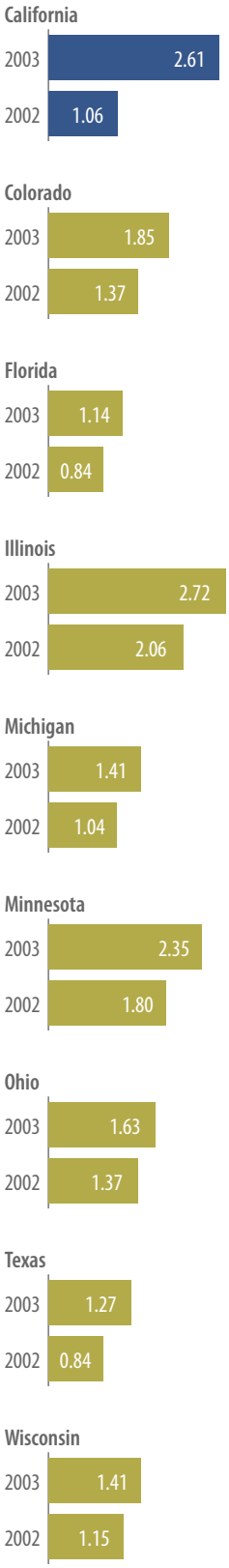
EXHIBIT 23. Administrative Expenses for California HMOs (Entire Plan), 2003

HMO	2003 Administration Expense	As a Share of Revenues	As a Share of Expenses	2003 Per Member Per Month	2002 Per Member Per Month
Large HMOs					
Aetna Health	$106,285,517	10.2%	11.2%	$22.65	$19.33
Blue Cross of California	1,238,449,000	12.3%	13.3%	34.63	21.22
Blue Shield of California	753,135,000	12.8%	13.1%	23.56	22.72
Health Net	567,815,244	10.0%	10.6%	21.08	18.60
Kaiser Foundation	822,979,000	3.2%	3.4%	10.51	5.23
PacifiCare	613,228,086	10.6%	11.3%	30.11	24.51
Smaller HMOs					
Care 1st Health Plan	$21,575,113	9.7%	10.2%	$9.62	$7.33
Chinese Community Health Plan	5,772,474	12.1%	12.5%	43.62	39.31
CIGNA Healthcare	197,820,293	15.1%	15.2%	38.50	27.07
Community Health Group	12,727,641	11.2%	11.0%	11.26	11.03
Community Health Plan	13,770,333	6.7%	7.6%	6.45	8.36
Great-West Health Plan	24,095,643	14.6%	15.2%	36.38	29.32
Inter Valley Health Plan	12,249,622	NA	9.7%	58.94	0.00
Molina Healthcare	31,364,413	9.9%	10.6%	9.47	10.36
On Lok Senior Health Services	2,324,202	4.3%	4.6%	213.82	190.36
SCAN Health Plan	49,186,701	7.8%	9.6%	79.45	70.28
Sharp Health Plan	13,727,869	7.3%	7.3%	9.16	9.19
Sistemas Medicos Nacionales	2,820,884	28.9%	29.3%	77.71	35.86
UC San Diego	2,322,976	14.0%	11.8%	14.61	16.55
Universal Care	52,450,170	11.5%	11.4%	12.89	9.09
Valley Health Plan	7,025,576	10.2%	10.3%	11.34	10.07
Ventura County	1,664,595	10.8%	11.0%	12.86	11.85
WATTSHealth Foundation	29,750,000	13.0%	13.4%	24.57	26.72
Western Health Advantage	13,234,835	10.2%	10.3%	17.65	18.23
County Systems and Local Initiatives					
Alameda Alliance for Health	$11,167,847	8.8%	8.3%	$10.52	$10.00
CalOptima	32,007,440	4.2%	4.2%	8.67	9.88
Central Coast Alliance	13,174,643	6.0%	6.0%	52.47	12.69
Contra Costa Health Plan	9,752,461	8.0%	8.3%	13.62	12.51
Inland Empire Health Plan	23,753,369	8.1%	8.2%	7.80	8.08
Kern Health Systems	6,200,242	6.7%	6.9%	6.68	7.96
LA Care	39,953,251	4.0%	4.1%	3.99	3.84
San Francisco Health Plan	5,626,290	9.1%	9.5%	11.49	11.37
San Joaquin County Health	8,845,296	11.1%	11.6%	11.56	13.06
San Mateo Health Commission	9,426,798	7.6%	7.6%	15.12	19.69
Santa Barbara	10,750,254	7.3%	7.7%	17.06	18.52
Santa Clara Family Health Plan	12,827,255	11.2%	11.8%	12.71	13.33
TOTAL	**$4,779,260,333**	**7.7%**	**8.0%**	**$19.20**	**$15.37**

Source: Author's analysis of HMO annual statements, Report No. 2.

HMO Net Worth

Average number of months of expenses that HMOs maintain in net worth.



NCQA Accreditation Status of California Health Plans

Aetna Health
Commercial/HMO/POS Combined
Excellent
Medicare/HMO
Commendable

Blue Cross of California*
Commercial/HMO/POS Combined
Excellent
Medicaid/HMO
Excellent

Blue Shield of California
Commercial/HMO/POS Combined
Excellent
Medicare/HMO
Commendable

CIGNA HealthCare
Commercial/HMO/POS Combined
Excellent

Community Health Group
Medicare/HMO
Commendable

Health Net
Commercial/HMO/POS Combined
Excellent
Medicare/HMO
Commendable

Inland Empire Health Plan
Medicare/HMO
Commendable

Kaiser Foundation Health Plan (Northern and Southern California)
Commercial/HMO
Excellent
Medicare/HMO
Excellent

Molina Healthcare
Medicare/HMO
Commendable

PacifiCare
Commercial/HMO/POS Combined
Excellent
Medicare/HMO
Commendable

*Blue Cross of California also has full accreditation for its PPO plans.

EXHIBIT 24. California HMO Net Worth, 2002 and 2003

HMO	2002 Net Worth	2003 Net Worth	Change	Weeks of Net Worth, 2003	Net Worth Per Enrollee, 2003
Large HMOs					
Aetna Health	$125,514,760	$80,567,999	– $44,946,761	4.42	$213.30
Blue Cross of California	1,042,880,000	1,303,215,000	260,335,000	7.30	438.64
Blue Shield of California	740,120,000	1,133,397,000	393,277,000	10.22	423.70
Health Net	487,303,979	463,986,678	– 23,317,301	4.50	234.17
Kaiser Foundation	916,746,000	8,263,199,000	7,346,453,000	17.60	1,280.34
PacifiCare	320,827,287	475,749,253	154,921,966	4.54	282.95
Smaller HMOs					
Care 1st Health Plan	$30,944,411	$36,805,097	$5,860,686	9.01	$205.09
Chinese Community Health Plan	4,401,977	5,264,472	862,495	5.92	468.49
CIGNA Healthcare	43,512,580	67,833,994	24,321,414	2.71	461.53
Community Health Group	20,868,038	18,520,269	– 2,347,769	8.30	179.09
Community Health Plan	37,935,566	62,499,282	24,563,716	17.84	340.88
Inter Valley Health Plan	– 7,635,559	– 8,642,566	– 1,007,007	– 3.56	– 583.05
Lifeguard	– 42,851,267	0.00	0.00	0.00	0.00
Molina Healthcare	26,390,516	22,726,117	– 3,664,399	4.00	89.33
On Lok Senior Health	28,695,747	31,909,910	3,214,163	32.55	34,164.79
One Health Plan	19,099,861	17,323,499	– 1,776,362	5.68	326.10
Prudential Health Care	26,473,316	0.00	0.00	0.00	0.00
SCAN Health Plan	53,270,228	168,983,497	115,713,269	17.10	3,191.68
Sharp Health Plan	4,592,743	6,223,181	1,630,438	1.73	50.42
SIMNSA Health Plan	1,134,624	1,073,559	– 61,065	5.80	89.51
UC San Diego Health Plan	1,802,622	1,228,803	– 573,819	3.23	95.11
Universal Care	7,212,326	2,984,891	– 4,227,435	0.34	9.73
Valley Health Plan	3,651,399	4,008,503	357,104	3.05	71.91
Ventura County	1,141,082	1,412,320	271,238	4.87	132.55
WATTSHealth Foundation	– 11,029,000	15,170,000	26,199,000	3.55	162.46
Western Health Advantage	1,573,850	2,165,146	591,296	0.87	33.54
County Systems and Local Initiatives					
Alameda Alliance for Health	$45,152,154	$36,843,132	– $8,309,022	14.17	$397.96
CalOptima	147,423,982	148,669,021	1,245,039	10.16	494.99
Central Coast Alliance	36,708,799	38,190,175	1,481,376	9.05	466.30
Contra Costa Health Plan	5,458,061	9,245,706	3,787,645	4.07	151.77
Health Plan of the Redwoods	– 18,443,147	0.00	18,443,147	0.00	0.00
Inland Empire Health Plan	25,434,448	30,797,270	5,362,822	5.53	116.15
Kern Health Systems	61,622,881	61,951,985	329,104	35.63	776.43
LA Care	61,924,533	85,884,839	23,960,306	4.62	4,909.39
San Francisco Health Plan	11,410,571	14,431,080	3,020,509	12.72	340.71
San Joaquin County Health	31,960,958	35,328,844	3,367,886	23.99	548.43
San Mateo	15,321,326	15,321,328	2	6.43	289.39
Santa Barbara	13,158,876	21,424,481	8,265,605	8.03	396.57
Santa Clara Family Health Plan	17,867,946	22,139,704	4,271,758	10.57	240.96
TOTAL	**$4,339,578,474**	**$12,697,832,469**	**$8,358,253,995**	**11.30**	**$667.45**
Without Kaiser Foundation	$3,422,832,474	$4,434,633,469	$1,011,800,995	6.78	$352.78

Source: Author's analysis of 2002 and 2003 HMO annual statements, Reports 1A and 1B, Assets, Liabilities and Net Worth.

Except for Kaiser, most of the HMOs added about 10 percent to their net worth during 2003. Some national companies will leave as little as possible on the balance sheets of their state companies, preferring to manage those assets at the corporate level. Or they will transfer money from their state plans in the form of dividends to shareholders. For example, Aetna reduced its net worth at the end of 2003 by distributing $38.1 million in dividends to shareholders.

3.13 Utilization and Effectiveness of Care Measures

This section compares many of the major commercial HMOs in the state on three types of measures: utilization of care, effectiveness of care, and enrollee satisfaction. The need for comparative information on health plans and on providers is as acute as ever. Even with significant investment by health plans and providers in recent years, it is not clear how much progress has been made. The HEDIS measures (the acronym for the Health Plan and Employer Data Information Set) have gained prominence and in some ways have become the standard for evaluative measures. HEDIS is administered by National Committee for Quality Assurance (NCQA), a Washington, D.C. organization. In addition to the HEDIS measures, the NCQA administers programs for accreditation of managed care organizations. Some states now require HEDIS reports and NCQA accreditation as a condition of licensure or for contracting for Medicaid. Many large employers impose a similar requirement on HMOs that want to do business with them.

The accreditation status of California HMOs is reported in the sidebar starting on the previous page, NCQA Accreditation Status of California HMOs. A sidebar on page 28 lists public resources on the Internet for comparative information about health plans and provider groups in California. One of those resources is the California Cooperative Healthcare Reporting Initiative (CCHRI), a collaborative of prominent employers, providers, and health plan companies. It has encouraged HMOs to prepare HEDIS reports, and disseminates the information through Web sites and publications. The CCHRI is committed to standardized, comparable reports on health care performance so that users are able to compare health plans on an "apples to apples" basis. The data comparisons are posted at the California HealthScope Web site, sponsored by the Pacific Business Group on Health. Those comparisons usually will display one to five stars as a way of showing meaningful differences between health plans. The tables in this report present the actual scores.

The data for this section were drawn from NCQA's Quality Compass® data set, based on operations for 2003. Note that the data here are for all commercial lines of business that they operate, including point-of-service plans, which may go beyond the commercial enrollment reported on the state filings. Kaiser Permanente uses only its HMO enrollment.

Some HMOs did not complete all sections of the reports for a variety of reasons, so some cells in the exhibits are blank. Rates of inpatient utilization for admissions for mental illness or chemical dependency diagnoses are in addition to the acute care utilization rates, and are calculated by multiplying the number of discharges times the average length of stay for each admission category. Other hospital stays, such as non-acute care, are reported separately and not included in the exhibits here.

Exhibit 25 on the following page compares California's major HMOs on their rates of acute care inpatient hospital utilization for commercial enrollees in 2003. California HMOs continue to report relatively low rates of inpatient hospital utilization, with all but one of those reporting here falling well below the national median. However, there does seem to be a general trend upward for most of the plans. For example, PacifiCare reported increases in both 2003 and 2002 and is now up to 165 days per 1,000 members,

NCQA Accreditation Status of California Health Plans, cont.

Universal Care
Commercial/HMO
Commendable

Western Health Advantage
Commercial/HMO
Accredited

RATING DEFINITIONS

Accredited: Must meet most of NCQA's basic requirements for consumer protection and quality improvement.

Excellent: NCQA's highest accreditation is granted to plans whose levels of service and clinical quality meet or exceed NCQA's requirements for consumer protection and quality improvement and achieve HEDIS® results in the highest range of national or regional performance.

Commendable: This accreditation outcome is awarded to plans whose levels of service and clinical quality meet or exceed NCQA's requirements for consumer protection and quality improvement.

Source: www.ncqa.com (Accessed June 2005).

EXHIBIT 25. Inpatient Hospital Utilization for Commercial Health Plans, 2003

HMO	Product Reporting Type	Acute Days Per 1,000 Members	Average Length of Stay	Discharges Per 1,000 Members	Days Per 1,000 Members Mental Health	Days Per 1,000 Members Chemical Dependency	Acute Days Per 1,000 Members 2002	Acute Days Per 1,000 Members 2001
Aetna Health	HMO/POS Combined	180.76	3.87	46.72	11.54	6.54	139.79	163.43
Blue Cross of California	HMO/POS Combined	142.97	3.49	40.91	31.87	6.91	142.42	134.96
Blue Shield of California	HMO/POS Combined	182.19	3.56	51.19	11.88	2.22	176.35	NR
CIGNA HealthCare	HMO/POS Combined	154.14	3.47	44.41	9.29	2.54	137.12	NR
Community Health Group	HMO/POS Combined	248.74	3.94	63.19	11.83	3.10	NR	NR
Health Net	HMO/POS Combined	151.42	3.55	42.63	NA	NA	137.82	121.45
Kaiser Foundation Southern California	HMO	157.21	3.22	48.81	15.44	5.25	158.06	150.57
Kaiser Foundation Northern California	HMO	153.94	3.40	45.29	16	2.17	154.63	154.40
PacifiCare	HMO/POS Combined	164.81	3.46	47.59	12.95	4.88	156.47	138.94
Sharp Health Plan	HMO	NR	NR	NR	NA	NA	NR	NR
Universal Care	HMO	165.42	3.62	45.66	10.31	1.95	NR	NR
Western Health Advantage	HMO	NR	NR	NR	NA	NA	NR	NR
U.S. Median		**214.62**	**3.66**	**58.07**	**16.32**	**4.6**	**208.61**	**206.98**

Source: Author's analysis of HMO HEDIS reports found in NCQA Quality Compass® data files. Some cells are shown as NA, not applicable, meaning that the HMO did not have enough members in that cell to meet NCQA standards of statistical significance or to protect privacy of individual members. Other cells show NR, meaning not reported. Utilization rates for mental health and chemical dependency were calculated using discharge rates and average length of stay.

about 20 percent more than two years ago. Similarly, Health Net has seen its inpatient utilization rate grow from 121.45 days per 1,000 in 2001 to 137.82 in 2002 and 151.42 in 2003.

The Quality Compass® data set includes four measures of ambulatory care utilization: outpatient visits, emergency room visits, ambulatory surgery, and observation room visits. The numbers of visits and procedures are presented as rates per 1,000 members. As shown in Exhibit 26, commercial enrollees in PacifiCare and Health Net used an average of about 2,800 outpatient (office) visits per 1,000 members, higher than in 2002 and 2001. The Kaiser Permanente plan for southern California came in with an average of 4,425 visits, higher than the northern Kaiser rate of 3,580 visits.

Limiting use of emergency departments has been a fundamental premise of managed care. When patients have a primary care home, they should have

EXHIBIT 26. Ambulatory Utilization Measures for Commercial Health Plans, Per 1,000 Members, 2003

HMO	Outpatient Visits	Emergency Room Visits	Ambulatory Surgery Procedures	Observation Room Stays	Emergency Room Visits, 2002
Aetna Health	2,560.41	190.75	43.30	2.88	101.71
Blue Cross of California	NR	153.89	NR	NR	137.81
Blue Shield of California	2,853.16	130.37	59.02	1.78	121.58
CIGNA HealthCare	NR	119.59	46.63	2.17	123.19
Community Health Group	3,764.86	209.11	118.67	12.28	NR
Health Net	2,866.65	125.74	58.34	2.69	122.52
Kaiser Foundation Southern California	4,424.73	203.04	23.86	7.80	246.07
Kaiser Foundation Northern California	3,579.53	170.24	31.13	6.36	160.46
PacifiCare	2,809.67	139.40	67.41	3.55	141.35
Sharp Health Plan	NR	NR	NR	NR	NR
Universal Care	2,610.52	135.95	52.29	2.46	NR
Western Health Advantage	NR	NR	NR	NR	NR
U.S. Median	**3,573.35**	**179.27**	**111.73**	**7.77**	**180.53**

Source: Author's analysis of HMO HEDIS reports found in NCQA Quality Compass® data files. Some cells are shown as NA, not applicable, meaning that the HMO did not have enough members in that cell to meet NCQA standards of statistical significance or to protect privacy of individual members. Other cells show NR, meaning not reported.

EXHIBIT 27. Effectiveness of Care Measures for Commercial Health Plans, 2003

HMO	Childhood Immunization Combo 1	Mammography	Cervical Cancer Screening	Eye Exams for Diabetics	Six Well Child Visits in First 15 Months	Beta Blockers	Control High Blood Pressure
Aetna Health	77.00	74.85	81.10	45.10	29.75	90.51	65.43
Blue Cross of California	76.69	74.57	78.50	57.45	NR	94.38	66.67
Blue Shield of California	73.51	79.24	79.60	49.27	36.99	87.21	63.46
CIGNA HealthCare	77.32	71.65	78.00	50.85	37.11	93.94	62.03
Community Health Group	81.49	79.17	81.74	38.20	67.34	94.53	60.76
Health Net	76.88	76.43	81.54	48.58	52.02	93.65	62.83
Kaiser Foundation Southern California	84.05	75.18	80.54	70.07	47.06	95.86	46.47
Kaiser Foundation Northern California	77.73	75.17	80.37	66.41	70.24	99.09	52.31
PacifiCare	76.86	76.05	81.85	55.70	40.33	97.95	68.05
Sharp Health Plan	NR	NR	NR	NR	NR	NR	NR
Universal Care	71.40	72.53	81.48	31.12	NR	93.55	67.35
Western Health Advantage	57.84	73.48	74.21	40.39	NR	NA	NR
U.S. Median	**75.37**	**75.55**	**82.48**	**48.02**	**69.98**	**95.80**	**63.66**

NA: Not applicable, meaning that the HMO did not have enough members in that cell to meet NCQA standards of statistical significance or to protect privacy of individual members.
NR: Not reported.

Explanation of Measures: *Childhood Immunization:* Using Combination 1 which identifies children who turned two years old during the reporting year and who received 4 DTP, 3 OPV, 1 MMR, 2 HepB and 1 HIB. *Mammography:* Identifies women age 52 through 69 who had one or more mammograms during the reporting year or the prior year. *Cervical Cancer Screening:* Identifies women age 21 through 64 who had one or more Pap tests during the reporting year or the prior two years. *Eye Exams for Diabetics:* Identifies members ages 18 to 75 with diabetes who received a retinal exam during the report year. *Six Well Child Visits:* The percentage of children who had six or more well child visits by the time they turned 15 months of age. *Beta Blockers:* The percentage of plan members who were discharged from the hospital after surviving a heart attack and who received a prescription for beta blockers. *Controlling High Blood Pressure:* Measures control of blood pressure, less than or equal to reading of 140/90 for adults ages 46 to 85 years who are diagnosed with hypertension.

Source: Author's analysis of HMO HEDIS reports found in NCQA Quality Compass® data files.

less need to go to the ER. As in previous years, the southern California Kaiser enrollees had higher rates of emergency room usage than their counterparts in northern California. However, the gap between the two has narrowed, as the rate increased for northern California while decreasing in the south. Blue Cross enrollees had lower rates of emergency room use than Kaiser patients, but their rate increased from 138 visits per 1,000 members in 2002 to 154 in 2003.

In general, emergency room visit rates have increased in recent years. Some suggest that this is because of state laws that ensure that an HMO cannot deny payment if a reasonable person thought that a medical emergency did exist. Others suggest that increased use of emergency rooms reflects a shortage of primary care capacity. Patients call to request appointments, but when none are available soon, some go to the emergency room.

Exhibit 27 compares HMOs on six effectiveness of care measures and one utilization of care measure. The results vary quite a bit, with some HMOs scoring very high on some measures and low on others. The range is widest on the well-child visits—even the two Kaiser plans reported quite different results on that measure. In northern California, 70 percent of Kaiser enrollees met the standard of six well child visits but only 47 percent of southern California Kaiser enrollees had six visits in 2003.

When HEDIS began measuring the effectiveness of care, it looked at the proportion of enrollees in certain demographic strata that had screenings for breast cancer or cervical cancer. Those measures have been expanded to include comprehensive diabetes care and care for several other chronic conditions. Because many HMOs have already met some of the national benchmarks for mammography or pap smears, less attention is sometimes paid to those measures.

3.14 Enrollee Satisfaction

As with clinical measures of quality, information on enrollee satisfaction began with the health plan as the unit of analysis. In California, more emphasis is now being placed on making that information available at the medical group level.

Because useful data measures of health care quality are hard to find, a good deal of emphasis is placed on something that can be measured, or at least asked about—namely, enrollee satisfaction. How useful satisfaction measures are as a substitute or proxy for measuring quality of care is often debated. The

EXHIBIT 28. Enrollee Satisfaction Measures Reported on CAHPS Survey for Commercial Health Plans, 2003

HMO	Customer Service	Getting Needed Care	Getting Care Quickly	Rating of All Health Care	Rating of Health Plan
Aetna Health	62.13%	66.93%	66.93%	65.43%	52.54%
Blue Cross of California	68.32%	68.66%	69.14 %	67.10%	58.85%
Blue Shield of California	74.82%	72.40%	71.49 %	69.82%	62.70%
CIGNA HealthCare	NA	68.43%	70.71 %	68.28%	57.81%
Community Health Group	69.88%	75.65%	72.08 %	76.19%	63.42%
Health Net	70.34%	70.13%	72.86 %	69.88%	61.19%
Kaiser Foundation Southern California	77.18%	75.28%	69.63 %	68.48%	67.32%
Kaiser Foundation Northern California	75.93%	75.95%	76.74 %	69.70%	66.72%
PacifiCare	70.91%	71.61%	71.47 %	70.93%	60.26%
Sharp Health Plan	74.78%	75.18%	73.90 %	73.33%	67.67%
Universal Care	71.21%	69.90%	66.92 %	70.62%	58.57%
Western Health Advantage	76.43%	70.62%	75.42 %	67.44%	63.29%
U.S. Median	**67.59%**	**75.18%**	**75.38%**	**72.97%**	**56.93%**

NA: Not applicable, meaning that the HMO did not have enough members in that cell to meet NCQA standards of statistical significance or to protect privacy of individual members.

Explanation of Measures: *Customer Service:* A composite score based on the percentage of members who responded "Not a problem" when asked if they had any problem with the health plan's written material, customer service call staff, or paperwork. *Getting Needed Care:* A composite score based on the percentage of members who responded "Not a problem" when asked about their experience in the past year in: (1) getting a provider they were happy with, (2) getting a referral to a specialist, (3) getting care believed necessary, and (4) delays in getting approval from the health plan. *Getting Care Quickly:* A composite score based on the percentage of members who responded "Always" or "Usually" when asked about: (1) their experience in the past year in getting help or advice requested during normal office hour, (2) getting a timely appointment for routine care, (3) getting care right away when needed because of illness or injury, and (4) how often they waited 15 minutes or more past appointed time to see the provider they went to see. *Rating of All Health Care:* Percentage of members who, on a scale from 1 to 10, with 10 being the best, rated all their health care in the past year with an 8, 9, or 10. *Rating of Health Plan:* Percentage of members who, on a scale from 1 to 10, with 10 being the best, rated their experiences with their health plan in the past year with an 8, 9, or 10.

Source: Author's analysis of HMO HEDIS reports found in NCQA Quality Compass® data files.

most widely used instrument to measure enrollee satisfaction with their health plans and health care is the Consumer Assessment of Health Performance Survey (CAHPS®). (A source of information on patient satisfaction with California hospital care is the California Hospital Experience Survey, available at www.calhospitals.org.)

Exhibit 28 shows a series of composite measures of enrollee satisfaction based on the CAHPS survey. Enrollees were asked about satisfaction with providers and care received and about the performance of the health plan. The first three measures in the table are based on a composite score for a series of questions in that area. The last two look at overall satisfaction with health care received and with the health plan. Consumers were asked to rate their satisfaction using a scale of 1 to 10, with 10 being the most satisfied.

As in past years, ratings of health care came out higher than the ratings of health plans. Still the gap is very narrow for southern California Kaiser. Sharp Health Plan had the highest score on health plan rating and the second highest score for rating of all health care; only Community Health Group came out higher on the latter rating. For many of the other health plans, there is a gap of 10 to 15 percentage points on those two measures.

4.0 Regional Sub-Markets and Provider Systems

The last two years have been relatively good for hospitals in California. On the whole, their net income is up, their negotiating position with health plans is strong, and most are making the necessary progress toward their seismic standard requirements. And yet, the outlook is mixed. Hospitals and physicians benefited from changes in the Medicare Modernization Act, yet 2005 is expected to be a year of new federal cuts to Medicare and Medicaid as concern over budget deficits may lead Congress to scale back the new money recently committed to these programs. Those federal cuts almost always fall on providers. Additional state cuts to Medi-Cal are also likely, and hospitals get hurt if provider payment rates are cut or eligibility standards tightened and the number of uninsured grows.

Hospitals will have significant capital needs going forward, both for construction and for investment in information systems and new equipment. Many nonprofit hospital systems will use the bond markets to raise capital, and the bond rating firms are likely to be concerned about future decisions that will reduce cash flow and increase the burden of care for persons without insurance.

Hospital systems have become somewhat fluid in the state. There are new transactions on a regular basis as one system seeks to grow and another seeks to cut back on its facilities in California. The result is sometimes the emergence of another new system of hospitals in the state. For example, Catholic Healthcare West (CHW) lost seven hospitals when the Daughters of Charity took back those hospitals in 2002, but CHW later acquired two hospitals in the San Luis Obispo area. Until 2002, Tenet had been in acquisition mode and had built one of the largest hospital networks in the state. But in 2003 and 2004, as part of a national strategy to pare down its holdings, it put 19 of its California hospitals up for sale. In 2004 it transferred three West Los Angeles hospitals to the newly created Centinela Freeman Health System. Tenet had bought two of the three hospitals only a few years earlier.

4.1 About This Analysis

This section of the report examines health market issues in six regions of the state:

- San Francisco Bay Area;
- Sacramento;
- Central Valley;
- Los Angeles and Orange Counties;
- Inland Empire of Riverside and San Bernardino Counties; and
- San Diego.

It focuses on the hospital systems and physician organizations in each region and provides additional details on competition among health plans in each area. Based on interviews with leaders in those regions, the analysis examines issues such as health care access, the role of safety net providers, and important initiatives by purchasers, provider systems, and health plans.

Hospital Analysis. In this report, the analysis is limited to acute care hospitals. It does not include specialty hospitals such as rehabilitation or behavioral health facilities, or hospitals for military veterans or active duty personnel.

Seniors, Long-Term Care and Medi-Cal Redesign

Services to seniors are a large segment of the state's Medi-Cal budget and will be central to any major redesign of the Medi-Cal program. Seniors (and persons with disabilities) who are Medi-Cal beneficiaries are generally getting their care paid for in Medi-Cal's fee-for-service system. The key exception is in those counties that have organized Medi-Cal service delivery into County Organized Health Systems. However, the Schwarzenegger administration's Medi-Cal redesign proposals would sharply increase the number of seniors in managed care arrangements. It would also expand managed care into new counties. For more information about Medi-Cal redesign proposals, go to www.medi-calredesign.org.

The Medi-Cal redesign proposals would also launch Acute and Long Term Care Integration projects in Contra Costa, Orange, and San Diego counties. Individuals in these counties who are eligible for Medi-Cal or dually eligible for both Medicare and Medi-Cal would enroll in either a managed care plan or the acute and long term care integration plan. In these demonstration counties, seniors electing the acute and long term care integration health plans would have access to a broad range of services intended to help them remain in community settings. The services would include interdisciplinary care management, primary care, acute care, drugs, emergency care, dental services, home and community-based services and long term care. They would have wider latitude to make choices about their care needs and living arrangements.

Many seniors are eventually faced with choices about moving into a nursing home or obtaining other kinds of services to assist them with daily living. Launched a few years ago, California Nursing Home Search is a resource developed by the University of California San Francisco and the California HealthCare Foundation.to help inform those choices. The Web site (www.calnhs.org) allows users to compare nursing homes, home health agencies and hospice services based on a variety of factors. Data are drawn from state and federal government reviews of the facilities and agencies.

Each regional section includes two tables of hospital data. The first presents financial performance data, looking at revenues and net income. The second shows measures of inpatient occupancy and payer mix, that is, the proportion of inpatient hospital days that were expected to be paid by Medicare, the state/federal Medi-Cal program, third-party insurers (including managed care plans), and other sources.

In each of the tables, hospitals are grouped based on their system or network affiliation at the end of 2003. Independent hospitals, some of which are quite large, are shown after the system hospitals.

Pie charts in the sections for three of the regions (the Bay Area, Los Angeles/Orange, and San Diego) show the market share of the major hospital systems and largest independent hospitals. A second pie chart in those sections shows the estimated market share of the HMOs in the region for 2003.

The hospital analysis in this section uses financial and utilization data that the Office of Statewide Health Policy and Development (OSHPD) collects from hospitals each year. The data presented here are for hospital reporting years ending between January 1 and December 31, 2003. That data set typically becomes available in the fall of the following year. OSHPD also produces a valuable hospital discharge database each quarter that enables researchers to compare hospitals on the volume of key procedures performed and the charges for those procedures. (Those data were not used for this report.)

Some other notes on the OSHPD data: First, Kaiser Foundation does not report financial results separately for its 28 hospitals as other hospital systems do. Instead, those numbers are rolled into two regional summaries for hospitals in northern and southern California. However, Kaiser does report inpatient days and payers for each separate hospital; these figures are included in the tables that follow.

Second, for all hospital systems, the OSHPD data might yield different results from the hospital systems' reports in their audited financial statements. The financial statements of a hospital system prepared using Generally Accepted Accounting Principles (GAAP) might include the finances of affiliated physician practices, home health, long-term care facilities, and so on.

According to the OSHPD data, if a health plan pays for a hospital stay for a senior enrollee, that stay is reported with stays for Medicare and not for the third-party payers. Similarly, a Medi-Cal managed care day would be attributed to Medi-Cal and not to the managed care payer.

For hospitals, market share is calculated based on the number of inpatient hospital days, as shown in the OSHPD data. Market share could also be measured using hospital discharges, patient revenues, or outpatient procedures, which would likely yield different results.

Physician Organization Analysis. Each section includes a table that provides an overview of physician organizations operating in the geographic region. Those tables were prepared by Mark Richardson, a Minnesota-based researcher, using a data set of California physician organizations. That data set is compiled and maintained by the Cattaneo & Stroud research firm, with support from the California HealthCare Foundation.

Within each table, physician organizations have been grouped into categories: integrated medical group practice, medical foundation, independent practice association (IPA), and other. Note that these distinctions have blurred in recent years, and some organizations are now hybrids of those categories.

A discussion of the different forms of physician organizations in California appears in Section 2.4 of this report.

The tables show the reported number of primary care and specialty physicians in each group, as well as each group's estimate of capitated managed care lives, that is, the number of patients for which it receives a monthly payment and takes responsibility for providing care. There is likely to be some overlap of physicians who contract through IPAs, since they may have managed care contracts through multiple IPAs.

The physician data are generally from 2003 and are as estimated and reported by the responding physician organizations. Medical groups are not required to report this information to the state. During a brief period in 2003 they were required to report their finances to the Department of Managed Health Care.

For reasons of clarity and space limitations, the tables do not include some of the smaller physician organizations. In general, organizations were included in the tables (except for Los Angeles) if they met a threshold of 30,000 or more managed care enrollees, or if they had 70 or more primary care physicians in that region. For Los Angeles, physician organizations were included if they had at least 40,000 enrollees or 100 or more primary care physicians.

4.2 San Francisco Bay Area

The San Francisco Bay Area analysis examines providers and health plans in six counties: Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara. The area's economy boomed in the 1990s as a center of high-tech commerce and has since declined with the dot-com bust.

The Bay Area extends from Walnut Creek in the east, to San Rafael in the north, and to San Jose at the south. The cities of San Francisco, Oakland, and Berkeley are in the middle. Some health care organizations cover the region widely while others have a dominant position in distinct sub-markets.

In Exhibits 29 and 30 that follow, hospitals are grouped into seven major systems, two large and prominent academic health centers, and an "Other Hospitals" section that includes public and independent hospitals. The systems are Catholic Healthcare West, Daughters of Charity, HCA: The Healthcare Company, Kaiser Foundation, Sutter Health, Tenet Health, and Muir/Mt. Diablo. HCA and Tenet are for-profit companies while the other five systems are organized as nonprofits. The two academic health centers, Stanford University and University of California – San Francisco, were briefly and unhappily married from 1997 to 1999 in a mega-merger of health systems that ultimately unraveled.

Overview of Hospitals

After a series of acquisitions the Sutter Health hospital group has become the largest in the region, with a total of 2,622 beds. There are now nine Sutter hospitals across the Bay Area, including St. Luke's in San Francisco, which was added in 2003. Summit Medical Center in Oakland became part of the Sutter system in 1999, in a deal that raised objections that it gave too much market power to the Sutter system in the East Bay area. Alta Bates in Berkeley and Summit in Oakland are considered as two campuses for a single hospital. The Sutter system also includes five Sacramento-area hospitals and six others in northern California. In addition, the Sutter system is tied to some of the leading physician groups in the Bay Area, including the Palo Alto Medical Foundation (which in turn includes the Camino Medical Group), and the Alta Bates IPA in Oakland.

There are nine Kaiser Foundation hospitals in the area with a total of 2,014 beds, comprising the second-largest system in the area. The largest Kaiser inpatient facility is its Oakland medical center. In the late 1990s, Kaiser considered a strategic shift away from hospital ownership. It was concerned about the amount of capital needed to retrofit its hospitals to meet seismic safety requirements. After a few years during which it made only modest investments in its Bay Area hospitals, Kaiser returned to its strategy of being a self-contained system relying heavily on its own hospitals. It has resumed making investments in its Bay Area hospitals and, in a project estimated to cost $500 million, plans to rebuild its Oakland hospital and medical center over the next eight years.

Catholic Healthcare West now administers three hospitals in the Bay Area. Ownership of the hospitals in the CHW network is retained by their respective religious orders. In 2002, the Daughters of Charity of St. Vincent de Paul of the West withdrew its four Bay Area hospitals from CHW, and now operates separately in the Bay Area and in Los Angeles.

Hospitals owned by for-profit companies like HCA: The Healthcare Company and Tenet Health are much less prominent in northern California than in the southern part of the state. In the Bay Area these two systems together have less than 10 percent of the inpatient hospital days. HCA has sold or closed hospitals and reduced its presence both in the Bay Area and overall in California. In 2004 it operated three hospitals in the San Jose area, but closed San Jose Medical Center at the end of the year after consecutive years of losses. Tenet Health has three hospitals in the Bay Area, the largest being Doctors Medical Center in San Pablo.

The John Muir/Mt. Diablo hospitals account for more than half of the inpatient hospital beds in Contra Costa County, which gives them a strong position in negotiations with health plans. Muir/Mt. Diablo also operates a psychiatric hospital in Concord. Its major competitors there are the Kaiser hospital in Walnut Creek, the Tenet hospital in San Ramon, and a public hospital, Contra Costa Regional Medical Center.

Financial Results

Exhibit 29 that follows compares Bay Area hospitals on their revenues and net income. In 2003, these hospitals reported a total of $780.2 million in net income. That is about 5.9 percent of total revenues of $13.1 billion. Note also the gap between billed charges of $31.1 billion and $12.2 billion of net patient revenues. That gap includes discounts taken by Medicare and Medi-Cal and negotiated by health plans. As a group they had $411.9 million in operating net income plus an additional $400 million in net income from other sources, including investments, philanthropy, government funds, and so on.

The Sutter hospitals reported average net income of $206.1 million or 8.8 percent of total revenues. Individual hospitals had quite varied results. For

EXHIBIT 29. Revenues and Profitability for Bay Area Hospitals, 2003

System/Hospitals	City	Total Charges	Net Patient Revenue	Total Revenue	Operating Expenses	Net from Operations	Net Income	% of Total Revenue
Catholic Healthcare West		**$1,509,753,556**	**$403,096,312**	**$416,302,195**	**$384,759,305**	**$25,085,858**	**$25,408,760**	**6.1%**
Sequoia Hospital	Redwood City	534,968,701	148,356,961	152,482,539	143,539,504	7,910,751	8,436,795	5.5%
St. Francis Memorial Hospital	San Francisco	437,737,463	117,380,674	122,253,258	108,916,313	10,173,890	8,464,033	6.9%
St. Mary's Medical Center	San Francisco	537,047,392	137,358,677	141,566,398	132,303,488	7,001,217	8,507,932	6.0%
Daughters of Charity		**$1,565,063,510**	**$400,490,674**	**$414,364,517**	**$382,085,324**	**$21,870,892**	**$27,399,705**	**6.6%**
O'Connor Hospital	San Jose	621,056,300	155,847,295	162,729,047	152,489,761	4,782,045	9,054,211	5.6%
Seton – Coastside	Moss Beach	21,471,397	11,653,726	11,968,979	13,358,325	– 1,512,221	– 1,389,346	– 11.6%
Seton Medical Center	Daly City	754,414,673	185,730,866	191,838,109	169,790,966	17,432,119	18,455,493	9.6%
St. Louise Regional Hospital	Gilroy	168,121,140	47,258,787	47,828,382	46,446,272	1,168,949	1,279,347	2.7%
HCA: The Healthcare Company		**$1,849,752,325**	**$508,151,710**	**$514,707,967**	**$534,704,200**	**$– 21,152,695**	**$– 20,338,525**	**– 4.0%**
Good Samaritan Hospital	San Jose	838,106,725	257,929,372	261,097,607	240,535,647	19,523,810	20,255,668	7.8%
Regional Medical Center	San Jose	514,323,371	113,521,928	114,245,269	138,502,408	– 24,294,945	– 24,257,139	– 21.2%
San Jose Medical Center	San Jose	497,322,229	136,700,410	139,365,091	155,666,145	– 16,381,560	– 16,337,054	– 11.7%
Kaiser Foundation North	**Oakland**	**$3,481,058,379**	**$3,417,971,802**	**$3,519,782,348**	**$3,235,713,577**	**$283,871,987**	**$284,068,771**	**8.1%**
Muir Mt. Diablo		**$2,021,556,879**	**$545,445,231**	**$595,841,516**	**$525,950,391**	**$64,065,787**	**$65,705,797**	**11.0%**
John Muir Medical Center	Walnut Creek	1,224,395,641	366,109,122	408,241,894	346,784,591	60,419,517	61,457,303	15.1%
Mt Diablo Medical Center	Concord	797,161,238	179,336,109	187,599,622	179,165,800	3,646,270	4,248,494	2.3%
Stanford University	**Palo Alto**	**$2,327,262,288**	**$865,078,776**	**$953,136,249**	**$905,918,692**	**$39,491,052**	**$35,956,000**	**3.8%**
Sutter Health		**$7,439,093,490**	**$2,208,596,896**	**$2,334,877,319**	**$2,113,969,432**	**$161,856,955**	**$206,078,021**	**8.8%**
Alta Bates Summit	Berkeley	1,423,680,340	394,105,046	407,170,100	377,710,594	25,559,047	25,711,813	6.3%
Alta Bates Summit	Oakland	1,212,099,177	300,212,540	329,889,452	316,157,342	8,911,830	12,587,988	3.8%
California Pacific Medical	San Francisco	2,080,954,070	662,527,121	708,391,636	591,566,008	86,713,452	116,825,628	16.5%
Eden Medical Center	Castro Valley	462,620,344	138,116,096	141,686,515	132,439,506	8,723,583	8,471,882	6.0%
Marin General Hospital	San Rafael	604,559,184	194,226,773	209,051,616	191,542,943	8,838,880	13,174,575	6.3%
Mills-Peninsula Medical	Burlingame	977,821,003	297,156,782	308,404,325	266,782,338	36,184,698	38,487,928	12.5%
Novato Community Hospital	Novato	119,723,396	42,386,657	44,250,015	40,422,117	2,459,069	2,835,273	6.4%
St. Luke's Hospital	San Francisco	274,720,774	82,475,910	86,171,964	119,384,610	– 35,432,029	– 33,230,646	– 38.6%
Sutter Delta Medical Center	Antioch	282,915,202	97,389,971	99,861,696	77,963,974	19,898,425	21,213,580	21.2%
Tenet Health		**$2,079,589,089**	**$352,640,568**	**$358,438,409**	**$334,617,432**	**$22,076,748**	**$21,916,474**	**6.1%**
Community Hospital	Los Gatos	588,104,976	114,676,287	115,585,478	97,280,973	17,822,907	17,032,438	14.7%
Doctors Medical Center	San Pablo	967,924,470	137,160,192	140,833,522	148,115,697	– 7,909,095	– 7,583,347	– 5.4%
San Ramon Regional	San Ramon	523,559,643	100,804,089	102,019,409	89,220,762	12,162,936	12,467,383	12.2%
UCSF Medical Center	**San Francisco**	**$2,580,571,221**	**$926,227,835**	**$957,625,014**	**$885,468,214**	**$60,560,757**	**$66,211,825**	**6.9%**
Other Hospitals		**$6,235,710,675**	**$2,599,377,476**	**$3,067,560,051**	**$2,960,374,870**	**$– 245,804,705**	**$67,834,932**	**2.2%**
Alameda Hospital	Alameda	132,539,100	27,478,784	33,479,811	31,113,194	– 3,559,887	2,253,321	6.7%
Alameda County Medical	Oakland	497,518,137	268,495,668	282,565,785	317,741,751	– 41,668,680	– 35,660,087	– 12.6%
Children's Hospital and Research Center	Oakland	398,844,773	206,984,687	266,395,868	258,672,368	1,068,233	4,248,622	1.6%
Chinese Hospital	San Francisco	83,934,995	47,169,370	48,676,278	45,938,444	2,131,901	2,737,834	5.6%

EXHIBIT 29. Revenues and Profitability for Bay Area Hospitals, 2003, cont.

System/Hospitals	City	Total Charges	Net Patient Revenue	Total Revenue	Operating Expenses	Net from Operations	Net Income	% of Total Revenue
Other Hospitals, cont.								
Contra Costa Regional	Martinez	$329,172,457	$156,766,928	$242,040,881	$236,682,722	$– 71,605,597	$633,807	0.3%
El Camino	Mountain View	723,646,636	224,525,743	246,136,347	216,564,347	15,695,000	29,572,000	12.0%
Lucile S. Packard Children's Hospital at Stanford	Palo Alto	747,919,088	344,717,463	372,237,389	311,222,421	55,936,607	60,207,597	16.2%
Menlo Park Surgical Hospital	Menlo Park	14,742,398	5,544,937	5,550,263	7,141,074	– 1,592,974	– 1,590,811	– 28.7%
San Francisco General	San Francisco	699,623,405	365,662,036	405,080,491	399,189,812	– 22,874,336	– 5,267,235	– 1.3%
San Mateo Medical Center	San Mateo	176,103,453	78,824,314	147,700,506	147,185,561	– 58,391,641	493,783	0.3%
Santa Clara Valley Medical	San Jose	1,135,075,548	442,970,869	572,798,245	586,820,560	– 136,432,117	– 14,022,315	– 2.4%
St. Rose Hospital	Hayward	246,108,488	74,019,131	74,725,585	72,815,568	1,910,017	1,910,017	2.6%
Valley Memorial Hospital	Livermore	498,036,256	136,659,742	140,044,812	134,445,776	4,478,608	5,175,174	3.7%
Washington Hospital	Fremont	552,445,941	219,557,804	230,127,790	194,841,272	9,100,161	17,143,225	7.4%
TOTAL		$31,089,411,412	$12,227,077,280	$13,132,635,585	$12,263,561,437	$411,922,636	$780,241,760	5.9%

Source: Author's analysis of annual hospital report data for years ending in 2003 from office of Statewide Health Planning and Development.

example, California Pacific Medical Center in San Francisco had net income of $116.8 million and Mills Peninsula Medical Center in Burlingame had net income of $38.5 million. Although they had lost money in previous years, the two Alta Bates campuses had combined net income in 2003 of $38.5 million. Of the Bay Area Sutter hospitals, only St. Luke in San Francisco lost money in 2003.

The Kaiser Foundation hospitals in northern California also had very strong results in 2003. As shown in the table, the Northern Region hospitals (including the Bay Area and hospitals in Sacramento) had net income of $284.1 million, or 8.1 percent of net patient revenues. In Kaiser's case, billed charges and net patient revenue are virtually the same, since it does not have the same issues of payers taking discounts.

The Catholic Healthcare West hospitals reported net income of 6.1 percent of total revenues and the Daughters of Charity hospitals in the Bay Area had similar results. Seton Medical Center in Daly City had the best results in the Daughters of Charity system.

The two Muir/Mt. Diablo hospitals in Contra Costa County combined for $65.7 million in net income, or 11.0 percent of total revenues. Almost all of that was from operations at John Muir Medical Center in Walnut Creek. In 2001, those hospitals had net income of $27.5 million. The two hospitals have a very strong geographic presence in Contra Costa County; their competition is the Contra Costa Regional Medical Center and the Tenet hospital in San Ramon.

The three HCA hospitals in the area reported a loss of $20.3 million, or 4.0 percent of total revenues. Good Samaritan Hospital has consistently made a profit, but HCA's other two hospitals in San Jose have lost money. The Tenet Health hospitals, on the other hand, reported $21.9 million in net income, or 6.1 percent of total revenues.

The public hospitals in the region generally lost money. Alameda County Medical Center lost $35.7 million and Santa Clara Valley Medical Center lost $14 million. Contra Costa Regional Medical Center broke even for the year. Public hospitals benefit from special funds for hospitals that serve a disproportionate number of uninsured patients, but they also are required to transfer funds out in order to leverage the disproportionate share funds. Both of the academic health center hospitals, Stanford and University of California – San Francisco, had positive net income in 2003. In 2001, both reported losses.

Occupancy

Major hospital construction projects are now underway in several parts of the Bay Area. As was noted in Section 2.3, inpatient hospital capacity has returned as an issue in California. In the past two years, emergency departments at certain hospitals in the Bay Area were often on diversion, meaning that their emergency rooms were full so that approaching ambulances were turned away and redirected to emergency departments at other hospitals.

Exhibit 30 on the following page shows inpatient occupancy for Bay Area

EXHIBIT 30. Inpatient Occupancy Rates and Payer Mix for Bay Area Hospitals, 2003

System/Hospital	Staffed Beds	Inpatient Days	Occupancy	Medicare Share of Days	Medi-Cal Share of Days	Third Party Share of Days	County Indigent Share of Days	Other Payers Share of Days
Catholic Healthcare West	**925**	**142,149**	**41.5%**	**60.2%**	**9.8%**	**26.4%**	**0.0%**	**3.6%**
Sequoia Hospital	286	41,582	38.0%	59.5%	3.6%	35.4%	0.0%	1.5%
St. Francis Memorial Hospital	209	50,304	65.9%	54.3%	14.8%	23.7%	0.0%	7.3%
St. Mary's Medical Center	430	50,263	32.0%	66.7%	10.0%	21.6%	0.0%	1.8%
Daughters of Charity	**713**	**187,422**	**64.7%**	**48.5%**	**27.9%**	**21.7%**	**0.0%**	**1.9%**
O'Connor Hospital	225	53,399	47.8%	48.0%	6.9%	43.9%	0.0%	1.2%
St. Louise Regional Hospital	89	15,611	48.1%	51.3%	10.8%	37.9%	0.0%	0.0%
Seton Medical Center	278	78,517	77.4%	57.7%	26.1%	13.8%	0.0%	2.4%
Seton Medical Center – Coastside	121	39,895	90.3%	29.8%	66.5%	1.2%	0.0%	2.5%
HCA: The Healthcare Company	**456**	**163,518**	**56.5%**	**44.0%**	**10.6%**	**41.4%**	**0.0%**	**3.9%**
Good Samaritan Hospital – San Jose	205	73,056	71.2%	35.4%	4.4%	59.3%	0.0%	0.9%
Regional Medical Center of San Jose	130	47,112	70.1%	46.6%	18.0%	31.3%	0.0%	4.0%
San Jose Medical Center	121	43,350	36.2%	55.7%	13.0%	22.3%	0.0%	9.0%
Kaiser Foundation	**2,014**	**500,907**	**68.1%**	**38.6%**	**0.5%**	**60.5%**	**0.0%**	**0.4%**
Kaiser Foundation – Geary	243	63,360	71.4%	36.9%	0.4%	62.2%	0.0%	0.5%
Kaiser Foundation – Hayward	283	64,791	62.7%	37.9%	0.4%	61.4%	0.0%	0.3%
Kaiser Foundation – Oakland Campus	315	74,173	64.5%	39.1%	0.5%	60.0%	0.0%	0.4%
Kaiser Foundation – Redwood City	192	36,634	52.3%	40.5%	0.5%	58.4%	0.0%	0.6%
Kaiser Foundation – San Rafael	120	25,322	57.8%	58.6%	1.2%	39.6%	0.0%	0.5%
Kaiser Foundation – Santa Clara	280	75,932	74.3%	26.9%	0.5%	72.2%	0.0%	0.4%
Kaiser Foundation – Santa Teresa	228	55,923	67.2%	35.6%	0.9%	63.2%	0.0%	0.3%
Kaiser Foundation – South San Francisco	124	26,478	58.5%	53.0%	0.7%	45.9%	0.0%	0.4%
Kaiser Foundation – Walnut Creek	229	78,294	93.7%	41.0%	0.1%	58.4%	0.0%	0.4%
Muir Mt. Diablo	**468**	**136,096**	**69.7%**	**52.1%**	**6.2%**	**39.2%**	**0.4%**	**2.2%**
John Muir Medical Center	284	87,787	68.5%	46.3%	5.5%	45.6%	0.5%	2.0%
Mt. Diablo Medical Center	184	48,309	71.9%	62.5%	7.4%	27.7%	0.0%	2.4%
Sutter Health	**2,622**	**725,823**	**68.2%**	**42.2%**	**20.4%**	**32.7%**	**0.4%**	**4.4%**
Alta Bates Summit Medical Center Alta Bates Campus	509	149,246	80.3%	28.4%	32.5%	38.1%	0.1%	0.9%
Alta Bates Summit Medical Center Summit – Hawthorne	279	101,212	67.1%	46.0%	24.3%	28.2%	0.0%	1.4%
California Pacific Medical Center	785	184,090	64.2%	43.5%	12.0%	37.7%	0.3%	6.4%
Eden Medical Center	234	54,371	63.7%	52.7%	10.3%	21.8%	0.0%	15.2%
Marin General Hospital	146	44,474	51.8%	45.9%	14.2%	31.0%	4.0%	5.0%
Mills-Peninsula Medical Center	363	97,504	71.4%	58.0%	2.2%	38.1%	0.0%	1.7%
Novato Community Hospital	25	8,699	50.7%	56.5%	8.4%	30.4%	1.8%	3.0%
St. Luke's Hospital	170	59,809	78.4%	27.2%	56.0%	11.4%	0.0%	5.4%
Sutter Delta Medical Center	111	26,418	65.2%	38.5%	18.2%	37.6%	0.0%	5.7%
Stanford University Hospital	**431**	**109,954**	**69.9%**	**42.1%**	**8.0%**	**44.9%**	**0.3%**	**4.7%**

EXHIBIT 30. Inpatient Occupancy Rates and Payer Mix for Bay Area Hospitals, 2003, cont.

System/Hospital	Staffed Beds	Inpatient Days	Occupancy	Medicare Share of Days	Medi-Cal Share of Days	Third Party Share of Days	County Indigent Share of Days	Other Payers Share of Days
Tenet Health	**499**	**100,795**	**55.3%**	**48.1%**	**14.4%**	**33.9%**	**0.0%**	**3.6%**
San Ramon Regional Medical Center	123	23,816	53.0%	40.6%	1.6%	52.9%	0.0%	4.9%
Community Hospital of Los Gatos	143	30,738	58.9%	52.8%	2.9%	43.1%	0.0%	1.2%
Doctors Medical Center – San Pablo	233	46,241	54.4%	48.8%	28.6%	18.1%	0.0%	4.6%
UC San Francisco Medical Center	**552**	**156,630**	**71.4%**	**29.2%**	**23.6%**	**43.2%**	**1.1%**	**3.0%**
Other Hospitals	**3,180**	**854,477**	**67.8%**	**22.6%**	**41.5%**	**23.0%**	**4.6%**	**8.3%**
El Camino	319	83,527	70.2%	35.3%	18.9%	44.5%	0.0%	1.3%
Alameda Hospital	135	13,707	42.0%	52.4%	27.4%	19.2%	0.0%	1.0%
Alameda County Medical Center	399	116,260	79.8%	10.3%	71.2%	4.5%	5.7%	8.3%
Children's Hospital of Oakland	170	50,078	80.7%	0.0%	63.3%	33.0%	0.0%	3.7%
Chinese Hospital	52	11,930	62.9%	79.0%	11.2%	8.3%	0.0%	1.6%
Contra Costa Regional	124	45,292	75.7%	26.2%	49.5%	7.1%	16.8%	0.4%
Lucile S. Packard Children's Hospital	244	73,187	82.2%	0.2%	33.9%	65.7%	0.0%	0.2%
Menlo Park Surgical Hospital	2	626	10.7%	9.4%	0.0%	37.9%	0.0%	52.7%
San Francisco General Hospital	426	156,272	62.8%	15.2%	35.2%	16.8%	6.5%	26.3%
San Mateo Medical Center	146	45,479	85.3%	21.8%	63.6%	1.9%	9.3%	3.5%
Santa Clara Valley Medical Center	510	119,312	64.1%	17.9%	50.4%	13.9%	9.3%	8.5%
St. Rose Hospital	175	35,240	55.2%	42.5%	38.3%	13.3%	0.0%	5.9%
Valley Memorial Hospital	167	41,183	67.6%	57.4%	6.7%	34.5%	0.0%	1.3%
Washington Hospital	311	62,384	55.0%	47.1%	18.3%	32.0%	0.0%	2.6%
Total	**11,860**	**3,077,771**	**65.0%**	**37.4%**	**21.4%**	**35.3%**	**1.5%**	**4.4%**

Source: Author's analysis of annual hospital report data for years ending in 2003 from office of Statewide Health Planning and Development.

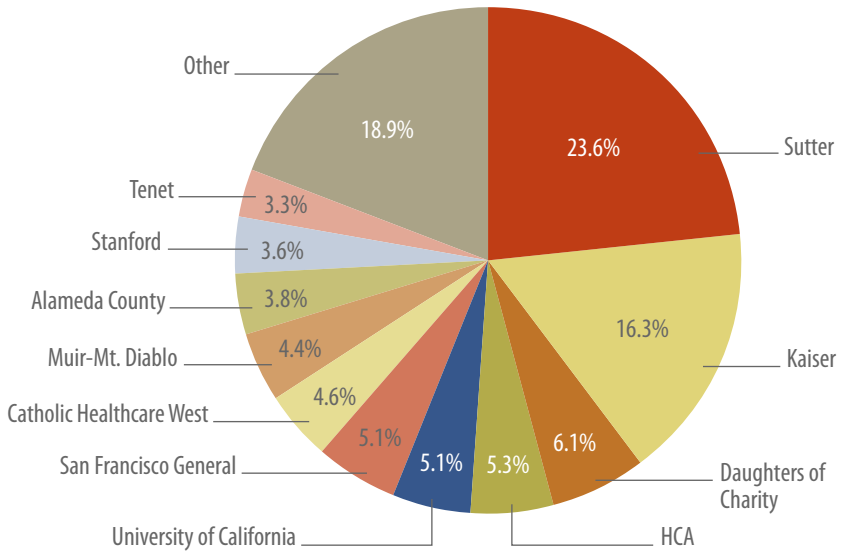
Hospitals averaged 65.0 percent in 2003, up from 63 percent in 2001. Average occupancy rates of 70 percent or more are generally considered high for acute care hospitals. Occupancy rates can vary within a year, or from year to year. A few years ago for example, a flu epidemic resulted in a few months of hospitals operating near capacity. In other months, occupancy may be relatively low. In addition, units such as mental health generally have low utilization, which brings down the average for hospitals with such departments.

Looking at the largest systems, Kaiser Foundation reported average inpatient occupancy of 68.1 percent in 2003, up from 61.3 percent two years earlier. Kaiser Foundation hospitals showed modest growth in inpatient care in the past two years. Inpatient hospital days at area Kaiser hospitals grew from 458,735 in 2001 to 500,907 in 2003. CHW hospitals and the Sutter system reported occupancy rates of 41.5 percent and 68.2 percent, respectively. (Note that the four Daughters of Charity hospitals had much higher occupancy rates than did the other CHW hospitals in the Bay Area.) The Sutter hospitals in the Bay Area had the same number of inpatient days in 2001 and 2003.

Stanford University reported occupancy of 69.9 percent and UC San Francisco had inpatient occupancy of 71.4 percent. Stanford has about the same number of inpatient days as in 2001, while UC San Francisco had 10,000 more patient days than in 2001. The Muir/Mt. Diablo hospitals had some of the highest occupancy rates in the area. Tenet Health's Bay Area hospitals had inpatient occupancy rates of about 55 percent, which is typical for Tenet facilities in several states. In their most profitable years, Tenet hospitals in California, Florida, and Texas had relatively low inpatient occupancy (less than 50 percent), but high net income. That suggests that Tenet hospitals fill those beds for which they can derive higher revenues and will leave other beds empty if those contracts or patients do not contribute to revenue and margin goals.

Exhibit 31 shows the inpatient market share of hospitals and systems in the Bay Area. Sutter is the largest, followed by the Kaiser Foundation hospitals in the area. Hospitals in the area had a total of 3.1 million inpatient days in 2003. The five public hospitals in the area (Alameda County, Contra Costa Regional, San Francisco General, San Mateo General and Santa Clara Valley) had 422,615 days, or 15.7 percent of the total market in 2003.

EXHIBIT 31. Market Share of Bay Area Hospital Systems, 2003



Source: Author's analysis of annual hospital report data for year-end 2003 from Office of Statewide Health Planning and Development.

Payer Mix

Exhibit 30 examines which payer is expected to pay for patients admitted to these hospitals. Commercial payers (shown in the exhibit as "Other Third Parties") include HMOs, PPOs, and other insurance plans that employers sponsor for their employees, and sometimes the dependents of their employees. For both Medicare and Medi-Cal, those government programs are considered to be the payer in this analysis, even if the patient belongs to an HMO that is contracting as a Medicare or Medi-Cal managed care plan. A few counties fund special programs for low-income families without insurance, and those admissions are shown in the column marked "County Indigent." Finally, the column headed "Other Payers" includes hospital stays by people without insurance, some of who will pay all or part of their hospital bill.

On average, Medicare was the largest payer for Bay Area hospitals, accounting for 37.4 percent of inpatient days in the market. Medicare is especially important to the CHW, Daughters of Charity and Muir/Mt. Diablo hospitals. Other third parties, including commercial managed care plans, covered 35.3 percent of inpatient days, but were particularly important for the Kaiser Foundation hospitals and for the two academic health centers.

Medi-Cal covered about 657,000 inpatient days, or an average of 21.4 percent of hospital days in the area. Alameda County Medical Center provided the most inpatient days to Medi-Cal patients, followed by Santa Clara Valley, San Francisco General and Alta Bates (Berkeley). Of the private systems, Sutter Health provides the most days of care for Medi-Cal recipients.

Physician Organizations

Exhibit 32 on the following page provides an overview of the medical groups and IPAs in the region. The Permanente Medical Group is by far the largest physician organization in the Bay Area. There are more than 3,300 Permanente Medical Group physicians in the area; that number has grown by almost 10 percent in the past two years. About 35 percent of Permanente physicians are in primary care.

The Palo Alto Medical Foundation and its affiliate, the Camino Medical Group, have about 141,000 capitated patients, fewer than two years ago. These two medical groups are affiliated with the Sutter Hospitals. Together they are developing a small new hospital in the area and plan a major health center in Mountain View. The Sutter system also provides management services to IPAs in the area. In Contra Costa County, the John Muir/Mt. Diablo Health Network is organized as a medical foundation and reports 70,900 capitated patients.

Many doctors in the Bay Area continue to practice in smaller clinics and contract for managed care through IPAs. For example, the Brown & Toland Medical Group reports more than 199,000 capitated patients, fewer than in previous years. It has said that its strategy for the future will include growing the PPO side of its patient base. One of the most successful IPAs is Hill Physicians, based in San Ramon, with about 196,000 patients. It is profitable, invests in information systems, and is regularly highly ranked in health plan report cards and surveys. Still, it is in the same boat with other physician organizations that are

EXHIBIT 32. Bay Area Physician Organizations, 2004 (includes Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara, and Sonoma counties)

Physician Organization	Estimated Enrollment	Number of PCPs	Number of Specs	Number of Clinic Sites	Management Entity	Notes
Group Practice						
Bay Valley Medical Group	20,100	90	350	4	Bay Valley Management Group	Includes IPA type panel.
Camino Medical Group	69,000	83	159	15	Palo Alto Medical Foundation (Sutter Health); MSO of Hospital System	Palo Alto Medical Foundation
Palo Alto Medical Foundation	72,000	105	133	5	Palo Alto Medical Foundation (Sutter Health)	Became group practice contractor with Palo Alto Medical Foundation May 1, 2000; Sutter Health is the sole corporate member.
The Permanente Medical Group	1,873,050	1,247	2,063	100	The Permanente Medical Group, Inc.	
San Jose Medical Group	42,000	66	160	3	San Jose Medical Management, Inc.	Includes old Good Samaritan Medical Group (absorbed into San Jose Medical Group). Includes IPA type panel.
IPA						
Affinity Medical Group	53,000	132	671	0	Pacific Partners Management Services, Inc./ Health Access Solutions	Umbrella corporation for Alameda, Contra Costa, Eden, and San Leandro IPAs, formerly panels of Alta Bates Medical Group.
Alta Bates Medical Group	75,700	221	293	0	Sutter Connect	
Brown & Toland Medical Group	199,800	365	884	0	Brown & Toland Physician Services Organization, Inc.	
Children First Medical Group	32,900	189	173	0	Children First Healthcare Network, Inc.	
Chinese Community Health Care Association	23,500	71	114	1	Chinese Community Health Plan	
Community Health Center Network	30,200	133	445	29	Community Health Center Network, Inc.	IPA of group practices/clinics. Uses Alta Bates, Pacific Health Care specialists' panels, and Children's First specialists.
Community Health Network of San Francisco	9,800	110	225	14	San Francisco City and County Government	IPA of Group Practices/Clinics
Hill Physicians Medical Group	195,800	412	654	0	PriMed Management Consulting Services, Inc.	Catholic Healthcare West is an investor (27%) in PriMed.
Marin IPA Medical Corp	29,300	80	160	0	Marin PHO	
Mills-Peninsula Medical Group	60,400	146	178	0	Mills-Peninsula Medical Group, Inc.	
Physicians Medical Group of San Jose	61,600	127	159	0	Excell MSO, LLC	Physicians Medical Group of San Jose, Inc purchased Regional Medical Management in 2001 and changed to Excel MSO LLC.
Santa Clara County IPA	114,500	300	700	0	Pacific Partners Management Services, Inc./ Health Access Solutions	
Medical Foundation						
John Muir/Mt. Diablo Health Network	70,900	227	514	15	John Muir/Mt. Diablo Health Network	Includes medical group and IPA.
Palo Alto Medical Foundation	72,000	105	133	5	Palo Alto Medical Foundation	Sutter Health is the sole corporate member of the foundation. Includes medical group.
Stanford Health Services	9,150	54	1,000	7	Stanford Hospitals and Clinics	Began separate operations from Brown & Toland Jan 1, 2000. Includes medical group.
Sutter Medical Group of The Redwoods	26,600	84	235	4	Sutter Connect	Includes medical group and IPA.
State/County/Faculty/Staff						
Contra Costa Health Services	37,500	90	330	9	Contra Costa County Dept. of Health Services	
Santa Clara Valley Health & Hospital System	63,900	143	284	11	Santa Clara Valley Health & Hospital System	

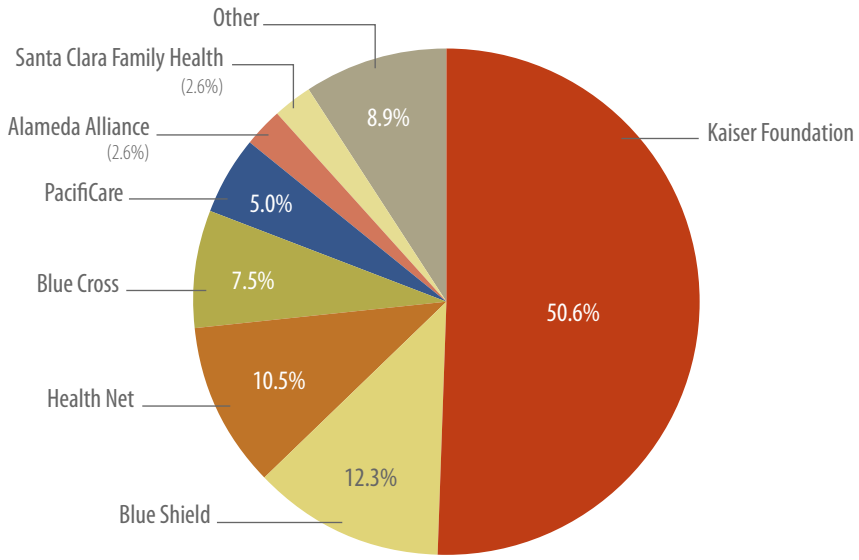
Source: Adopted from Cattaneo & Stroud's medical group inventory, April 2004.

seeing an erosion of their capitated HMO business.

As physician groups have sought to reposition themselves, a few have run afoul of federal or state regulators. In 2004, Brown & Toland Medical Group settled with the Federal Trade Commission on charges of price fixing and other antitrust violations. Brown & Toland had formed a PPO network in 2003 with 600 of its physicians. The FTC said that the PPO did not have sufficient clinical or financial integration and had raised prices for physician care in the San Francisco area. Brown & Toland signed a consent decree agreeing not to negotiate on behalf of physicians without adequate integration.

Sutter Health is planning to expand or develop medical foundations in several locations on the outskirts of the Bay Area. It has started medical foundations in Santa Cruz and Fremont, and is proposing new foundations in Antioch, Pittsburg, and Fairfield. It plans improvements to its hospitals in those areas and will inject capital into the physician practices. The formula has been successful for Sutter in its ties to the Palo Alto Medical Foundation. The availability of capital and information systems is attractive to physicians that want to join a group practice.

EXHIBIT 33. Estimated Market Share for Bay Area HMOs, 2003



Sources: Based on HMO annual statements and author's surveys of health plans. Where health plan did not respond to survey, commercial enrollment is based on author's estimates compared to results of Cattaneo & Stroud annual survey of health plan enrollment; Medi-Cal enrollment based on monthly enrollment reports from the Department of Health Services; Medicare enrollment based on quarterly enrollment reports posted by Center for Medicare and Medicaid Services on www.cms.hhs.gov.

Health Plans

Exhibit 33 shows the market share of the largest health plans in the Bay Area in 2003. (This analysis is a component of what was reported in Exhibit 13.) With approximately half of the HMO enrollment in the region, Kaiser Permanente is by far the largest HMO in the Bay Area. It is especially strong in the East Bay counties, where it has just under 900,000 enrollees. Blue Shield and Health Net are second and third in HMO enrollment, respectively. Blue Shield was in fourth place a year earlier, but added thousands of CalPERS members in 2003.

HMO enrollment and penetration in the Bay Area have declined in the past year. As shown in Exhibit 13, in 2003 about 3.6 million people in the Bay Area—down from 3.8 million a year earlier—were enrolled in an HMO. In the two East Bay counties HMO penetration was 64.4 percent; on the San Francisco side, it was 56.9 percent.

The analysis summarized in Exhibit 13 calculates enrollment by plan and line of business for each region. Based on that analysis, about 2.9 million people in the area are enrolled in commercial HMOs and the rest are in Medicare, Medi-Cal, and Healthy Families. Commercial HMO enrollment is down by about 3 percent in 2003.

Enrollment in Medicare HMOs grew rapidly during the 1990s but then reached a plateau. In 2000, six HMOs offered Medicare+Choice plans in Alameda County and seven had senior plans in San Francisco. The reports posted on the CMS Web site were used to calculate penetration of HMO Medicare plans. In 2000, 41.2 percent of seniors in Alameda County and 26.4 percent of seniors in San Francisco were in a Medicare+Choice plan. At the end of 2003, about 61,000 (37 percent) of seniors in Alameda County were in an HMO while 29.2 percent of seniors in San Francisco were in an HMO plan. Those percentages have stayed even for the past few years. Kaiser and some other HMOs offer more than one Medicare plan, with different benefit designs and premium options.

For 2005, three HMOs will offer senior plans in Alameda County and San Francisco: Health Net, Kaiser Permanente, and PacifiCare Secure Horizons. Chinese Community Health Plan will also offer its senior plan in San Francisco.

Enrollment in Medi-Cal managed care and Healthy Families had been growing but has now leveled off at about 440,000 enrollees in the area, according to the analysis used to prepare Exhibit 13. All six counties in the Bay Area use some version of Medi-Cal managed care, and four of them have a two-plan arrangement. (See Section 3.4 for a description of the two-plan arrangement and the other versions of Medi-Cal managed care.) Counties have formed HMOs (local initiative county plans) in San Francisco, Alameda, Santa Clara, and Contra Costa. Blue Cross is the competing commercial plan in each of those counties. Marin has a small Prepaid Health Plan arrangement plan, in which Kaiser Permanente administers services for a few hundred recipients. San Mateo County has a county-organized health system. The county HMOs also contract with the Managed Risk Medical Insurance Board for the Healthy Families program.

Even with the expansions of Medi-Cal, Healthy Families, and some niche programs, a significant segment of the population in the Bay Area has no health insurance. According to one estimate from 2003, about 9 percent of the Bay Area's population under age 65 is uninsured. That represents about 469,000 uninsured persons, of which 52,000 are children under 18. There have been several initiatives in the area to try to improve access to health coverage by offering subsidized health plans through small employers. Foundations have provided funding to launch pilot projects to increase the number of small businesses that are able to offer health insurance, and to improve the take-up rate of employees who are able to combine their own funds with a contribution from the employer and the participating foundations.

4.3 Sacramento

Sacramento is a center for integrated health care systems and very active managed care markets. Besides being the seat of state government, Sacramento has the University of California – Davis and its medical school. The eight counties in and around Sacramento have a combined population estimated at 2.2 million in 2003 — up from 2 million in 2000 — and continue to experience significant population and economic growth. This growth has been driven both by elements of state government (agencies, lobbying associations, and companies that contract with states), and by the development of high-tech industries.

Overview of Hospitals

Four nonprofit hospital systems have emerged in the Sacramento area. The five Sutter hospitals in the area are now the largest system in Sacramento, with $904 million in net patient revenues in 2003. The University of California – Davis Medical Center, with one hospital in Sacramento, is the second largest, with net patient revenues in 2003 of $746.5 million.

Sutter's flagship hospital in the area is Sutter Medical Center – Sacramento, with 678 acute care beds and $553.5 million in net patient revenues in 2003. Kaiser Permanente has two hospitals in Sacramento and a third in nearby Roseville. For-profit hospitals have not entered this part of the state, except for the period in which Tenet owned Redding Medical Center, about 165 miles north of Sacramento.

Catholic Healthcare West (CHW) has six hospitals and is third in size in the area. CHW is made up of three Mercy hospitals — the largest of which is Mercy General in Sacramento — and three others that affiliated with Mercy in 1993 and 1996. CHW used to operate those six hospitals as a separate Sacramento region. It has largely dismantled that regional structure and now runs the hospitals as a statewide organization based in San Francisco.

Hospital and clinical capacity has emerged as a major issue in the Sacramento area. As will be described below, each hospital system has one or more associated medical groups, and each has developed new clinics in emerging suburbs like Elk Grove, south of the city. Kaiser has the only hospital in Elk Grove and has outlined plans to expand that hospital as well as its other facilities there. It plans a major expansion of its Roseville campus (northeast of Sacramento on Interstate Highway 80), including a new unit for women and children.

Kaiser also plans to develop a major new campus in Folsom, east of Sacramento. That project, planned to take place over the next 20 years, will begin with an ambulatory surgery center, then add a new hospital, medical office buildings, and other facilities. The hospital, to be built in three phases, will eventually have 430 inpatient beds. The entire development is projected to grow to more than a million square feet in the next 25 years.

In an issue related to hospital capacity, Sacramento-area hospitals went through a period in 2002 when their emergency departments were frequently full and had to divert ambulances to other hospitals. To resolve this problem, the systems invested into expanding their emergency departments and providing other options for urgent care. They also focused on improving through-put within the hospitals — in other words, moving patients more quickly through and out of the upstairs units. Some consultants suggest this is a fundamental challenge

EXHIBIT 34. Revenues and Profitability for Sacramento Area Hospitals, 2003

System/Hospitals	City	Total Charges	Net Patient Revenue	Total Revenue	Operating Expenses	Net from Operations	Net Income	% of Total Revenue
Catholic Healthcare West		**$2,577,467,470**	**$724,946,755**	**$755,118,292**	**$710,425,196**	**$36,347,287**	**$40,399,154**	**5.4%**
Mercy General Hospital	Sacramento	1,003,823,322	245,256,295	256,763,150	244,306,658	10,154,608	11,050,977	4.5%
Mercy Hospital	Folsom	150,471,678	49,376,767	51,244,194	45,262,464	5,770,036	5,192,619	10.5%
Mercy San Juan Hospital	Carmichael	755,477,330	212,558,191	217,582,592	198,664,829	18,334,205	17,930,343	8.4%
Methodist Hospital of Sacramento	Sacramento	292,134,890	85,691,207	90,982,293	92,944,514	– 6,455,928	– 2,188,873	– 2.6%
Sierra Nevada Memorial	Grass Valley	207,747,355	77,382,454	77,382,369	73,191,059	5,430,215	3,531,549	4.6%
Woodland Memorial Hospital	Woodland	167,812,895	54,681,841	61,163,694	56,055,672	3,114,151	4,882,539	8.9%
Kaiser Foundation*								
Sutter Health		**$3,289,395,974**	**$904,032,325**	**$948,193,319**	**$802,715,538**	**$122,171,186**	**$133,319,157**	**14.1%**
Sutter Auburn Faith Hospital	Auburn	215,427,189	68,470,468	70,841,140	65,855,610	3,558,893	4,285,113	6.3%
Sutter Center For Psychiatry	Sacramento	38,505,796	17,250,756	18,258,112	16,451,020	1,724,439	1,761,930	10.2%
Sutter Davis Hospital	Davis	157,260,074	52,308,557	59,081,591	47,797,583	6,515,572	8,687,342	– 3.2%
Sutter Medical Center	Sacramento	2,188,234,046	553,532,262	579,485,907	497,235,380	70,220,951	76,623,548	13.8%
Sutter Roseville Medical Center	Roseville	689,968,869	212,470,282	220,526,569	175,375,945	40,151,331	41,961,224	0.6%
University of California Davis Medical Center		**$2,767,449,162**	**$746,521,173**	**$798,515,915**	**$758,090,098**	**$3,277,183**	**$12,375,086**	**1.7%**
Others		**$754,632,615**	**$363,362,413**	**$437,387,842**	**$393,941,882**	**$7,843,282**	**$24,049,726**	**6.6%**
Barton Memorial Hospital	S. Lake Tahoe	143,797,115	77,962,303	95,042,639	73,176,140	5,167,433	7,030,501	9.0%
Fremont Hospital	Yuba City	110,822,995	56,620,427	62,798,337	55,312,877	1,749,482	7,485,460	13.2%
Marshall Medical Center	Placerville	212,965,599	91,908,507	94,814,399	84,804,614	8,058,629	9,504,834	10.3%
Rideout Memorial Hospital	Marysville	217,657,367	93,274,931	96,211,060	100,511,616	– 6,519,809	– 4,324,887	– 4.6%
Shriners Hospital Northern California	Sacramento	0	0	35,203,705	34,623,299	580,406	580,406	NA
Sierra Valley District Hospital	Loyalton	4,103,213	2,796,591	3,147,423	3,773,524	– 953,980	– 626,101	– 22.4%
Tahoe Forest Hospital	Truckee	69,389,539	43,596,245	53,317,702	45,513,336	– 1,192,859	3,773,412	5.8%
TOTAL		**$9,388,945,221**	**$2,738,862,666**	**$2,939,215,368**	**$2,665,172,714**	**$169,638,938**	**$210,143,123**	**7.1%**

NA: Not available.
*Data for Kaiser hospitals is incorporated into Exhibit 29 with other northern California hospitals.

Source: Author's analysis of annual hospital report data for year-end 2003 from office of Statewide Health Planning and Development.

for hospitals, and that more efficient performance in this area would relieve capacity pressure in their emergency rooms. As patients are efficiently moved through and out of the acute care units, space is freed up for new admissions from the emergency department, which in turn frees up space for new emergency patients.

Financial Results

Sacramento-area hospitals generally had strong net income in 2003, though lower than in 2001. As shown in Exhibit 34, the 20 hospitals in this region had net income of $210.1 million in 2003, including operating income of $169.7 million. Their net income was 7.1 percent of total revenues of $2.9 billion.

The Sutter Health hospitals were the most profitable in the region in 2003. They had net income of $133.3 million in 2003, up from $81.4 million in 2001. The Sutter hospital in Sacramento accounted for more than half that amount, and its Roseville facility had net income of $42 million. The Catholic Healthcare West hospitals in this area had net income of $40.4 million in 2003.

Financial results for the two Kaiser hospitals in Sacramento are not included in this table but are rolled into the results shown earlier for the northern California region of Kaiser. The University of

California – Davis Medical Center reported net income of $12.4 million. It benefits from disproportionate share hospital funding (funds for hospitals that see a large number of Medi-Cal patients) and is the major beneficiary of county funds for indigent care.

Occupancy

Exhibit 35 compares the hospital systems on their inpatient occupancy rates and payer mix for 2003. On average, Sacramento-area hospitals had inpatient occupancy of 68.0 percent in 2003, up slightly from 2001. Total inpatient days increased by about 2.5 percent. Occupancy was highest at the Sutter hospitals and at University of California – Davis Medical Center, both at about 75 percent. The occupancy rate for Sutter was up from 71.5 percent in 2001. Combined, the two Kaiser hospitals had occupancy rates of 70.0 percent, up from 68.1 percent in 2001. Kaiser has increased its presence in the Sacramento area based on two measures. First, inpatient hospital days at its two area hospitals grew from 154,819 in 2001 to 168,622 in 2003. Second, the number of patients in Permanente clinics grew from 389,300 in 2000 to 439,000 in 2003.

Payer Mix

As Exhibit 35 shows, Medicare covered an average of 37.5 percent of inpatient hospital days in Sacramento-area hospitals while Medi-Cal covered 24.7 percent. Medicare covered a higher than average percentage of inpatient days at the Sutter hospitals and at some of the rural hospitals in the area. Commercial plans including managed care covered 33.3 percent of inpatient days for these hospitals.

EXHIBIT 35. Inpatient Occupancy Rates and Payer Mix for Sacramento Area Hospitals, 2003

System/Hospital	Staffed Beds	Inpatient Days	Occupancy	Medicare Share of Days	Medi-Cal Share of Days	Third Party Share of Days	County Indigent Share of Days	Other Payers Share of Days
Catholic Healthcare West	**1,288**	**277,168**	**59.0%**	**38.6%**	**27.7%**	**31.4%**	**1.2%**	**1.1%**
Mercy General Hospital	391	76,210	53.4%	43.7%	15.2%	40.3%	0.8%	0.1%
Mercy Hospital – Folsom	85	11,511	37.1%	40.7%	6.7%	51.9%	0.2%	0.5%
Mercy San Juan Hospital	247	69,100	76.6%	40.2%	24.4%	33.4%	2.0%	0.1%
Methodist Hospital of Sacramento	333	77,446	63.7%	19.6%	55.3%	21.5%	0.6%	3.0%
Sierra Nevada Memorial Hospital	121	27,778	62.9%	67.0%	5.9%	23.5%	2.9%	0.7%
Woodland Memorial Hospital	111	15,123	37.3%	49.7%	20.1%	27.3%	1.0%	1.8%
Kaiser Foundation	**660**	**168,622**	**70.0%**	**37.5%**	**0.8%**	**61.3%**	**0.0%**	**0.4%**
Kaiser Foundation – Sacramento	498	120,478	66.3%	37.1%	1.0%	61.6%	0.0%	0.3%
Kaiser Foundation – South Sacramento	162	48,144	81.4%	38.7%	0.2%	60.7%	0.0%	0.4%
Sutter Health	**1,064**	**292,899**	**75.4%**	**43.1%**	**24.1%**	**29.7%**	**1.6%**	**1.5%**
Sutter Auburn Faith Hospital	89	21,534	66.3%	63.5%	9.0%	22.8%	1.7%	2.9%
Sutter Center For Psychiatry	69	18,506	73.5%	24.8%	12.4%	61.2%	0.0%	1.5%
Sutter Davis Hospital	48	7,784	44.4%	41.9%	18.6%	29.6%	7.7%	2.2%
Sutter Medical Center – Sacramento	678	194,009	78.4%	42.4%	30.1%	25.3%	1.3%	1.0%
Sutter Roseville Medical Center	180	51,066	77.7%	43.9%	12.8%	38.1%	2.5%	2.7%
UC Davis Medical Center	**526**	**144,663**	**75.3%**	**24.7%**	**37.3%**	**30.2%**	**7.3%**	**0.6%**
Others	**573**	**153,444**	**65.8%**	**36.8%**	**34.9%**	**15.5%**	**2.2%**	**10.6%**
Barton Memorial Hospital	121	29,288	66.3%	19.2%	55.4%	14.8%	1.1%	9.5%
Fremont Hospital – Yuba City	132	25,244	52.4%	45.9%	25.4%	25.1%	2.6%	1.0%
Marshall Medical Center.	105	25,438	66.4%	65.7%	11.4%	19.8%	2.0%	1.2%
Rideout Memorial Hospital	109	32,749	82.3%	58.3%	16.6%	16.4%	5.9%	2.8%
Shriners Hospital – Northern California	40	10,549	48.2%	0.0%	0.0%	0.0%	0.0%	100.0%
Sierra Valley District Hospital	35	11,758	80.5%	6.1%	91.0%	0.1%	0.0%	2.9%
Tahoe Forest Hospital	66	18,418	47.8%	48.0%	6.9%	43.9%	0.0%	1.2%
TOTAL	**3,451**	**1,036,796**	**68.0%**	**37.5%**	**24.7%**	**33.3%**	**2.1%**	**2.4%**

Source: Author's analysis of annual hospital report data for year-end 2003 from office of Statewide Health Planning and Development.

The number of inpatient days covered by Medi-Cal increased from 220,000 in 2001 to 256,000 in 2003. Responsibility for Medi-Cal patients is shared broadly in the area. The University of California – Davis Medical Center served the most Medi-Cal patients of any one hospital, with about 54,000 inpatient days in 2003. The CHW hospitals provided 76,700 inpatient days to Medi-Cal recipients and the Sutter Health systems served 70,600 inpatient days at their Sacramento-area hospitals.

Physician Organizations

Exhibit 36 lists the largest physician organizations in Sacramento County in 2003. The largest group practice was the Permanente Medical Group, with 419 primary care physicians and specialists in the area. Many of the other large medical groups are tied to the hospital systems. For example, Sutter Health provides administrative services to Sutter Independent Physicians, an IPA, and the Sutter Medical Foundation through an entity called Sutter Connect. Sutter Health is also a part owner of PriMed, the management company that administers Hill Physicians, the largest IPA in the area in membership. Hill Physicians has more than 450 primary care physicians and specialists in Sacramento. The faculty group at the University of California – Davis Medical Center grew from about 324 primary care and specialty physicians in 2000 to 376 at 10 clinic sites in 2003.

Health Plans

Based on Exhibit 13, 63.6 percent of the residents in the Sacramento area were enrolled in an HMO, down from an estimated 69 percent in 2002. Six statewide HMOs plus Western Health Advantage, based in Sacramento, compete for commercial business in the area. Kaiser Permanente has more than 625,000 Sacramento-area enrollees, accounting for about 44 percent of HMO enrollment in the region. Now one of only three HMOs serving state employees, Blue Shield has grown to be the second largest HMO in the area with about 20 percent of HMO enrollees.

Five HMOs compete for Medi-Cal enrollees in a geographic managed care arrangement in Sacramento: Blue Cross, Health Net, Kaiser Foundation, Molina, and Western Health Advantage. Blue Cross is the largest Medi-Cal contractor in Sacramento County with about 76,000 of the 162,000 total enrollees. Health Net is the second largest Medi-Cal plan in the region with about 30,500 enrollees. Kaiser, Molina, and Western Health Advantage all have about 20,000 or less Medi-Cal enrollees.

As shown in Exhibit 9, four Medicare HMOs offered senior plans in Sacramento in 2004, enrolling almost 40 percent of the 170,000 seniors in the county. Federal payment rates are lower here than in the Bay Area counties. According to the CMS Web site, the Average Area Per Capita Cost rate for Sacramento County in 2005 will be $664, compared to $765 in Alameda County and $724 in San Francisco.

EXHIBIT 36. Sacramento Area Physician Organizations, 2004 (includes Sacramento county)

Physician Organization	Estimated Enrollment	Number of PCPs	Specs	Clinic Sites	Management Entity	Notes
Group Practice						
Molina Healthcare, Inc.	10,700	7	0	5	Molina Healthcare of California, Inc.	
The Permanente Medical Group, Inc.	439,200	163	256	12	The Permanente Medical Group, Inc.	
IPA						
Golden State Physicians Medical Group	10,700	145	212	0	Medical Benefits Administration, Inc.	
Hill Physicians Medical Group	107,400	157	294	0	PriMed Management Consulting, Inc.	Catholic Healthcare West is an investor (27%) in PriMed.
River City Medical Group	33,250	96	425	0	River City Medical Group, Inc.	
Sutter Independent Physicians	36,300	91	420	0	Sutter Connect	
Medical Foundation						
MedClinic of Sacramento	57,600	43	78	6	Catholic Healthcare West Medical Foundation	Includes medical group.
Sutter Medical Foundation	90,100	62	213	9	Sutter Connect	Includes medical group.
State/County/Faculty/Staff						
UC Davis Medical Group	74,300	115	261	10	UC Davis Medical Center	

Source: Adopted from Cattaneo & Stroud's medical group inventory, April 2004.

4.4 Central Valley

California's Central Valley extends from Stockton in San Joaquin County in the north through Bakersfield in Kern County to the south. The analysis here is based on the counties included in health planning regions 6 (North San Joaquin) and 9 (Central).

An extensive range of food products are grown or processed here and exported across the country and the world. The Central Valley's population is diverse—for example, Fresno has one of the largest communities of Hmong Americans in the United States. This diversity means that language can be a barrier to gaining access to health care and that cultural sensitivity of providers is an important issue.

A high percentage of the agricultural workforce has no health insurance, which puts an enormous strain on the health care providers who provide free care or collect fees on a sliding scale. And the wide use of fertilizers and other chemicals creates a variety of public health challenges and questions about the health cost of agriculture in the area.

Overview of Hospitals

As in northern California, almost all hospitals in the Central Valley are nonprofit. Tenet, which has two hospitals in the Modesto area, is currently the only for-profit hospital company in the area. Besides Tenet, there are four other systems in the region: Adventist, Catholic Healthcare West (CHW), Community Health System, and Sutter Health. In addition, Kaiser has a Fresno hospital.

Catholic Healthcare West is the largest system in the region. It has eight hospitals from Stockton to Bakersfield, one of which is a mental health facility. Its two largest facilities in the area are both in Bakersfield.

Sutter Health has hospitals in Jackson and Tracy. It also has affiliation arrangements with the Memorial Hospitals in Los Banos and Modesto. Memorial Hospital in Modesto is the largest one in that city. The Stanislaus Surgical Hospital in Modesto is a new specialty hospital. The Adventist Health system has five hospitals in the Central Valley.

Two of the largest hospitals in the Central Valley, Community Medical Center and St. Agnes, are historic competitors in Fresno. Community Medical Center is part of the Community Health System, which absorbed University Medical Center, Fresno's county hospital. A new medical center for Community Health is under construction in downtown Fresno. Community Health System is a minority owner of Fresno Heart Hospital, which opened in October 2003. MedCath, a national operator of cardiac hospitals and laboratories, owns the Bakersfield Heart Hospital.

St. Agnes is part of the Trinity Health System, a Catholic hospital system based in Novi, Michigan. In the past, each of the Fresno hospitals had close ties to HMOs, but those relationships changed over time. St. Agnes Medical Center is completing its own major construction project, adding 100 hospital rooms and a new heart and vascular center.

Kaiser currently has only one hospital in the region, and uses other hospitals and doctors to serve its enrollees. Kaiser's Fresno hospital has 95 beds. In Stockton, Kaiser uses Dameron Hospital. In Modesto and Turlock, Kaiser uses Emanuel Medical Center and many non-Kaiser doctors.

Public hospitals are an important part of the health care infrastructure in the region. There are several district hospitals and county hospitals in the area, including Memorial Hospital at Exeter in Tulare County, Kern Medical Center (county) in Bakersfield, and Kern Valley Healthcare District (Lake Isabella). District hospitals have elected boards and independent taxing authority.

As in other parts of the state, competing hospitals have been busily building their facilities to try to gain or maintain an advantage. And as in other communities, cardiac care is often the focus of the new construction projects because it contributes to hospital margins. In Fresno, St. Agnes just completed construction of its new heart center. Community Health System is a minority owner of the new Fresno Heart Hospital.

Financial Results

Exhibit 37 on the following page compares area hospitals on their revenues and net income. Across the entire region, hospitals reported net income of $301.4 million, or 7.4 percent of total revenues. That is up from $226 million, or 7.1 percent of total revenues in 2001. Hospitals had net income on patient operations of $200.5 million.

The Sutter hospitals reported net income of $103.8 million, or 20.5 percent of total revenues. Memorial Hospital in Modesto accounted for more than 75 percent of that amount. The Catholic Healthcare West hospitals in the Central Valley lost $16.1 million in 2003, a smaller loss compared to 2001. CHW's Bakersfield Memorial had a small amount of net income but Mercy Hospital in Bakersfield reported a loss for the year.

Doctors Medical Center, the Tenet hospital in Modesto and the largest hospital in the area, reported the highest net income of any hospital in the region. Its 2003 net income was $160.0 million, or 39.2 percent of total revenues. The hospitals of Community Health System had net income of $4.0 million, or 0.8 percent of total revenues. Two years

EXHIBIT 37. Revenues and Profitability for Central Valley Hospitals, 2003

System/Hospitals	City	Total Charges	Net Patient Revenue	Total Revenue	Operating Expenses	Net from Operations	Net Income	% of Total Revenue
Adventist Health		**$1,195,199,116**	**$306,163,125**	**$314,517,993**	**$316,721,742**	**$– 5,770,056**	**$– 6,467,257**	**– 2.1%**
Central Valley General Hospital	Hanford	117,316,915	37,825,170	38,077,369	37,969,618	– 26,587	107,751	0.3%
Hanford Community Hospital	Hanford	279,279,223	62,317,240	64,636,697	68,375,650	– 5,456,296	– 7,854,345	– 12.2%
San Joaquin Community Hospital	Bakersfield	452,921,556	101,442,552	104,524,069	99,315,545	3,850,575	5,208,524	5.0%
Selma Community Hospital	Selma	117,518,029	26,809,163	27,397,933	28,500,868	– 1,347,459	– 1,217,854	– 4.4%
Sonora Regional Medical Center	Sonora	228,163,393	77,769,000	79,881,925	82,560,061	– 2,790,289	– 2,711,333	– 3.4%
Catholic Healthcare West		**$2,498,848,990**	**$629,163,195**	**$653,816,313**	**$656,904,015**	**$– 15,917,427**	**$– 12,002,290**	**– 1.8%**
Bakersfield Memorial Hospital	Bakersfield	553,294,668	141,498,569	143,386,706	140,087,319	2,176,885	2,359,868	1.6%
Mercy Hospital	Bakersfield	379,850,064	103,389,324	107,757,612	116,796,260	– 12,075,628	– 9,952,635	– 9.2%
Mercy Med Center (Community)	Merced	260,941,941	61,356,167	61,994,663	61,693,687	172,852	297,871	0.5%
Mercy Med Center (Dominican)	Merced	178,934,722	47,548,575	52,001,846	52,172,603	– 4,244,673	– 4,766,423	– 9.2%
Mercy Westside Hospital	Taft	18,978,529	7,463,534	7,542,070	9,666,434	– 2,192,724	– 2,124,364	– 28.2%
Oak Valley District Hospital	Oakdale	85,423,490	32,669,465	34,375,240	33,013,910	748,883	1,361,330	4.0%
St. Dominic's Hospital	Manteca	145,591,772	28,969,682	29,425,712	32,572,222	– 3,459,704	– 3,425,095	– 11.6%
St. Joseph's Behavioral Health Center	Stockton	20,454,212	6,996,333	7,004,247	6,895,659	111,475	102,588	1.5%
St. Joseph's Medical Center	Stockton	855,379,592	199,271,546	210,328,217	204,005,921	2,845,207	4,144,570	2.0%
Community Health System		**$1,212,913,881**	**$468,609,072**	**$498,042,192**	**$493,929,292**	**$– 8,657,962**	**$3,956,311**	**0.8%**
Community Medical Center	Clovis	196,801,543	83,235,341	84,253,841	80,182,952	3,664,992	4,066,087	4.8%
Community Medical Center	Fresno	1,016,112,338	385,373,731	413,788,351	413,746,340	– 12,322,954	– 109,776	0.0%
Kaiser Foundation*	**Fresno**							
St. Agnes Medical Center	**Fresno**	**$838,813,012**	**$288,878,567**	**$297,701,570**	**$283,920,696**	**$11,192,500**	**$13,272,795**	**4.5%**
Sutter Health		**$1,888,716,848**	**$492,433,759**	**$505,725,985**	**$400,017,508**	**$96,635,839**	**$103,794,176**	**20.5%**
Memorial Hospital Los Banos	Los Banos	102,074,483	29,211,960	30,108,029	25,737,022	3,555,823	4,334,445	14.4%
Memorial Hospital Modesto	Modesto	1,478,321,414	352,778,746	362,913,321	281,191,060	75,059,167	80,749,010	22.3%
Sutter Amador Hospital	Jackson	103,891,405	42,140,698	42,300,485	41,572,177	728,308	728,308	1.7%
Sutter Tracy Community Hospital	Tracy	204,429,546	68,302,355	70,404,150	51,517,249	17,292,541	17,982,413	25.5%
Tenet Health		**$3,516,017,806**	**$459,830,827**	**$462,731,375**	**$287,890,889**	**$174,350,596**	**$174,139,616**	**37.6%**
Doctors Hospital of Manteca	Manteca	471,039,346	54,191,911	54,398,844	39,918,938	14,443,718	14,177,557	26.1%
Doctors Medical Center	Modesto	3,044,978,460	405,638,916	408,332,531	247,971,951	159,906,878	159,962,059	39.2%
Other Hospitals		**$4,479,092,433**	**$1,448,044,672**	**$1,589,720,205**	**$1,536,093,672**	**$– 52,287,074**	**$25,003,333**	**1.6%**
Bakersfield Heart Hospital	Bakersfield	92,054,254	40,351,691	40,811,755	44,613,233	– 3,815,388	– 3,801,478	– 9.3%
Children's Hospital Central CA	Madera	456,320,683	226,340,690	241,149,391	232,123,518	1,293,980	1,244,138	0.5%
Dameron Hospital	Stockton	543,231,154	115,665,579	122,695,513	113,707,247	3,428,599	6,519,832	5.3%
Delano Regional Medical Center	Delano	118,890,060	48,600,870	49,237,702	47,212,503	2,191,694	2,025,199	4.1%
Emanuel Medical Center	Turlock	247,944,686	65,360,362	59,730,232	68,324,009	– 1,505,259	– 8,791,131	– 14.7%
Fresno Surgery Center	Fresno	81,727,961	27,970,677	28,731,839	28,103,698	550,960	– 432,423	– 1.5%
John C. Fremont Healthcare District	Mariposa	13,245,331	9,051,151	10,774,561	9,890,126	– 407,374	883,317	8.2%

*Data for Kaiser hospitals is incorporated into Exhibit 29 with other northern California hospitals.

EXHIBIT 37. Revenues and Profitability for Central Valley Hospitals, 2003, cont.

System/Hospitals	City	Total Charges	Net Patient Revenue	Total Revenue	Operating Expenses	Net from Operations	Net Income	% of Total Revenue
Other Hospitals, cont.								
Kaweah Delta District Hospital	Visalia	$793,311,676	$239,872,140	$253,721,534	$239,873,237	$8,338,866	$13,531,629	5.3%
Kern Medical Center	Bakersfield	296,731,861	101,348,517	157,254,725	166,497,155	– 60,294,695	– 9,242,430	– 5.9%
Kern Valley Healthcare District	Lake Isabella	41,080,991	17,649,472	18,342,009	19,186,627	– 1,306,878	– 993,912	– 5.4%
Lodi Memorial Hospital	Lodi	417,120,709	87,412,029	90,299,762	81,567,757	6,486,506	8,392,465	9.3%
Madera Community Hospital	Madera	100,226,541	46,107,527	47,460,928	46,846,881	166,779	413,447	0.9%
Ridgecrest Regional Hospital	Ridgecrest	66,474,897	34,368,530	35,104,698	32,273,183	2,230,249	2,736,719	7.8%
San Joaquin General Hospital	French Camp	257,353,071	128,863,322	147,301,616	157,068,991	– 21,938,531	– 12,164,366	– 8.3%
Sierra View District Hospital	Porterville	244,150,689	75,564,637	79,748,711	68,157,325	7,828,702	11,459,978	14.4%
Stanislaus Surgical Hospital	Modesto	121,960,977	22,024,891	22,189,810	19,063,751	3,125,094	3,097,555	14.0%
Tehachapi Hospital	Tehachapi	15,095,336	7,832,234	8,363,308	8,050,482	– 165,327	312,826	3.7%
Tulare District Hospital	Tulare	91,779,703	45,602,751	46,150,669	45,446,384	– 1,583,699	704,285	1.5%
Tuolumne General Hospital	Sonora	63,271,144	22,797,145	27,692,279	26,519,808	– 3,397,858	715,218	2.6%
TOTAL		$15,629,602,086	$4,093,123,217	$4,322,255,633	$3,975,477,814	$199,546,416	$301,696,684	7.0%

Source: Author's analysis of annual hospital report data for year-end 2003 from office of Statewide Health Planning and Development.

earlier the Community Health hospitals had much better results. Also in Fresno, St. Agnes Medical Center had a margin of 4.5 percent of total revenues, with net income of $13.3 million. That is also less than its net income in 2001.

Most of the independent hospitals reported positive net income. The district hospital in Porterville had net income of $11.5 million. However, Kern Medical Center had a loss of $9.2 million in 2003. It had additional revenues that largely offset an operating loss of $60.3 million.

Occupancy

As shown in Exhibit 38 on the following page, inpatient occupancy in Central Valley hospitals averaged 69.8 percent in 2003. That is higher than the average of 64.7 percent in 2001. The Sutter hospitals in the area had average occupancy rates of 73.2 percent, while the CHW hospitals had an average of 66.1 percent. Occupancy rates at the Community Health System hospitals were lower, averaging 62.5 percent. Inpatient occupancy at St. Agnes was 86.0 percent and 82.8 percent at Kaiser's hospital in Fresno. The Tenet hospital in Modesto had an inpatient occupancy rate of 77.1 percent, which is higher than most Tenet hospitals in the state.

Payer Mix

Medicare is the most significant payer for hospitals in the Central Valley. On average, Medicare covered 37.3 percent of inpatient days in Central Valley hospitals. Medicare was a less significant payer for Community Health System, but covered 60.2 percent of inpatient days at St. Agnes and 53.7 percent at the Sutter hospitals in the area. The Adventist hospitals had relatively high proportions of Medicare days, 44.9 percent.

Medi-Cal covered 34.3 percent of inpatient days in the area. Out of 603,000 Medi-Cal inpatient days, Community Medical Center – Fresno provided 76,000 and was the largest single provider for Medi-Cal patients. Valley Children's Hospital in Madera was the second largest provider in the Central Valley.

Other commercial payers including managed care covered 21.9 percent of inpatient days in 2003, on average. Except for Kaiser's Fresno hospital, the Sutter Health hospitals had the highest proportion of commercial and managed care payers, covering 29.7 percent of all its inpatient days. Commercial business was less important for the Adventist Hospitals in the area.

Physician Organizations

Exhibit 39 on page 77 presents an overview of the major physician groups in the Central Valley. Both Permanente groups — Northern and Southern — are represented in the Central Valley. The Northern Permanente Medical Group is the largest group practice in the region, with centers in Fresno, Modesto, and other locations. It has about 404,000 patients and 717 physicians practicing in 48 locations. In the Bakersfield area, the Southern California Permanente Medical Group has 169 primary care and specialty physicians with about 90,000 patients.

EXHIBIT 38. Inpatient Occupancy Rates and Payer Mix for Central Valley Hospitals, 2003

System/Hospital	Staffed Beds	Inpatient Days	Occupancy	Medicare Share of Days	Medi-Cal Share of Days	Third Party Share of Days	County Indigent Share of Days	Other Payers Share of Days
Adventist	**404**	**121,077**	**70.7%**	**44.9%**	**34.3%**	**16.9%**	**0.7%**	**3.2%**
Central Valley General Hospital	26	9,003	57.4%	27.4%	36.5%	27.6%	1.6%	7.0%
Hanford Community Hospital	51	18,168	83.0%	55.5%	13.8%	21.8%	2.9%	6.1%
San Joaquin Community Hospital	166	49,912	82.4%	50.4%	28.2%	19.0%	0.0%	2.4%
Selma Community Hospital	27	9,023	43.4%	54.4%	27.8%	12.1%	0.4%	5.3%
Sonora Regional Medical Center	134	34,971	67.0%	33.7%	54.8%	9.7%	0.2%	1.5%
Catholic Healthcare West	**1,438**	**393,467**	**68.4%**	**45.2%**	**28.1%**	**23.8%**	**0.3%**	**2.6%**
Bakersfield Memorial Hospital	385	88,560	63.0%	48.3%	9.6%	40.9%	0.0%	1.2%
Mercy Hospital – Bakersfield	261	64,517	67.7%	61.1%	6.1%	31.6%	0.0%	1.3%
Mercy Westside Hospital	84	23,759	77.5%	5.4%	93.4%	0.3%	0.0%	0.9%
Mercy Med Center – Merced (Community)	88	29,896	47.1%	47.1%	30.2%	15.7%	1.7%	5.3%
Mercy Med Center – Merced (Dominican)	64	22,085	52.6%	63.6%	13.7%	21.0%	1.0%	0.7%
Oak Valley District Hospital	150	45,708	83.5%	17.5%	67.0%	3.4%	0.3%	11.9%
St. Dominic's Hospital	77	23,004	81.9%	13.9%	69.2%	15.0%	0.0%	1.9%
St. Joseph's Behavioral Health Center	35	11,477	89.8%	67.2%	0.0%	32.6%	0.0%	0.3%
St. Joseph's Medical Center	294	84,461	78.7%	56.2%	20.5%	22.4%	0.5%	0.4%
Community Health System	**865**	**197,349**	**62.5%**	**32.0%**	**39.8%**	**20.7%**	**4.0%**	**3.6%**
Community Medical Center – Clovis	110	27,232	67.8%	38.4%	10.0%	50.1%	0.2%	1.9%
Community Medical Center – Fresno	755	170,117	61.7%	31.0%	44.5%	16.0%	4.6%	3.9%
Kaiser Foundation – Fresno	**121**	**36,573**	**82.8%**	**40.1%**	**0.0%**	**59.6%**	**0.0%**	**0.3%**
St. Agnes Medical Center	**330**	**103,644**	**86.0%**	**60.2%**	**12.2%**	**26.3%**	**0.0%**	**1.3%**
Sutter Health	**446**	**133,831**	**73.2%**	**53.7%**	**14.7%**	**29.7%**	**0.3%**	**2.9%**
Memorial Hospital Los Banos	48	8,702	49.7%	59.2%	20.0%	16.9%	0.0%	3.9%
Memorial Hospital Modesto	253	92,594	82.4%	53.4%	13.5%	32.0%	0.2%	2.9%
Sutter Amador Hospital	66	16,997	70.6%	59.9%	19.6%	16.9%	1.3%	2.3%
Sutter Tracy Community Hospital	79	15,538	53.9%	46.3%	13.7%	37.1%	0.0%	2.9%
Tenet Health	**373**	**125,205**	**73.9%**	**34.9%**	**34.0%**	**24.8%**	**3.0%**	**3.3%**
Doctors Hospital of Manteca	73	15,197	57.0%	40.5%	11.3%	46.2%	0.0%	1.9%
Doctors Medical Center – Modesto	300	110,008	77.1%	34.1%	37.1%	21.8%	3.4%	3.5%
Other Hospitals	**2,653**	**746,032**	**69.8%**	**30.0%**	**42.3%**	**17.7%**	**5.1%**	**4.8%**
Bakersfield Heart Hospital	47	10,642	62.0%	65.3%	4.2%	27.6%	0.0%	2.9%
Children's Hospital Central California	243	67,448	76.0%	0.3%	70.4%	29.2%	0.0%	0.1%
Dameron Hospital	188	56,443	82.3%	47.4%	13.9%	37.2%	0.1%	1.4%
Delano Regional Medical Center	106	36,112	63.4%	24.7%	55.7%	17.2%	1.5%	0.9%
Emanuel Medical Center	297	85,832	71.7%	24.4%	45.6%	7.4%	0.0%	22.7%
Fresno Surgery Center	20	4,503	61.7%	17.9%	0.0%	81.0%	0.0%	1.1%
John C. Fremont Healthcare District	34	9,946	80.1%	11.8%	80.7%	1.4%	0.6%	5.6%
Kaweah Delta District Hospital	389	131,259	74.0%	44.8%	24.2%	17.5%	11.3%	2.1%
Kern Medical Center	180	55,505	71.4%	12.1%	58.2%	13.0%	16.7%	0.0%
Kern Valley Healthcare District	101	30,427	82.5%	12.6%	81.6%	2.6%	0.2%	3.0%

EXHIBIT 38. Inpatient Occupancy Rates and Payer Mix for Central Valley Hospitals, 2003, cont.

System/Hospital	Staffed Beds	Inpatient Days	Occupancy	Medicare Share of Days	Medi-Cal Share of Days	Third Party Share of Days	County Indigent Share of Days	Other Payers Share of Days
Other Hospitals, cont.								
Lodi Memorial Hospital	172	42,861	68.3%	42.2%	35.4%	19.2%	0.0%	3.2%
Madera Community Hospital	106	22,463	58.1%	44.4%	24.2%	23.8%	5.1%	2.4%
Ridgecrest Regional Hospital	80	10,579	36.2%	45.5%	19.5%	33.1%	0.0%	2.0%
San Joaquin General Hospital	146	50,711	70.9%	19.0%	46.1%	7.2%	8.0%	19.7%
Sierra View District Hospital	147	38,208	71.2%	39.7%	44.2%	12.2%	1.9%	2.0%
Stanislaus Surgical Hospital	8	2,910	34.7%	16.3%	0.0%	73.5%	0.0%	10.2%
Tehachapi Hospital	25	7,163	78.5%	7.2%	78.3%	7.6%	0.0%	7.0%
Tulare District Hospital	112	19,211	47.0%	45.9%	30.0%	17.5%	2.7%	3.8%
Tuolumne General Hospital	80	20,948	71.7%	15.8%	69.3%	7.8%	3.6%	3.5%
TOTAL	**6,630**	**1,857,178**	**70.1%**	**38.4%**	**33.5%**	**21.9%**	**2.8%**	**3.6%**

Source: Author's analysis of annual hospital report data for year-end 2003 from office of Statewide Health Planning and Development.

EXHIBIT 39. Central Valley Physician Organizations, 2004 (includes Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, Tulare, and Tuolumne counties)

Physician Organization	Estimated Enrollment	Number of PCPs	Number of Specs	Number of Clinic Sites	Management Entity	Notes
Group Practice						
Clinica Sierra Vista	18,000	38	5	12	Clinica Sierra Vista	Self-managed
Northern Permanente Medical Group	403,550	266	451	48	The Permanente Medical Group, Inc.	
Southern California Permanente Medical Group	89,600	51	118	7	Southern California Permanente Medical Group	
IPA						
Allcare IPA	45,000	142	170	0	Independent Physicians Associates Medical Group, Inc.	
Central Valley Medical Group	7,000	60	73	0	North American Medical Management California, Inc.	
ChildNet Medical Associates	800	57	142	0	Children's Hospital Central California	
Delano Regional Medical Group, Inc.	4,100	20	125	0	Managed Care Systems, LP	
Delta Individual Practice Association	84,400	114	370	0	Delta Individual Practice Association	
Gemcare Medical Group	51,400	88	180	0	Managed Care Systems, LP	
Key Medical Group	15,350	73	175	0	Foundation for Medical Care of Tulare & Kings Counties, Inc.	
Medcore Medical Group	15,000	132	232	0	Medcore HP	
Sante Community Physicians IPA	127,700	329	721	0	Sante Health System, Inc.	
Medical Foundation						
Sutter Gould Medical Foundation	103,300	127	210	16	Sutter Connect	Sutter Health is the sole corporate member of Gould Medical Foundation. Includes medical group and IPA.
State/County/Faculty/Staff						
Central California Faculty Medical Group	5,800	29	69	6	Central California Faculty Medical Group, Inc.	
San Joaquin Faculty Medical Group	6,500	35	72	6	San Joaquin County Health Care Services	

Source: Adopted from Cattaneo & Stroud's medical group inventory, April 2004.

The largest IPA in the area is Sante Community Physicians, which is affiliated with St. Agnes in Fresno. It has 1,050 primary care and specialty physicians and about 127,700 capitated patients. Sutter Gould Medical Foundation has 16 clinic locations in Modesto and nearby areas. The Gould Medical Foundation affiliated with Sutter Health in 1993.

Health Plans

Based on the analysis in Exhibit 13, Blue Cross remains the largest health plan in the area, with about 305,600 enrollees in that part of the Central Valley that extends from Fresno to Bakersfield. Kaiser Permanente has about 215,000 enrollees in the area and has grown in recent years. In 2003, it opened new health centers in Clovis and Selma, both in the northern end of the valley.

Blue Shield added about 40,000 new HMO members in the region in 2003, while PacifiCare's enrollment decreased. It used to have a much larger presence in the area, including a large Secure Horizon plan for seniors. Health Net has about 135,000 enrollees in the region.

In 2005, only two HMOs in Fresno County will have Medicare Advantage plans: Kaiser and PacifiCare. Based on reports from the Centers for Medicare and Medicaid Services, Kaiser had about 15,000 seniors in 2003, and PacifiCare Secure Horizons had less than 4,000. Although federal payment rates in those counties have increased, HMOs have not returned.

Several of the counties in the Central Valley have two-plan arrangements for Medi-Cal managed care. In Fresno and Tulare, the counties don't operate a local initiative plan, so two commercial HMOs, Blue Cross and Health Net, compete. In San Joaquin and Kern Counties, Blue Cross is the commercial plan that competes against the local initiative plan.

4.5 Los Angeles/Orange Counties

Health care in southern California is distinct from other parts of the state, and the differences are especially visible in Los Angeles and Orange Counties. The population of the two counties was estimated at about 13 million in 2003 and continues to grow. About 2.7 million people in Los Angeles County (28 percent of the population) have no health insurance, limiting their access to care providers.

There is a large private and public health care infrastructure in this region: more than 140 acute care hospitals (many of them organized into integrated systems), plus dozens of specialty care facilities. Some of those hospitals are world-class, staffed by star physicians. A high percentage of the physicians in the area practice in multi-specialty group practices, some of which are widely recognized for their sophistication both in medicine and in business operations. The Los Angeles area is probably one of the few parts of the country where more than a few doctors can refuse to take managed care contracts but still have full waiting rooms of patients willing and able to pay their own way.

The challenges of meeting the health care needs of this area are enormous. More than in other parts of the state, governments in Los Angeles have responded to health care demands by constructing a large public infrastructure to deliver and administer care to underserved populations. About 300,000 uninsured or low-income persons receive health care through the clinics and hospitals operated by the Los Angeles County Department of Health Services (Los Angeles County DHS). Maintaining this system demands an ongoing commitment of a huge amount of resources.

Twice in the last decade Los Angeles county has turned to the federal government for a bailout of its public health system. A bailout in the 1990s called for the expansion of local clinic services and a reduction in hospital services. While the Los Angeles County DHS did expand clinical services, it remained heavily committed to its hospitals. County leaders have tried to balance the budget by closing some of the county's facilities, but those efforts have been entangled in litigation.

Orange County, by contrast, has no public hospitals except for the University of California–Irvine Medical Center, which provides much of the care for the county's indigent patients. About 335,000 adults in the county have no health insurance. Orange County has a well-developed system of 19 community health centers to provide ambulatory care. In 2002, community activists successfully pushed to designate a portion of the county's tobacco settlement dollars for community health services. Los Angeles County, on the other hand, has not similarly designated tobacco funds.

In such a spread-out area, geographic access to hospitals and physicians is important. This could drive some consolidation of providers, particularly physician groups. Development of new residential areas continues to sprawl in different parts of the region, such as the valleys to the north. Some successful medical groups are watching this development and trying to be the first to build new clinics to serve the new communities. This, in turn, has helped them in their managed care negotiations. In a sense it reverses what had been the conventional wisdom, which had been that physicians needed to contract with health plans to have access to patients. Now the health plans need those medical groups who have been able to extend their reach to new population centers so that they can have access to those patients.

Overview of Hospitals

There are many hospital systems in the Los Angeles area, though some of them are relatively small. For-profit hospitals are much more common in this part of the state than in northern California. With 4,846 inpatient beds, Tenet Health is the largest for-profit system in the area, though it is reducing its size through sales of its hospitals. The Kaiser Foundation hospitals in the area are the largest nonprofit system, with 2,244 inpatient beds. Los Angeles County has 1,870 beds in its six hospitals, while Catholic Healthcare West has 1,756 beds.

The two exhibits that follow list 15 hospital systems in the area and about 45 hospitals that are not part of those systems. A few of the independent hospitals, like Cedars-Sinai, are bigger than some systems in the area. Still, of the 26,687 inpatient hospital beds in the area, all but about 8,000 are in one of those 15 systems.

Development of hospital systems is an ongoing process in Los Angeles and Orange counties, with affiliations often changing. For example, the Daughters of Charity took back three of their Los Angeles area hospitals that had been part of Catholic Healthcare West: Robert F. Kennedy Medical Center, St. Francis Medical Center, and St. Vincent Medical Center. St. Francis and St. Vincent had been two of CHW's more profitable hospitals in the Los Angeles area.

In 2003, Tenet Health had 28 hospitals in Los Angeles and Orange Counties with 4,846 acute care beds. Most Tenet hospitals in the area are relatively small community hospitals; only four of the Tenet hospitals have 300 or more inpatient beds. The Tenet network for southern California also includes the academic medical center at the University of Southern California.

Tenet acquired the two Daniel Freeman hospitals from the Carondolet system a few years ago, but was blocked in its attempt to buy a third Carondolet hospital. It has since sold the two Daniel Freeman hospitals and Centinela, also in West Los Angeles. In 2004 Tenet also sold four hospitals in eastern Los Angeles County: Garfield Medical Center, Monterey Park Hospital, Greater El Monte Community Hospital, and Whittier Hospital Medical Center. The buyer was AHMC Inc., a privately owned California company that operates Alhambra Hospital Medical Center and Doctors' Hospital Medical Center of Montclair. Toward the end of 2004, Tenet finalized the sale of Hollywood Presbyterian Medical Center in Los Angeles to the CHA Medical Group.

HCA: The Healthcare Company had three hospitals in 2001 but is now operating only one in the Los Angeles/Orange County area. The Los Angeles hospitals owned by Paracelsus Health Care Corporation (a Houston-based company that emerged from bankruptcy reorganization under the name Clarent Health) changed ownership to Alta Health Corporation. In turn, some of those hospitals were sold to other investor-owned companies.

There are three Adventist hospitals in the Los Angeles area, including one in Orange County. White Memorial Medical Center in East Los Angeles is in the process of building a new patient care tower that will meet seismic standards and replace the old hospital. The new phase of the new construction will be complete in 2005, but the project will not be finished until 2008. The hospital is getting help from the Federal Emergency Management Agency.

Financial Results

Exhibit 40 compares Los Angeles/Orange County hospitals and systems on their revenues and net income in 2003. Hospitals in the two counties had total net income of $986.7 million. On average, hospitals in the area reported net income of 5.5 percent on total revenues (patient care and other revenue sources) of $18.1 billion. That was an improvement over average margins of 4.5 percent of total revenue in 2001. However, about 40 hospitals reported losses for their 2003 operations.

The Kaiser hospitals for southern California, including San Diego and the Inland Empire, had net income of $389.1 million, or 12.8 percent of total revenues. That is a significant improvement over 2001, when the Kaiser hospitals in this region had net income of $229.2 million. In turn, 2001 was a major improvement over 2000 when the Kaiser hospitals had total losses of $104.8 million.

Tenet Health had the next highest net income, with $262 million after taxes, or 10.7 percent of total revenues. The most profitable Tenet hospitals in the area are Centinela in Inglewood and Garfield in Monterey Park, which have both been sold, plus Encino Tarzana and the University of Southern California University Hospital in Los Angeles.

Of the other nonprofit systems in the area, the St. Joseph hospitals in Orange County had the best results, with net income of $40.2 million, an improvement over 2001. It has pursued a strategy of selective contracting with a smaller number of health plans, trying (apparently successfully) to use its geographic strength in Orange County to leverage better payments from health plans.

Adventist had the second best results among nonprofit systems. In 2003, the three Adventist hospitals in the area had

EXHIBIT 40. Revenues and Profitability for Los Angeles Area Hospitals, 2003

System/Hospitals	City	Total Charges	Net Patient Revenue	Total Revenue	Operating Expenses	Net from Operations	Net Income	% of Total Revenue
Adventist		**$1,628,766,297**	**$420,629,816**	**$466,342,344**	**$454,044,787**	**$– 4,651,130**	**$24,123,499**	**5.2%**
Glendale Adventist Medical	Glendale	859,455,386	195,891,244	219,407,879	219,469,788	– 1,636,974	15,688,303	7.2%
South Coast Medical Center	South Laguna	214,130,329	56,642,262	58,519,447	59,008,128	– 1,045,615	– 2,538,509	– 4.3%
White Memorial Medical	Los Angeles	555,180,582	168,096,310	188,415,018	175,566,871	– 1,968,541	10,973,705	5.8%
Alta Healthcare		**$234,568,800**	**$60,171,178**	**$61,794,183**	**$62,917,076**	**$– 2,231,632**	**$– 1,163,356**	**– 1.9%**
Hollywood Community	Hollywood	76,773,522	21,275,801	22,065,283	21,783,179	– 227,406	282,104	1.3%
Los Angeles Community	Los Angeles	139,958,822	36,123,564	36,916,244	35,911,214	426,501	995,320	2.7%
Orange County Community	Buena Park	17,836,456	2,771,813	2,812,656	5,222,683	– 2,430,727	– 2,440,780	– 86.8%
Catholic Healthcare West		**$3,271,387,660**	**$766,149,028**	**$788,146,823**	**$813,071,318**	**$– 33,119,347**	**$– 35,315,083**	**– 4.5%**
California Hospital	Los Angeles	494,657,483	123,033,303	129,714,003	141,981,452	– 12,354,860	– 12,270,365	– 9.5%
Glendale Memorial	Glendale	666,376,166	145,937,164	148,783,225	150,688,194	– 3,148,019	– 2,677,306	– 1.8%
Northridge Hospital	Northridge	813,374,917	196,940,651	202,918,562	196,827,231	2,741,180	2,386,738	1.2%
Northridge Hospital	Van Nuys	250,474,464	55,549,196	59,356,418	65,213,603	– 8,420,922	– 7,789,484	– 13.1%
San Gabriel Valley Medical	San Gabriel	407,401,451	95,543,562	96,119,534	97,510,671	– 1,547,915	– 1,597,607	– 1.7%
St. Mary Medical Center	Long Beach	639,103,179	149,145,152	151,255,081	160,850,167	– 10,388,811	– 13,367,059	– 8.8%
Cedars-Sinai Medical	**Los Angeles**	**$3,445,896,376**	**$999,367,990**	**$1,130,890,482**	**$1,112,193,810**	**$– 3,102,839**	**$18,387,897**	**1.6%**
Daughters of Charity		**$1,383,061,046**	**$410,234,245**	**$429,139,517**	**$427,049,181**	**$– 12,625,708**	**$ – 5,271,489**	**– 1.2%**
Robert F. Kennedy Medical	Hawthorne	209,356,487	67,689,178	68,214,828	72,339,398	– 4,322,041	– 4,308,622	– 6.3%
St. Francis Medical Center	Lynwood	634,783,808	188,096,950	196,963,427	185,434,100	5,275,416	10,128,275	5.1%
St. Vincent Medical Center	Los Angeles	538,920,751	154,448,117	163,961,262	169,275,683	– 13,579,083	– 11,091,142	– 6.8%
Kaiser Foundation – South	**Pasadena**	**$3,054,870,853**	**$2,967,358,766**	**$3,046,428,146**	**$2,657,301,860**	**$389,126,286**	**$389,126,286**	**12.8%**
Los Angeles County		**$4,905,676,438**	**$1,497,041,201**	**$2,024,670,543**	**$1,946,023,508**	**$– 401,573,279**	**$71,599,956**	**3.5%**
LAC / Harbor – UCLA	Torrance	1,088,616,223	282,824,652	356,099,123	349,627,555	– 60,179,824	2,985,464	0.8%
LAC / High Desert Hospital	Lancaster	88,659,028	41,319,069	63,144,806	58,898,590	– 16,506,749	4,246,216	6.7%
LAC / MLK Jr. – Drew	Los Angeles	867,160,461	255,212,662	367,358,961	367,713,855	– 104,692,650	– 354,894	– 0.1%
LAC / Olive View – UCLA	Sylmar	476,702,864	186,218,927	251,287,138	224,107,181	– 31,513,800	25,584,001	10.2%
LAC / Rancho Los Amigos National Rehab Center	Downey	348,363,626	124,629,460	170,120,009	161,940,228	– 34,490,072	8,156,107	4.8%
LAC / USC Medical Center	Los Angeles	2,036,174,236	606,836,431	816,660,506	783,736,099	– 154,190,184	30,983,062	3.8%
Memorial Health Services		**$3,180,802,406**	**$990,943,967**	**$1,074,125,552**	**$1,021,309,545**	**$– 13,893,381**	**$29,799,795**	**2.8%**
Anaheim Memorial	Anaheim	580,779,363	139,507,957	143,174,187	140,247,076	100,228	678,384	0.5%
Earl & Lorraine Miller Children's Hospital	Long Beach	266,892,452	102,319,288	115,686,504	105,987,311	161,652	6,625,987	5.7%
Long Beach Memorial	Long Beach	1,031,891,423	339,173,015	386,403,320	360,491,584	– 13,516,726	19,283,674	5.0%
Orange Coast Memorial	Fountain Valley	278,024,486	89,897,669	92,595,146	91,253,486	– 864,714	708,837	0.8%
Saddleback Memorial	Laguna Hills	529,000,821	179,148,966	193,026,789	180,383,611	1,700,641	4,310,166	2.2%
Pacific Health Corp.		**$494,213,861**	**$140,897,072**	**$143,239,606**	**$142,946,477**	**$– 1,474,462**	**$– 1,807,253**	**– 1.3%**
Anaheim General Hospital	Anaheim	124,971,765	31,021,542	32,849,233	35,415,835	– 4,307,850	– 3,370,904	– 10.3%
Bellflower Medical Center	Bellflower	159,934,044	39,461,089	39,599,113	38,233,065	1,339,705	726,678	1.8%
Los Angeles Metropolitan	Los Angeles	149,350,098	57,370,799	57,456,650	49,924,142	7,532,508	4,218,204	7.3%
Tustin Hospital	Tustin	59,957,954	13,043,642	13,334,610	19,373,435	– 6,038,825	– 3,381,231	– 25.4%

EXHIBIT 40. Revenues and Profitability for Los Angeles Area Hospitals, 2003, cont.

System/Hospitals	City	Total Charges	Net Patient Revenue	Total Revenue	Operating Expenses	Net from Operations	Net Income	% of Total Revenue
Sisters of Providence		**$2,675,501,976**	**$667,019,031**	**$683,324,080**	**$664,192,920**	**$13,697,679**	**$18,316,045**	**2.7%**
Little Company of Mary	San Pedro	355,709,072	97,891,256	101,587,218	94,196,120	5,176,159	7,312,894	7.2%
Little Company of Mary	Torrance	656,792,257	183,652,210	188,802,104	186,371,665	1,387,276	2,429,340	1.3%
Providence Holy Cross	Mission Hills	703,995,864	145,562,595	148,426,206	145,238,833	1,846,993	2,837,110	1.9%
Providence Saint Joseph	Burbank	959,004,783	239,912,970	244,508,552	238,386,302	5,287,251	5,736,701	2.3%
St. Joseph		**$2,373,276,558**	**$718,108,962**	**$799,972,939**	**$734,080,882**	**$48,884,172**	**$40,211,110**	**5.0%**
Mission Hospital Regional	Mission Viejo	665,504,200	204,765,475	223,500,890	199,485,270	12,500,555	11,069,682	5.0%
St. Joseph Hospital	Orange	962,288,390	294,900,003	346,268,210	321,395,067	19,497,047	14,646,277	4.2%
St. Jude Medical Center	Fullerton	745,483,968	218,443,484	230,203,839	213,200,545	16,886,570	14,495,151	6.3%
Tenet Health		**$14,491,714,274**	**$2,413,148,024**	**$2,447,334,526**	**$2,140,893,633**	**$289,369,538**	**$262,024,341**	**10.7%**
Los Angeles County								
Brotman Medical Center	Culver City	747,487,233	112,911,815	113,992,819	97,489,492	15,610,137	16,019,675	14.1%
Centinela Hospital	Inglewood	1,501,030,873	231,273,851	234,057,725	200,725,590	32,452,443	31,435,807	13.4%
Century City Hospital	Los Angeles	562,436,360	78,354,270	78,642,238	77,436,423	1,134,845	– 121,524	– 0.2%
Community and Mission	Huntington Park	216,008,565	40,257,688	40,491,441	40,459,411	– 159,313	– 229,760	– 0.6%
Daniel Freeman Marina	Marina Del Rey	182,803,968	34,613,678	36,753,301	49,874,258	– 14,225,274	– 13,321,718	– 36.2%
Daniel Freeman Memorial	Inglewood	764,186,632	118,059,862	119,128,529	113,768,753	5,246,099	5,323,340	4.5%
Encino Tarzana Regional	Encino	448,073,132	50,753,501	51,815,083	60,759,365	– 9,542,528	– 9,611,851	– 18.6%
Encino Tarzana Regional	Tarzana	1,089,277,153	179,379,727	181,307,186	143,332,914	36,898,214	13,711,116	7.6%
Garfield Medical Center	Monterey Park	1,002,281,738	143,951,763	146,352,376	107,921,465	36,685,453	35,712,113	24.4%
Greater El Monte	South El Monte	237,476,338	36,225,786	36,429,829	37,317,579	– 995,912	– 911,366	– 2.5%
Lakewood Regional – South	Lakewood	603,363,647	93,375,261	96,582,419	78,981,574	17,552,843	15,921,974	16.5%
Midway Hospital	Los Angeles	639,416,132	73,307,042	75,785,574	66,400,214	7,175,998	6,360,241	8.4%
Monterey Park Hospital	Monterey Park	355,115,851	49,926,078	50,207,491	41,363,632	8,783,537	8,770,426	17.5%
Queen of Angels – Hollywood Presbyterian	Los Angeles	971,520,565	144,218,750	144,982,304	148,308,381	– 3,608,220	– 3,564,948	– 2.5%
San Dimas Community	San Dimas	366,622,572	46,046,604	47,009,968	41,310,375	5,009,861	5,322,117	11.3%
Suburban Medical Center	Paramount	342,076,563	52,678,014	53,557,256	51,539,806	1,371,462	1,081,207	2.0%
USC University Hospital	Los Angeles	1,510,603,610	313,131,304	317,140,697	230,401,715	84,288,007	85,675,353	27.0%
Whittier Hospital	Whittier	526,186,376	73,345,760	74,890,396	72,669,402	1,585,159	1,694,304	2.3%
Orange County								
Chapman Medical Center	Orange	219,423,416	46,100,113	46,713,969	45,808,043	439,832	119,174	0.3%
Coastal Communities	Santa Ana	270,111,445	55,637,253	56,412,816	46,927,895	8,896,895	9,002,617	16.0%
Fountain Valley Regional	Fountain Valley	1,103,739,375	230,837,705	231,605,098	195,919,083	35,586,496	33,584,956	14.5%
Garden Grove	Garden Grove	346,166,114	67,317,064	68,444,546	63,228,144	4,173,642	4,425,674	6.5%
Irvine Medical Center	Irvine	535,803,909	87,719,459	88,345,622	86,019,542	1,927,361	1,681,046	1.9%
Los Alamitos Medical Center	Los Alamitos	632,986,337	99,288,010	102,392,963	77,768,543	23,435,601	23,693,041	23.1%
Placentia-Linda Community	Placentia	206,789,615	39,542,775	39,859,714	33,347,606	6,427,006	6,380,674	16.0%
Santa Ana Hospital	Santa Ana	49,580,217	12,709,492	13,690,202	16,034,325	– 2,890,039	– 2,836,374	– 20.7%
Western Medical Center	Anaheim	366,736,191	74,382,230	75,241,004	67,710,009	7,490,245	7,206,634	9.6%
Western Medical Center	Santa Ana	942,928,453	171,988,835	173,552,504	146,285,176	26,682,268	26,955,875	15.5%

EXHIBIT 40. Revenues and Profitability for Los Angeles Area Hospitals, 2003, cont.

System/Hospitals	City	Total Charges	Net Patient Revenue	Total Revenue	Operating Expenses	Net from Operations	Net Income	% of Total Revenue
University of California		**$2,184,000,004**	**$817,290,634**	**$874,096,753**	**$862,544,757**	**$9,987,471**	**$11,551,996**	**1.3%**
UCLA Medical Center	Santa Monica	329,839,207	97,624,216	102,786,031	131,035,672	– 28,460,281	– 28,249,641	– 27.5%
UCLA Medical Center	Los Angeles	1,813,708,973	685,960,807	736,251,226	699,799,269	36,451,957	36,451,957	5.0%
UCLA Neuropsychiatric	Los Angeles	40,451,824	33,705,611	35,059,496	31,709,816	1,995,795	3,349,680	9.6%
UC Irvine	Orange	1,109,760,727	333,853,457	358,098,812	319,451,718	37,029,640	38,545,001	10.8%
West Hills Hospital	**West Hills**	**$430,265,631**	**$106,807,833**	**$109,113,623**	**$104,613,318**	**$3,569,823**	**$3,305,259**	**3.0%**
Other Hospitals		**$13,077,240,680**	**$3,948,472,245**	**$4,430,768,770**	**$4,192,364,530**	**$– 114,430,998**	**$161,835,308**	**3.7%**
Los Angeles County								
Alhambra Hospital	Alhambra	107,181,673	53,966,467	54,664,930	47,687,021	6,743,606	6,881,238	12.6%
Antelope Valley Hospital	Lancaster	689,969,514	186,544,915	193,636,980	197,859,218	– 7,077,426	– 5,743,841	– 3.0%
Avalon Municipal	Avalon	3,901,699	2,670,204	3,437,162	3,556,669	– 835,227	– 119,507	– 3.5%
Beverly Hospital	Montebello	219,599,471	77,447,545	77,831,906	85,650,134	– 7,905,760	– 7,878,872	– 10.1%
Children's Hospital	Los Angeles	624,056,798	249,424,044	361,646,981	360,376,189	– 86,050,389	– 2,192,929	– 0.6%
Citrus Valley Medical Center QV Campus	West Covina	856,981,045	209,759,989	214,928,803	218,349,787	– 5,687,255	– 3,420,984	– 1.6%
City of Angels Medical	Los Angeles	108,807,736	44,043,774	47,293,480	41,090,736	6,202,744	5,970,766	12.6%
Coast Plaza Doctors Hospital	Norwalk	221,935,151	76,425,216	77,801,276	63,632,168	13,312,896	12,238,270	15.7%
Community Hospital	Long Beach	79,018,876	24,787,450	26,635,906	27,296,648	– 2,208,615	– 998,128	– 3.7%
Doctors Hospital	West Covina	33,529,063	9,482,538	10,753,704	10,096,378	– 567,604	471,180	4.4%
Downey Regional	Downey	350,610,613	86,707,732	95,159,646	106,107,993	– 19,078,797	– 11,809,000	– 12.4%
East Los Angeles Doctor's	Los Angeles	123,160,798	35,060,897	35,293,333	36,489,180	– 1,331,238	– 1,254,018	– 3.6%
East Valley Hospital	Glendora	75,556,661	24,735,164	25,151,090	26,493,847	– 1,342,757	– 1,342,757	– 5.3%
Elastar Community Hospital	Los Angeles	120,341,490	29,906,995	30,232,202	30,728,922	– 623,414	– 496,720	– 1.6%
Foothill Presbyterian	Glendora	185,209,846	43,828,676	44,551,004	43,934,979	488,361	616,025	1.4%
Good Samaritan Hospital	Los Angeles	720,961,795	185,889,825	201,122,210	200,667,144	– 12,734,259	450,893	0.2%
Henry Mayo Newhall Memorial Hospital	Valencia	442,826,822	106,592,986	113,093,673	102,952,637	3,749,118	10,141,036	9.0%
Huntington Memorial	Pasadena	1,039,703,416	302,845,011	327,379,681	311,889,659	878,699	14,213,787	4.3%
Kindred Hospital	La Mirada	199,590,435	64,965,754	65,061,572	55,194,502	9,867,070	9,867,070	15.2%
Lancaster Community	Lancaster	262,077,093	57,755,305	58,290,870	64,371,154	– 6,574,977	– 6,222,789	– 10.7%
Lincoln Hospital	Los Angeles	15,885,085	6,354,034	6,376,679	11,166,867	– 4,812,688	– 4,790,188	– 75.1%
Memorial Hospital	Gardena	145,954,713	47,249,743	48,565,015	48,870,968	– 1,476,718	– 1,107,401	– 2.3%
Methodist Hospital of Southern California	Arcadia	489,868,574	146,198,628	151,402,011	140,941,042	6,965,815	10,427,410	6.9%
Mission Community	Panorama City	89,999,377	30,556,662	31,097,131	39,061,348	– 8,368,050	– 8,219,463	– 26.4%
Motion Picture & Television	Woodland Hills	78,202,368	51,337,465	59,289,819	74,360,200	– 22,260,070	– 19,857,134	– 33.5%
Orthopaedic Hospital	Los Angeles	77,274,823	25,747,101	49,399,591	44,776,265	– 14,013,742	3,804,412	7.7%
Pacific Alliance Medical	Los Angeles	$74,992,658	$45,263,389	$73,308,739	$52,705,367	$– 7,199,779	$17,828,456	24.3%
Pacific Hospital	Long Beach	368,905,042	116,711,517	117,902,088	109,949,330	7,114,104	4,720,994	4.0%
Pomona Valley Hospital	Pomona	1,015,088,782	233,897,384	246,755,908	237,118,084	1,055,463	3,000,006	1.2%
Presbyterian Intercommunity	Whittier	754,562,249	203,588,991	227,492,006	178,493,604	26,932,038	48,998,402	21.5%

EXHIBIT 40. Revenues and Profitability for Los Angeles Area Hospitals, 2003, cont.

System/Hospitals	City	Total Charges	Net Patient Revenue	Total Revenue	Operating Expenses	Net from Operations	Net Income	% of Total Revenue
Other Hospitals, cont.								
Los Angeles County, cont.								
San Vicente Hospital	Los Angeles	$2,680,706	$3,000,973	$3,059,543	$3,421,466	$– 361,923	– 361,923	– 11.8%
Santa Teresita Hospital	Duarte	64,816,501	21,795,517	28,068,741	30,141,503	– 7,916,151	– 2,319,224	– 8.3%
Sherman Oaks Hospital	Sherman Oaks	238,773,630	63,686,291	64,254,495	60,350,808	3,673,428	3,903,687	6.1%
Shriners Hospital	Los Angeles	0	0	283,989	22,223,328	– 21,939,339	– 21,939,339	– 7725.4%
St. John's Hospital	Santa Monica	828,166,717	209,729,505	293,177,857	206,928,736	7,214,806	43,496,116	14.8%
Orange County								
Children's Hospital	Mission Viejo	$58,927,067	$26,919,117	$27,769,553	$25,126,152	$2,344,243	$2,003,452	7.2%
Children's Hospital	Orange	447,797,219	177,319,049	214,538,989	211,574,540	1,764,768	2,778,751	1.3%
College Hospital Costa Mesa	Costa Mesa	73,480,162	28,293,077	28,862,660	31,181,982	– 2,319,322	– 2,319,322	– 8.0%
Healthbridge Children's	Orange	34,629,021	7,093,373	7,114,329	6,895,867	218,462	218,462	3.1%
Hoag Memorial Presbyterian	Newport Beach	901,380,651	396,790,165	451,518,044	395,617,067	21,241,704	53,906,983	11.9%
Huntington Beach Hospital	Huntington Beach	151,262,838	40,000,464	40,257,611	43,969,972	– 3,712,361	– 3,938,693	– 9.8%
Kindred Hospital	Brea	65,889,820	20,526,174	20,572,511	19,044,717	1,527,794	1,527,794	7.4%
Kindred Hospital	Westminster	177,626,356	50,020,444	50,094,830	39,136,321	10,958,509	10,958,509	21.9%
La Palma Intercommunity	La Palma	113,123,998	32,045,588	33,034,310	36,068,564	– 3,790,628	– 3,534,785	– 10.7%
San Clemente Hospital	San Clemente	103,833,618	27,590,705	28,148,823	28,951,181	– 1,088,940	– 1,314,177	– 4.7%
West Anaheim Medical	Anaheim	239,098,710	63,916,402	64,457,089	59,864,286	4,592,803	4,592,803	7.1%
Total		**$56,831,242,860**	**$16,923,639,992**	**$18,080,248,370**	**$16,511,926,411**	**$991,153,384**	**$986,724,311**	**5.3%**

Source: Author's analysis of annual hospital report data for year-end 2003 from office of Statewide Health Planning and Development.

net income of $24.1 million, or 5.2 percent of total revenues. That was less than the 10.7 percent net income they reported in 2001. The Catholic Healthcare West hospitals had net losses of $35.3 million. California Hospital Medical Center in Los Angeles, a profitable hospital in 2001, lost $12.3 million in 2003. The Los Angeles County hospitals had net income of $71.6 million, or 3.5 percent of total revenues.

Occupancy

Hospital capacity is a major issue in the Los Angeles/Orange County region. Major new construction or reconstruction projects are now underway or in the planning stages. Besides fundamental capacity needs, the driving forces behind these projects also include the need to modernize outmoded facilities and the competitive pressure to have the most cutting-edge technology and equipment. New construction is often designed to emphasize money-making practices like cardiology and surgery, and to keep or attract star physicians who have lucrative practices.

Other projects are tied to the need to bring hospitals up to the state's new standards for seismic safety. Children's Hospital in Los Angeles will construct a new patient care tower designed to meet the new standards. Several other hospital projects are already underway to address seismic safety standards. Reconstruction of the UCLA Medical Center, heavily earthquake-damaged, is almost complete. The University of California – Irvine Medical Center is campaigning to raise money for a new hospital. Kaiser has announced plans to replace six of its hospitals in southern California over the next 10 years, largely to comply with the state's standards for seismic safety in hospital construction. When combined with the expansions described in earlier sections, Kaiser has an enormous agenda of construction planned for California in the next 15 years.

Exhibit 41 that follows compares Los Angeles and Orange County hospitals and systems on their inpatient occupancy rates and payer mix in 2003. Hospitals in the area had, on average, 63.8 percent inpatient occupancy. That is higher than in 2000 when average occupancy for the region was about 60 percent, and higher

EXHIBIT 41. Inpatient Occupancy Rates and Payer Mix for Los Angeles Area Hospitals, 2003

System/Hospital	Staffed Beds	Inpatient Days	Occupancy	Medicare Share of Days	Medi-Cal Share of Days	Third Party Share of Days	County Indigent Share of Days	Other Payers Share of Days
Adventist	**782**	**233,446**	**65.9%**	**43.7%**	**36.8%**	**16.8%**	**0.0%**	**2.7%**
Glendale Adventist Medical Center	428	106,891	68.4%	53.7%	27.9%	17.3%	0.0%	1.2%
South Coast Medical Center	81	30,443	43.2%	40.2%	17.0%	38.4%	0.2%	4.3%
White Memorial Medical Center	273	96,112	75.2%	33.8%	53.0%	9.4%	0.0%	3.8%
Alta Healthcare	**290**	**56,658**	**41.3%**	**39.6%**	**54.9%**	**3.1%**	**0.0%**	**2.4%**
Hollywood Community Hospital	160	23,838	40.8%	56.5%	43.3%	0.1%	0.0%	0.1%
Los Angeles Community Hospital	92	29,187	44.4%	26.5%	64.1%	5.0%	0.0%	4.5%
Orange County Community Hospital	38	3,633	27.4%	33.9%	57.1%	8.1%	0.0%	0.8%
Catholic Healthcare West	**1,756**	**420,865**	**58.5%**	**45.0%**	**33.2%**	**18.5%**	**0.0%**	**3.3%**
California Hospital Medical Center	275	63,815	63.6%	30.7%	62.8%	4.9%	0.0%	1.7%
Glendale Memorial Hospital	334	80,061	65.7%	47.8%	23.7%	19.1%	0.0%	9.4%
Northridge Hospital Medical Center	420	88,513	57.7%	32.8%	26.6%	39.3%	0.0%	1.3%
Northridge Hospital – Sherman	209	42,055	55.1%	39.7%	44.9%	13.9%	0.0%	1.4%
San Gabriel Valley Medical Center	270	63,641	63.9%	66.0%	17.6%	15.0%	0.0%	1.5%
St. Mary Medical Center	248	82,780	49.2%	53.1%	32.4%	11.3%	0.0%	3.1%
Cedars-Sinai Medical Center	**875**	**278,307**	**87.1%**	**39.7%**	**15.5%**	**39.8%**	**0.2%**	**4.7%**
Daughters of Charity	**810**	**208,984**	**60.5%**	**44.1%**	**38.7%**	**12.4%**	**1.2%**	**3.7%**
Robert F. Kennedy Medical Center	246	47,704	53.1%	43.3%	45.1%	8.5%	0.0%	3.1%
St. Francis Medical Center	383	96,159	68.8%	33.4%	49.5%	9.2%	2.5%	5.3%
St. Vincent Medical Center	181	65,121	56.1%	60.5%	18.0%	19.8%	0.0%	1.8%
Los Angeles County	**1,870**	**613,337**	**72.1%**	**7.7%**	**52.3%**	**5.0%**	**33.9%**	**1.2%**
LAC / Harbor – UCLA Medical Center	321	117,057	73.9%	11.0%	53.2%	3.9%	31.2%	0.6%
LAC / High Desert Hospital	70	21,864	85.6%	2.4%	60.7%	10.5%	22.1%	4.4%
LAC / Martin Luther King Jr. / Drew	298	78,281	59.4%	9.4%	51.1%	2.3%	37.0%	0.1%
LAC / Olive View – UCLA Medical Center	238	65,658	75.6%	5.7%	53.6%	1.3%	38.7%	0.7%
LAC / Rancho Los Amigos National Rehab	207	67,290	64.0%	9.3%	65.2%	3.6%	18.1%	4.0%
LAC / USC Medical Center	736	263,187	76.8%	6.2%	47.9%	7.1%	37.9%	1.0%
Kaiser Foundation	**2,244**	**472,549**	**57.7%**	**41.7%**	**2.9%**	**53.6%**	**0.0%**	**2.2%**
Kaiser Foundation – Anaheim	176	46,799	72.9%	34.3%	2.3%	61.5%	0.0%	2.0%
Kaiser Foundation – Baldwin Park	207	44,754	59.2%	38.1%	1.8%	58.8%	0.0%	1.4%
Kaiser Foundation – Bellflower	334	68,137	55.9%	33.4%	5.2%	57.9%	0.0%	3.5%
Kaiser Foundation – Harbor City	235	49,873	58.1%	43.7%	3.5%	51.4%	0.0%	1.4%
Kaiser Foundation – Panorama City	262	42,503	44.4%	45.9%	1.9%	49.9%	0.2%	2.1%
Kaiser Foundation – Sunset	519	124,450	65.7%	40.1%	2.5%	54.7%	0.0%	2.6%
Kaiser Foundation – West LA	293	44,353	41.5%	51.5%	3.7%	42.7%	0.0%	2.1%
Kaiser Foundation – Woodland Hills	218	51,680	64.9%	50.7%	1.4%	46.4%	0.0%	1.5%
Memorial Health Services	**1,711**	**429,366**	**56.9%**	**40.1%**	**24.9%**	**31.1%**	**0.6%**	**3.3%**
Anaheim Memorial Medical Center	163	55,965	69.1%	39.0%	12.5%	42.3%	2.2%	3.9%
Earl and Lorraine Miller Children's Hospital	166	49,442	68.4%	0.1%	57.7%	39.4%	0.0%	2.7%
Long Beach Memorial Medical Center	382	136,290	72.8%	46.9%	17.1%	31.6%	0.5%	4.0%

EXHIBIT 41. Inpatient Occupancy Rates and Payer Mix for Los Angeles Area Hospitals, 2003, cont.

System/Hospital	Staffed Beds	Inpatient Days	Occupancy	Medicare Share of Days	Medi-Cal Share of Days	Third Party Share of Days	County Indigent Share of Days	Other Payers Share of Days
Memorial Health Services, cont.								
Orange Coast Memorial Medical Center	150	31,508	39.6%	43.6%	2.8%	50.4%	0.7%	2.5%
Saddleback Memorial Medical Center	167	57,337	62.8%	55.8%	1.7%	39.3%	0.4%	2.9%
Pacific Health Corp.	**683**	**98,824**	**40.7%**	**41.1%**	**46.7%**	**8.8%**	**0.5%**	**2.8%**
Anaheim General Hospital	143	22,986	44.0%	45.5%	41.6%	6.0%	1.9%	5.0%
Bellflower Medical Center	144	30,092	57.3%	43.3%	46.5%	6.5%	0.0%	3.8%
Los Angeles Metropolitan Medical Center	219	37,060	50.5%	43.7%	47.3%	8.2%	0.0%	0.8%
Tustin Hospital Medical Center	177	8,686	13.4%	11.7%	58.2%	27.1%	0.4%	2.7%
Sisters of Providence	**1,597**	**411,591**	**70.3%**	**46.0%**	**21.6%**	**28.1%**	**0.0%**	**4.3%**
Little Company of Mary – San Pedro	509	117,152	63.1%	36.0%	28.3%	30.8%	0.0%	4.8%
Little Company of Mary – Torrance	410	108,610	71.5%	45.9%	16.6%	31.2%	0.0%	6.3%
Providence Holy Cross Medical Center	251	79,519	86.8%	46.1%	25.0%	24.6%	0.0%	4.3%
Providence Saint Joseph Medical Center	427	106,310	68.2%	57.1%	16.8%	24.6%	0.0%	1.5%
St. Joseph	**935**	**231,437**	**63.2%**	**46.3%**	**8.6%**	**42.0%**	**1.3%**	**1.8%**
Mission Hospital Regional Medical Center	272	70,410	56.6%	48.4%	10.0%	38.0%	1.8%	1.8%
St. Joseph Hospital – Orange	354	86,285	66.8%	37.4%	10.1%	50.1%	0.9%	1.5%
St. Jude Medical Center	309	74,742	66.3%	54.5%	5.6%	36.5%	1.3%	2.1%
Tenet Health	**4,846**	**1,122,429**	**62.8%**	**44.7%**	**33.1%**	**19.2%**	**1.0%**	**2.1%**
Los Angeles County								
Brotman Medical Center	385	77,070	54.8%	59.0%	25.0%	13.6%	0.0%	2.4%
Centinela Hospital Medical Center	318	90,096	77.6%	59.5%	24.3%	14.4%	0.0%	1.8%
Century City Hospital	112	39,266	96.1%	66.9%	10.4%	21.2%	0.0%	1.5%
Community and Mission Hospitals	145	21,755	41.1%	22.1%	70.9%	4.3%	0.0%	2.8%
Daniel Freeman Marina Hospital	166	15,689	25.9%	65.4%	6.1%	17.8%	0.0%	10.6%
Daniel Freeman Memorial Hospital	339	66,332	53.6%	47.8%	38.8%	10.4%	0.0%	3.1%
Encino Tarzana Regional – Encino	151	38,755	64.8%	56.4%	31.4%	7.9%	0.0%	4.4%
Encino Tarzana Regional – Tarzana	210	64,375	83.6%	45.1%	17.5%	35.5%	0.0%	1.9%
Garfield Medical Center	208	70,348	92.7%	50.5%	36.7%	11.6%	0.0%	1.1%
Greater El Monte Community Hospital	117	25,109	58.8%	33.6%	60.2%	3.5%	0.0%	2.7%
Lakewood Regional – South	161	42,289	72.0%	67.4%	13.2%	17.8%	0.0%	1.6%
Midway Hospital Medical Center	225	35,916	43.7%	73.0%	21.5%	4.2%	0.0%	1.3%
Monterey Park Hospital	101	26,704	72.4%	37.8%	55.9%	5.3%	0.0%	1.0%
Queen of Angels – Hollywood Presbyterian	410	113,693	76.0%	38.1%	54.4%	5.7%	0.0%	1.7%
San Dimas Community Hospital	93	27,202	80.1%	35.4%	46.1%	17.1%	0.0%	1.3%
Suburban Medical Center	182	32,993	49.7%	18.1%	75.6%	4.7%	0.0%	1.6%
USC University Hospital	219	73,401	78.6%	48.7%	11.0%	39.5%	0.0%	0.8%
Whittier Hospital Medical Center	181	40,155	60.8%	39.7%	42.1%	16.6%	0.0%	1.6%
Orange County								
Chapman Medical Center	106	27,387	70.8%	27.0%	31.6%	36.4%	1.4%	3.6%
Coastal Communities Hospital	178	40,952	63.0%	33.1%	57.8%	4.2%	2.9%	2.0%

EXHIBIT 41. Inpatient Occupancy Rates and Payer Mix for Los Angeles Area Hospitals, 2003, cont.

System/Hospital	Staffed Beds	Inpatient Days	Occupancy	Medicare Share of Days	Medi-Cal Share of Days	Third Party Share of Days	County Indigent Share of Days	Other Payers Share of Days
Tenet Health, cont.								
Orange County, cont.								
Fountain Valley Regional Hospital – Euclid	387	93,289	66.0%	40.3%	24.1%	30.3%	2.7%	2.5%
Garden Grove Hospital	168	28,709	46.8%	37.1%	37.2%	20.3%	3.0%	2.4%
Irvine Medical Center	176	31,027	48.3%	42.1%	1.9%	53.6%	0.6%	1.8%
Los Alamitos Medical Center	167	41,292	67.7%	71.3%	8.0%	18.5%	1.0%	1.2%
Placentia – Linda Community Hospital	114	12,271	29.5%	45.0%	10.0%	40.5%	1.8%	2.7%
Santa Ana Hospital Medical Center	69	4,098	16.3%	34.4%	56.3%	7.0%	0.0%	2.3%
Western Medical Center – Anaheim	181	44,496	67.4%	35.6%	35.2%	21.5%	5.2%	2.6%
Western Medical Center – Santa Ana	280	64,926	63.5%	37.0%	29.7%	27.1%	4.1%	2.1%
University of California	**1,460**	**350,860**	**64.6%**	**32.3%**	**20.1%**	**41.1%**	**1.9%**	**4.7%**
Santa Monica UCLA Medical Center	337	60,307	49.0%	50.4%	7.5%	39.4%	0.0%	2.7%
UCLA Medical Center	670	170,647	69.8%	31.3%	15.3%	48.4%	0.2%	4.7%
UCLA Neuropsychiatric Hospital	70	25,005	69.2%	26.2%	11.4%	54.1%	0.0%	8.3%
UC Irvine Medical Center	383	94,901	67.9%	24.0%	39.2%	25.5%	6.5%	4.7%
West Hills Hospital & Medical Center	**138**	**43,147**	**50.1%**	**57.4%**	**3.0%**	**38.3%**	**0.0%**	**1.4%**
Other Hospitals	**7,589**	**2,013,500**	**64.7%**	**42.5%**	**28.5%**	**22.0%**	**0.3%**	**6.6%**
Los Angeles County								
Alhambra Hospital – Alhambra	144	39,721	75.6%	54.0%	37.4%	3.6%	0.0%	5.0%
Antelope Valley Hospital Medical Center	329	97,447	81.1%	40.2%	26.8%	26.3%	0.0%	6.7%
Avalon Municipal Hospital and Clinic	12	2,150	49.1%	17.1%	80.2%	2.5%	0.0%	0.2%
Beverly Hospital	223	51,649	63.5%	47.6%	35.6%	14.7%	0.0%	2.1%
Children's Hospital of Los Angeles	279	84,654	81.1%	0.3%	71.4%	27.4%	0.2%	0.7%
Citrus Valley Medical Center	547	129,681	65.0%	41.6%	35.4%	20.5%	0.0%	2.6%
City of Angels Medical Center	180	40,235	61.2%	30.1%	60.6%	2.2%	0.0%	7.1%
Coast Plaza Doctors Hospital	123	18,436	41.1%	46.5%	26.5%	23.3%	0.0%	3.7%
Community Hospital of Long Beach	71	13,799	25.7%	75.2%	5.0%	13.2%	0.0%	6.5%
Doctors Hospital of West Covina	28	9,563	51.4%	15.2%	81.5%	3.0%	0.0%	0.2%
Downey Regional Medical Center	193	42,653	60.5%	51.7%	20.2%	25.0%	0.0%	3.1%
East Los Angeles Doctor's Hospital	127	26,303	56.7%	26.0%	61.3%	4.3%	0.1%	8.3%
East Valley Hospital Medical Center	118	17,669	41.0%	55.7%	30.4%	11.6%	0.0%	2.3%
Elastar Community Hospital	110	16,071	40.0%	55.2%	31.3%	9.9%	0.0%	3.7%
Foothill Presbyterian Hospital	106	20,611	53.3%	54.0%	11.9%	32.1%	0.0%	2.0%
Good Samaritan Hospital	362	95,081	72.0%	51.9%	17.2%	27.8%	0.0%	3.1%
Henry Mayo Newhall Memorial Hospital	217	51,670	65.2%	49.1%	10.1%	33.8%	0.9%	6.0%
Huntington Memorial Hospital	374	136,150	71.5%	51.7%	14.1%	30.6%	0.2%	3.4%
Kindred Hospital – La Mirada	224	59,051	65.2%	90.7%	1.6%	7.7%	0.0%	0.0%
Lancaster Community Hospital	78	27,989	65.5%	71.7%	5.8%	19.2%	0.0%	3.3%
Lincoln Hospital Medical Center	36	2,546	19.4%	41.1%	50.9%	6.5%	0.0%	1.5%
Memorial Hospital of Gardena	107	36,537	58.2%	31.7%	62.0%	4.0%	0.0%	2.3%
Methodist Hospital of Southern California	238	73,315	70.5%	64.0%	10.1%	23.6%	0.0%	2.3%

EXHIBIT 41. Inpatient Occupancy Rates and Payer Mix for Los Angeles Area Hospitals, 2003, cont.

System/Hospital	Staffed Beds	Inpatient Days	Occupancy	Medicare Share of Days	Medi-Cal Share of Days	Third Party Share of Days	County Indigent Share of Days	Other Payers Share of Days
Other Hospitals, cont.								
Los Angeles County, cont.								
Mission Community Hospital – Panorama	145	33,141	62.6%	44.1%	49.0%	2.8%	0.0%	4.0%
Motion Picture and Television Hospital	366	107,512	76.1%	8.1%	42.3%	1.6%	0.0%	47.9%
Orthopaedic Hospital	73	5,687	13.9%	19.3%	41.0%	28.3%	0.0%	11.4%
Pacific Alliance Medical Center	79	28,265	56.1%	54.6%	42.1%	2.2%	0.0%	1.0%
Pacific Hospital of Long Beach	139	46,453	69.2%	22.0%	67.2%	10.4%	0.0%	0.4%
Pomona Valley Hospital Medical Center	436	102,558	64.4%	38.5%	39.7%	19.7%	0.0%	2.0%
Presbyterian Intercommunity Hospital	234	77,665	62.8%	45.9%	17.5%	32.4%	0.0%	4.3%
San Vicente Hospital	17	221	3.6%	0.0%	54.3%	45.7%	0.0%	0.0%
Santa Teresita Hospital	216	60,037	76.2%	15.8%	52.0%	6.6%	0.0%	25.7%
Sherman Oaks Hospital & Health Center	153	28,564	51.1%	72.6%	7.9%	16.4%	0.0%	3.0%
Shriners Hospital – Los Angeles	60	13,479	61.5%	0.0%	0.0%	0.0%	0.0%	100.0%
St. John's Hospital and Health Center	233	69,440	81.7%	67.4%	0.8%	29.8%	0.0%	2.1%
Orange County								
Children's Hospital at Mission	48	8,210	46.9%	0.0%	24.7%	73.8%	0.0%	1.6%
Children's Hospital of Orange County	202	43,084	58.4%	0.2%	48.1%	50.9%	0.0%	0.8%
College Hospital Costa Mesa	82	30,349	70.3%	15.3%	48.5%	34.3%	0.7%	1.2%
Healthbridge Children's Hospital – Orange	24	8,478	96.8%	0.0%	59.2%	40.8%	0.0%	0.0%
Hoag Memorial Hospital Presbyterian	345	106,742	84.8%	44.8%	2.7%	47.6%	1.3%	3.6%
Huntington Beach Hospital	64	22,511	47.1%	55.5%	22.2%	15.6%	5.0%	1.7%
Kindred Hospital Brea	48	15,889	90.7%	76.5%	10.9%	12.7%	0.0%	0.0%
Kindred Hospital Westminster	109	38,001	95.5%	63.7%	9.3%	27.1%	0.0%	0.0%
La Palma Intercommunity Hospital	141	21,015	40.8%	31.7%	15.2%	52.2%	0.0%	0.8%
San Clemente Hospital & Med Center	33	11,605	44.8%	63.1%	3.2%	27.7%	2.1%	3.9%
West Anaheim Medical Center	116	41,613	52.1%	71.8%	5.6%	18.1%	3.7%	0.8%
TOTAL	27,606	7,053,642	63.9%	40.1%	28.2%	24.5%	3.4%	3.9%

Source: Author's analysis of annual hospital report data for year-end 2003 from office of Statewide Health Planning and Development.

than 2001 when average occupancy for the area was 62.9 percent.

Within the largest systems, occupancy rates ranged from 72.1 percent at the Los Angeles County hospitals and 70.3 percent at the four Sisters of Providence hospitals to 57.7 percent at the Kaiser hospitals in Los Angeles to 62.8 percent at the Tenet hospitals. Cedars-Sinai reported occupancy of 87.1 percent in 2003. Total inpatient days at the Los Angeles County hospitals decreased from 622,000 in 2001 to 613,000 in 2003. Similarly, inpatient days declined at the St. Joseph hospitals from 249,000 to 231.000.

Payer Mix

Medicare (including senior HMO plans) covered 40.1 percent of inpatient days for hospitals in the Los Angeles/Orange County region in 2003. Medicare was a more significant payer for the CHW and Sisters of Providence hospitals, and it covered 44.7 percent of inpatient days at the Tenet hospitals in the area. The Los Angeles County hospitals see a relatively small number of Medicare patients.

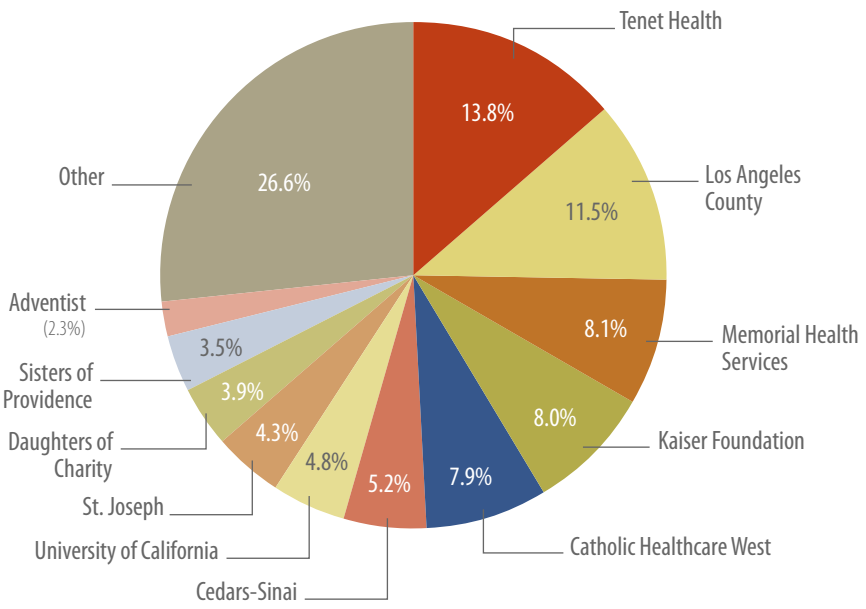
Medi-Cal paid for about 28.2 percent of inpatient days in the area in 2003. Medi-Cal is an especially important payer to the Los Angeles County hospitals (as are county indigent funds) and some of the Tenet hospitals. According to the OSHPD data there were about 1.9 million inpatient days covered by Medi-Cal for these hospitals in 2003. Tenet hospitals

had 372,000 inpatient days covered by Medi-Cal, more than the Los Angeles County hospitals, which had 321,000. The CHW hospitals had 140,000 Medi-Cal days.

Commercial insurers and managed care plans covered 24.5 percent of inpatient days. Some systems see a higher proportion of managed care patients, including St. Joseph in Orange County and Cedars-Sinai. By comparison with the Bay Area, southern California hospitals see a higher proportion of Medi-Cal patients and a smaller share of commercially insured patients.

Exhibit 42 looks at hospital market share across the Los Angeles/Orange Counties area. The figure shows that Tenet Health had almost 14 percent of the market, less than it had two years earlier. And, as it sells off other hospitals in the state, Tenet's market share will continue to decline. The Los Angeles County hospitals accounted for 11.5 percent of inpatient hospital days in the two counties for 2003. Memorial Health Services, Kaiser and Catholic Healthcare West each had about 8 percent of the market that year.

EXHIBIT 42. Market Share for Los Angeles Area Hospital Systems, 2003



Source: Author's analysis of annual hospital report data for year-end 2003 from the Office of Statewide Health Planning and Development.

Physician Organizations

Integrated medical groups are the most prominent form of physician organization in southern California. Exhibit 43 provides an overview of the larger Los Angeles and Orange County medical groups. Some of them have grown in the past two years by internal growth and by absorbing other medical groups.

By far the largest medical group in the area is the Southern California Permanente Medical Group. However, it reports fewer patients in 2004 than in 2002 and the same number of physicians. HealthCare Partners is a large medical group with 28 clinic locations around Los Angeles County. Its patient base of about a half million capitated patients has not grown in the past two years, reflecting the decision of employers to switch out of HMO plans. However, HealthCare Partners continues to add physicians, both in its medical group and in the IPAs for which it provides administrative services. Other large medical groups include LaVida Medical Group, Facey Medical Foundation in the northern valleys, and Bristol Park Medical Group in Orange County. Large medical foundations include St. Joseph Heritage Healthcare, Monarch Healthcare, and Greater Newport Physicians Medical Group. The largest IPA listed here is Physician Associates of the Greater San Gabriel Valley.

Many of these medical groups are trying to reposition themselves so that they can gain PPO patients to replace the capitated HMO lives they have lost. However, their administrative systems and their medical practice protocols are very focused on capitated HMO lives. They also face the possibility that patients switched to a PPO plan in part to get away from "managed care medicine" in these medical groups. Still, they are bullish on the capitated model and think that Medicare HMO plans will gain enrollees again, which would be good for the medical groups.

Medicare enrollees have been generally more profitable for medical groups than commercial patients. In interviews, medical group executives and consultants agreed this was one reason that commercial payment rates (and HMO premiums) have been lower in southern than in northern California: Medical groups were willing to accept lower payments for commercial business knowing that their Medicare profits would offset the lower commercial payments.

See Section 2.1 for a description of the new regional pricing by CalPERS that illustrates this regional difference in health care costs and health plan premiums.

EXHIBIT 43. Los Angeles Area Physician Organizations, 2004 (includes Los Angeles and Orange counties)

Physician Organization	Estimated Enrollment	Number of PCPs	Number of Specs	Number of Clinic Sites	Management Entity	Notes
Group Practice						
Bright Medical Associates	41,000	73	250	6	Integrated Medical Management, Inc. (Bright Medical Associates)	Includes IPA type panel.
Bristol Park Medical Group	109,000	90	550	11	Bristol Park Medical Group, Inc.	Self-managed
Community Medical Group of the West Valley, Inc.	41,750	37	121	2	Progressive Healthcare Systems, LLC (Community Medical Group)	Includes IPA type panel.
Facey Medical Foundation	121,000	95	107	11	Facey Medical Foundation	MSO of Hospital System
Gateway Medical Group	42,000	181	865	0	Pinnacle Health Resources	MSO of Sponsoring Group
Harriman Jones Medical Group	43,150	23	116	3	Harriman Jones Medical Group, a Professional Corporation	MSO of Sponsoring Group
HealthCare Partners Medical Group	497,300	613	866	28	HealthCare Partners Management Company, Inc.	
Hispanic Physicians IPA	12,600	43	171	0	Physicians Care Management Company, Inc.	Includes IPA type panel.
La Vida Medical Group	189,100	580	3,500	10	La Vida Medical Group, Inc.	Includes IPA type panel.
Lakeside Medical Group	90,700	208	645	5	Lakeside Healthcare, Inc.	Includes IPA type panel.
Pacific Alliance Medical Group	10,250	64	195	5	SynerMed	
Southern California Permanente Medical Group	1,747,100	1,053	1,537	69	Southern California Permanente Medical Group	
Talbert Medical Group, Inc.	73,500	79	282	9	Talbert Medical Management Corporation	
IPA						
Accountable Health Care IPA	29,850	161	290	0	Accountable Healthcare MSO	
Affiliated Doctors of Orange County	61,200	285	630	0	Affiliated Management Services (a Partnership)	MSO of Own Medical Group
Allied Physicians of California	57,800	311	272	0	Network Medical Management, Inc.	
Arta Health Network	14,200	257	461	0	Western Medical Management, LLC	
Arta Western Medical Group	40,900	298	437	0	Western Medical Management, LLC	
Bay Area Community Medical Group	30,400	70	250	0	Santa Monica Bay Physicians Health Services, Inc.	MSO of Own Medical Group
Capnet IPA	5,900	70	80	0	Meridian Holdings, Inc.	
CareMore Medical Group	72,000	200	500	0	CareMore Medical Management Company, a California Limited Partnership	
Exceptional Care Medical Group	26,900	143	196	0	CAP Management Systems (CMS-Tenet)	
Global Care Medical Group	49,700	360	458	0	MedPoint Management, Inc.	
Good Samaritan Medical Practice Association	29,800	122	351	0	Advanced Medical Management, Inc.	
Greater Covina Medical Group	29,500	98	197	0	Heritage Provider Network, Inc.	
Lakewood Health Plan	53,800	150	195	0	Lakewood Health Plan, Inc, a Medical Group	
Memorial Healthcare IPA	67,200	236	264	1	Independent Physician Management, LLC	
New Horizon Medical Group IPA	8,900	48	111	0	MV Medical Management	
Noble Community Medical Associates	38,300	145	232	0	Quality Medical Management, Inc. / Cap Management Systems	
Northridge Medical Group IPA	35,200	100	385	0	Meridian Health Care Management	
Omnicare Health Systems Medical Group	50,900	178	239	0	Advanced Medical Management, Inc.	
Pacific Independent Physicians Association	48,100	175	290	0	California Management Service Enterprise, a California Limited Partnership	
Physician Associates of the Greater San Gabriel Valley	133,800	325	610	0	Physician Associates of the Greater San Gabriel Valley, a Medical Group Inc.	
Physicians' Healthways	60,700	386	185	0	HealthCare Partners, Ltd.	

EXHIBIT 43. Los Angeles Area Physician Organizations, 2004 (includes Los Angeles and Orange counties), cont.

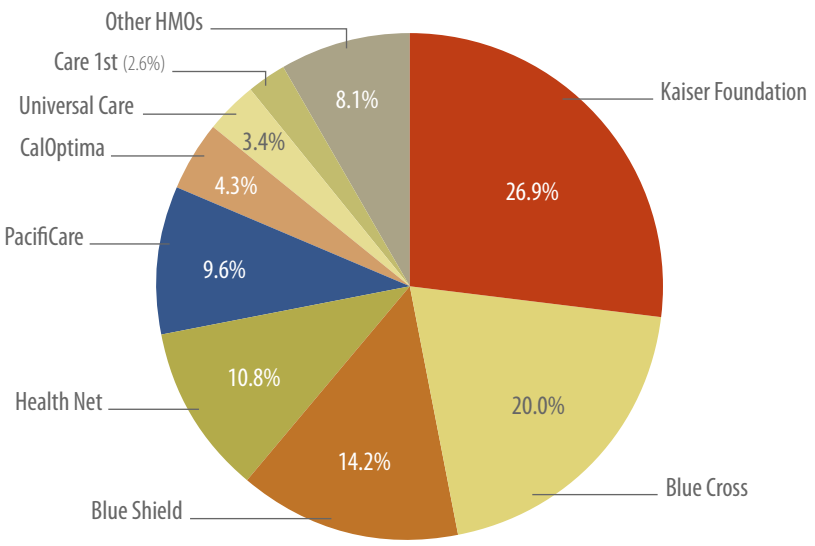
Physician Organization	Estimated Enrollment	Number of PCPs	Number of Specs	Number of Clinic Sites	Management Entity	Notes
IPA, cont.						
Physicians of Greater Long Beach IPA	16,150	86	149	0	Managed Care Innovations	
Preferred IPA of California	71,500	370	580	0	Thrifty Management Services, Inc.	
Pro Med Health Network of Pomona Valley	66,100	109	170	0	Pro Med Healthcare Administrators	
Prospect Health Source Medical Group	41,100	110	125	0	Prospect Medical Systems, Inc.	
Prospect Medical Group	15,000	353	535	0	Prospect Medical Systems, Inc.	
Prospect NWOC Medical Group	25,500	111	175	0	Prospect Medical Systems, Inc.	
Prospect Professional Care Medical Group	44,800	233	283	0	Prospect Medical Systems, Inc.	Listed 22,400 for each county.
Universal Care Medical Group	63,200	110	500	12	Universal Care (HMO)	Self-managed
West Covina Medical Group	28,000	23	60	3	Combined Management Services, Inc.	
Medical Foundation						
Cedars-Sinai Medical Care Foundation	62,500	125	500	7	Cedars-Sinai Medical Care Foundation	MSO of Hospital System
Greater Newport Physicians Medical Group	137,100	142	346	0	Greater Newport Physicians Medical Group, Inc.	Self-managed
Monarch Healthcare	157,100	434	1,273	0	Physician Weblink of California	MSO of Sponsoring Group
Presbyterian Health Physicians	39,100	140	160	3	HealthMed Services, Inc. (Presbyterian Intercommunity Hospital)	Includes medical group.
St. Joseph Heritage Healthcare	191,500	310	667	15	St. Jude Hospital Yorba Linda	MSO of Hospital System
State/County/Faculty/Staff						
Los Angeles County Dept. of Health Services	105,100	402	3,598	27	County of Los Angeles Dept. of Health Services	
UCLA Medical Group	70,980	130	1,200	28	UCLA Medical Center	Includes 100-physician Internal Medicine Faculty Group, consisting of old Santa Monica Medical Center Group and United Physicians Association of Santa Monica; both merged into UCLA July 1, 2001.

Source: Adopted from Cattaneo & Stroud's medical group inventory, April 2004.

Although the environment for medical groups is calmer now, all are aware of the problems that plagued some groups in the late 1990s. At that time some large medical groups went bankrupt, in some cases causing significant disruption. One example is the group that at the end was called the KPC/Chaudhari Medical Centers. It was constructed from the remnants of some other medical groups that had once been prominent in the area, including Friendly Hills Health Care Network and Mullikin Medical Center. A key problem was that some of these groups seemed always to be willing to accept less than other groups. In other words, they were all racing to the bottom. In the end, some groups failed and they also helped to drive down payment rates for other medical groups.

Even if the atmosphere is calmer than in the past, the challenges remain. Some medical groups are concerned that their size is not adequate to support the kind of investment in administrative systems that they need, or to give them the geographic coverage that some health plans demand. There have been some tentative efforts to bring smaller medical groups (50,000 to 100,000 patients) together for both purposes—broader geographic coverage and a bigger base of patients to cover investment in systems—but these have not succeeded. There have also been discussions between Kaiser Permanente and some medical groups in southern California about entering the Kaiser system. Kaiser generally adds capacity internally, but it has recently shown more interest in acquisition.

EXHIBIT 44. Estimated Market Share for Los Angeles Area HMOs, 2003



Sources: Based on HMO annual statements and author's surveys of health plans. Where health plan did not respond to survey, commercial enrollment is based on author's estimates compared to results of Cattaneo & Stroud annual survey of health plan enrollment; Medi-Cal enrollment based on monthly enrollment reports from the Department of Health Services; Medicare enrollment based on quarterly enrollment reports posted by Center for Medicare and Medicaid Services on www.cms.hhs.gov.

Health Plans

According to the estimates made in constructing Exhibit 13, 7.6 million people in the area, or 52.3 percent of Los Angeles County residents and 56.1 percent of Orange County residents were enrolled in an HMO in 2003. The largest HMO in the area is Kaiser Permanente followed by Blue Cross.

Exhibit 44 shows an estimate of market share of the largest health plans in Los Angeles and Orange Counties combined. Blue Shield has grown its enrollment and is now the third largest HMO in the region. Three HMOs that are primarily contracting with the state for Medi-Cal managed care — CalOptima, Universal Care, and Care 1st — are now among the largest in the region.

In 2003 about 4.7 million people in the area were enrolled in a commercial HMO plan, which is fewer than in previous years and is expected to decline further in the next few years. However, there is no hard data about where these enrollees migrate. Some may end up as uninsured, while others may have employers who move them to different types of plans that are less expensive for the employer because employees pay a larger share of the costs in co-payments and deductibles. Most of those plans, whether they are coupled with a spending account, high deductible, or other kinds of features, are being offered outside of HMOs.

The number of Los Angeles/Orange County seniors in Medicare+Choice HMOs peaked at about 508,000 in 2000 but then declined to 446,000 in 2002. Based on quarterly data reports from the Centers for Medicare and Medicaid Services, that trend changed and the number of seniors in Medicare HMO plans in the two counties increased to 483,000 at the end of 2003. There are still 10 or 11 HMOs offering senior plans in the Los Angeles area, including one new plan. Seniors here have more options than in other parts of the state, and have become justifiably apprehensive about joining Medicare HMOs. The supplementary benefits that were once so appealing were cut back and the once-low enrollee co-premium has increased significantly. For now, the infusion of new federal dollars (to the point where the federal government is paying more for HMOs than for traditional plans) has enabled the HMOs to expand benefits and reduce enrollee co-premiums and co-payments.

Enrollment in Medi-Cal managed care plans has fallen in the first half of 2004. In Los Angeles, a two-plan model county, L.A. Care reported a decrease in Medi-Cal enrollment from 767,000 at the end of 2003 to 720,000 in June 2004. That is based on its report to the Department of Managed Health Care for the second quarter of 2004. The county continues its model of subcontracting out enrollees and risk to health plan partners. With the demise two years ago of MaxiCare and Tower Health, Los Angeles County has fewer partners left. Health Net is the commercial plan for the county and it also subcontracts out a portion of its enrollees to Molina and Universal Care.

CalOptima did not experience the same kind of decrease as L.A. Care did in 2004. Orange County operates as a county-organized health system but also has subcontracting arrangements for a portion of its Medi-Cal enrollees. One of its key subcontractors has been Blue Cross, but that arrangement ended earlier in 2003. As often happens, this arrangement came to an end with disputes over money. Even after leaving its 30,000 enrollees in Orange County, Blue Cross remains the largest Medi-Cal contractor for the rest of the state.

4.6 Inland Empire

The growing counties of Riverside and San Bernardino are referred to as California's Inland Empire. The region's population has grown from 3 million in the 2000 census to 3.7 million according to the state's 2003 estimate. Almost two-thirds of the population is enrolled in one of 15 HMOs. While the economy of the area is linked to Los Angeles and Orange Counties, it is in many respects its own territory. This is also true of the health care systems in these counties. Some of the major hospital systems in the state are represented here, yet most of the 5,550 inpatient beds in the area are not in systems.

Overview of Hospitals

Kaiser has two acute care hospitals in the area, in Fontana and Riverside. It also operates an inpatient facility for chemical dependency. Both San Bernardino and Riverside Counties own their own county hospitals and there is a district hospital at San Gorgonio. For-profit systems that have a presence here include Tenet, Universal Health Systems, and HCA, which owns Riverside Community Hospital.

The religious hospital systems in the area include Catholic Healthcare West and St. Joseph Health System of Orange, which operates St. Mary Regional Medical Center in Apple Valley.

With 653 acute care beds, the largest hospital in the area is Loma Linda University Medical Center, which is affiliated with the Seventh Day Adventist church (though separate from the Adventist Health system). A group of doctors and investors has submitted plans to build a new $40 million surgical hospital in Loma Linda, which would specialize in cardiovascular and orthopedic surgeries. For the time being, the hospital is probably subject to a moratorium on new specialty hospitals that was inserted in the Medicare Modernization Act.

As often happens in these situations, established hospitals were critical of the proposed new Loma Linda facility, saying it would draw patients away from the other hospitals, reducing necessary revenues to offset shortfalls from government payers and uninsured patients. In some places (Columbus, Ohio is a prominent example), established hospitals have fought bitterly against new specialty hospitals, threatening to revoke the staff privileges of doctors who invest in competing specialty facilities.

Financial Results

As shown in Exhibit 45 on the next page, hospitals in the area posted net income of $188.0 million or 6.0 percent of total revenues. That is well above the net income of $126.6 million they reported in 2001. Much of the net income was from Desert Regional Medical Center in Palm Springs, a Tenet Health hospital. On the other hand, CHW hospitals in the area lost $12.6 million in 2003 and Valley Health, a local three-hospital system, reported a small loss in 2003.

Some of the independent hospitals, including Eisenhower Medical Center in Rancho Mirage had strong net income. Loma Linda University Medical Center, had net income of $19.2 million in 2003. Arrowhead Regional in Colton had a significant operating loss in 2003, even more than in 2001.

Occupancy

As shown in Exhibit 46 on page 94, occupancy in hospitals in the region averaged 68.4 percent in 2003, up from 66.2 percent in 2001. The largest hospital in the area, Loma Linda University Medical Center, had occupancy of 78.8 percent. The Tenet hospitals had average occupancy of 92.3 percent, the Kaiser hospitals averaged 64.8 percent, and the Catholic Healthcare West hospitals averaged 67.9 percent. Arrowhead Regional hospital had occupancy of 77.8 percent. Inpatient hospital days were virtually the same in 2001 and 2003.

Payer Mix

Exhibit 46 shows that Medicare covered an average of 42.8 percent of inpatient days in 2003, while Medi-Cal covered 29.2 percent. Commercial payers including managed care covered 22.4 percent of inpatient days.

Medicare was an especially important payer to the Valley Health system, where 69.7 percent of inpatient days are covered by Medicare. Medicare is less significant to Loma Linda University Medical Center.

Hospitals in this region provided 440,000 inpatient days of care to Medi-Cal recipients. Loma Linda University was the biggest provider, with 81,000 Medi-Cal days. The two CHW hospitals provided 66,000 Medi-Cal days while Arrowhead Regional provided 53,000 Medi-Cal days.

Physician Organizations

Exhibit 47 on page 95 shows that the Permanente Medical Group clinics in this region now have more than 1,200 doctors serving about 572,000 patients. That is fewer patients than a year ago. The Loma Linda University Health Care group has about 418 physicians, most of them specialists. The Beaver Medical Group now numbers about 133 physicians, plus it provides IPA management services. It reported 93,500 capitated lives.

Another large group is PrimeCare Medical Network, which includes 941 doctors in the area in medical groups and IPA arrangements. PrimeCare Medical

EXHIBIT 45. Revenues and Profitability for Inland Empire Hospitals, 2003

System/Hospitals	City	Total Charges	Net Patient Revenue	Total Revenue	Operating Expenses	Net from Operations	Net Income	% of Total Revenue
Catholic Healthcare West		**$1,104,198,285**	**$265,630,466**	**$270,969,601**	**281,801,398**	**$– 12,993,721**	**$– 12,618,307**	**– 4.7%**
Community Hospital	San Bernardino	452,631,547	107,210,395	109,957,398	113,731,826	– 4,495,409	– 4,040,881	– 3.7%
St. Bernardine Medical	San Bernardino	651,566,738	158,420,071	161,012,203	168,069,572	– 8,498,312	– 8,577,426	– 5.3%
Kaiser Foundation*								
Tenet Health		**$2,274,859,042**	**$407,485,698**	**$413,877,491**	**$328,438,865**	**$81,506,458**	**$82,024,865**	**19.8%**
Desert Regional	Palm Springs	1,473,856,505	286,359,026	291,173,396	209,537,382	78,953,524	79,842,424	27.4%
John F. Kennedy Memorial	Indio	458,925,974	68,448,658	69,146,839	67,361,677	1,181,472	1,101,234	1.6%
Suburban Medical Center	Paramount	342,076,563	52,678,014	53,557,256	51,539,806	1,371,462	1,081,207	2.0%
Valley Health		**$595,757,175**	**$158,095,749**	**$159,681,841**	**$163,797,004**	**$– 4,964,843**	**$– 4,131,380**	**– 2.6%**
Hemet Valley Medical	Hemet	338,881,023	93,005,320	93,748,706	94,743,335	– 1,206,807	– 1,010,846	– 1.1%
Menifee Valley Medical	Sun City	134,325,994	32,134,938	32,614,832	33,186,728	– 896,212	– 571,896	– 1.8%
Moreno Valley Community	Moreno Valley	122,550,158	32,955,491	33,318,303	35,866,941	– 2,861,824	– 2,548,638	– 7.6%
Other Hospitals		**$6,655,186,869**	**$2,121,943,474**	**$2,309,076,988**	**$2,158,163,450**	**$35,635,004**	**$122,697,300**	**5.3%**
Arrowhead Regional	Colton	604,623,078	249,005,753	308,046,735	307,834,092	– 57,314,163	212,643	0.1%
Barstow Community	Barstow	121,635,332	29,605,659	29,669,689	23,562,196	6,107,493	5,025,179	16.9%
Bear Valley Community	Big Bear Lake	13,144,362	10,698,359	11,218,293	9,840,316	915,439	1,377,977	12.3%
Canyon Ridge Hospital	Chino	16,582,410	7,973,989	8,008,980	8,233,069	– 224,089	– 224,089	– 2.8%
Chino Valley Medical Center	Chino	142,639,508	43,874,375	44,250,439	45,965,310	– 1,814,324	– 1,896,673	– 4.3%
Colorado River Medical	Needles	65,934,973	24,053,061	24,360,834	19,877,467	4,244,722	4,483,367	18.4%
Corona Regional Medical	Corona	304,290,520	86,354,459	91,187,559	78,398,687	10,192,927	5,886,768	6.5%
Desert Valley Hospital	Victorville	175,452,793	47,301,377	48,612,806	44,634,118	2,833,426	1,934,496	4.0%
Doctors' Hospital	Montclair	69,824,077	20,910,902	21,242,792	23,112,914	– 2,099,325	– 2,135,747	– 10.1%
Eisenhower Medical Center	Rancho Mirage	948,249,831	231,037,769	260,620,001	231,142,077	5,599,023	23,328,628	9.0%
Hi-Desert Medical Center	Joshua Tree	68,557,094	35,083,903	37,770,476	39,659,251	– 4,637,757	– 3,022,823	– 8.0%
Kindred Hospital Ontario	Ontario	145,182,381	40,563,654	40,666,300	33,599,949	7,066,351	7,066,351	17.4%
Loma Linda University	Loma Linda	1,793,651,052	603,989,634	674,056,397	654,083,694	3,893,039	19,158,227	2.8%
Mammoth Hospital	Mammoth Lakes	32,934,000	24,767,401	27,317,279	23,678,885	1,373,780	2,848,591	10.4%
Northern Inyo Hospital	Bishop	38,853,876	25,225,255	26,604,746	25,494,820	– 38,881	1,109,763	4.2%
Riverside Community	Riverside	622,259,178	186,004,670	189,680,355	174,749,925	13,327,772	14,461,640	7.6%
San Gorgonio Memorial	Banning	54,387,912	19,321,982	19,457,504	20,626,182	– 1,181,927	– 1,170,478	– 6.0%
Southern Inyo Hospital	Lone Pine	7,156,932	4,415,143	5,485,986	4,795,692	– 109,514	690,294	12.6%
Southwest Healthcare	Murrieta	461,179,946	139,820,654	140,867,109	114,633,414	25,825,511	26,134,346	18.6%
St. Mary Regional Medical	Apple Valley	325,377,841	103,394,590	104,793,776	99,526,145	5,239,977	4,157,112	4.0%
Sun Health Robert H. Ballard Rehab Hospital	San Bernardino	22,505,532	13,665,153	13,719,566	13,395,571	309,930	323,995	2.4%
Valley Plaza Doctors	Perris	30,676,895	8,200,668	8,823,691	9,389,926	– 1,108,000	– 836,088	– 9.5%
Victor Valley Community	Victorville	140,614,445	39,756,951	40,761,816	39,931,114	– 25,684	830,702	2.0%
TOTAL		**$10,630,001,371**	**$2,953,155,387**	**$3,153,605,921**	**$2,932,200,717**	**$99,182,898**	**$187,972,478**	**6.0%**

*Data for Kaiser hospitals is incorporated into Exhibit 40 with other southern California hospitals.
Source: Author's analysis of annual hospital report data for year-end 2003 from office of Statewide Health Planning and Development.

EXHIBIT 46. Inpatient Occupancy Rates and Payer Mix for Inland Empire Hospitals, 2003

System/Hospital	Staffed Beds	Inpatient Days	Occupancy	Medicare Share of Days	Medi-Cal Share of Days	Third Party Share of Days	County Indigent Share of Days	Other Payers Share of Days
Catholic Healthcare West	**577**	**145,731**	**67.9%**	**37.0%**	**45.4%**	**14.1%**	**0.4%**	**3.1%**
Community Hospital of San Bernardino	292	77,033	69.7%	30.1%	62.5%	5.2%	0.0%	2.2%
St. Bernardine Medical Center	285	68,698	66.0%	44.8%	26.2%	24.2%	0.8%	4.1%
Kaiser Foundation	**639**	**151,246**	**64.8%**	**43.0%**	**3.0%**	**51.1%**	**0.3%**	**2.5%**
Kaiser Foundation – Fontana	424	97,084	62.7%	41.3%	3.5%	51.9%	0.3%	3.0%
Kaiser Foundation – Riverside	215	54,162	69.0%	46.0%	2.2%	49.8%	0.4%	1.6%
Tenet Health	**561**	**160,669**	**92.3%**	**41.1%**	**38.7%**	**1.4%**	**15.6%**	**3.2%**
Desert Regional Medical Center	263	96,029	81.0%	48.2%	25.7%	19.9%	2.0%	4.3%
John F. Kennedy Memorial Hospital	116	31,647	57.0%	43.7%	39.7%	14.0%	1.0%	1.7%
Suburban Medical Center	182	32,993	49.7%	18.1%	75.6%	4.7%	0.0%	1.6%
Valley Health	**551**	**127,894**	**63.6%**	**69.7%**	**17.0%**	**10.1%**	**0.2%**	**3.1%**
Hemet Valley Medical Center	395	87,783	60.9%	71.5%	16.7%	8.2%	0.2%	3.3%
Menifee Valley Medical Center	84	21,168	69.0%	84.2%	3.5%	10.2%	0.2%	1.9%
Moreno Valley Community Hospital	72	18,943	72.1%	45.3%	33.2%	18.4%	0.0%	3.1%
Other Hospitals	**3,403**	**920,567**	**70.1%**	**40.2%**	**31.0%**	**3.8%**	**21.9%**	**3.2%**
Arrowhead Regional Medical Center	353	105,912	77.8%	12.5%	50.2%	10.2%	27.1%	0.0%
Barstow Community Hospital	27	9,772	63.7%	51.2%	23.9%	21.6%	0.0%	3.3%
Bear Valley Community Hospital	24	7,396	84.4%	4.0%	93.9%	1.7%	0.0%	0.4%
Canyon Ridge Hospital	59	14,442	67.1%	27.8%	18.5%	43.0%	8.8%	1.9%
Chino Valley Medical Center	55	19,129	41.6%	37.1%	30.2%	26.5%	0.0%	6.1%
Colorado River Medical Center	49	9,103	50.9%	57.6%	10.1%	29.6%	0.0%	2.7%
Corona Regional Medical Center – Main	216	48,204	61.1%	48.5%	29.4%	20.4%	0.8%	0.8%
Desert Valley Hospital	73	17,111	64.2%	62.3%	11.6%	22.5%	1.0%	2.6%
Doctors' Hospital of Montclair	102	11,118	60.2%	36.8%	32.2%	26.1%	0.1%	4.8%
Eisenhower Medical Center	249	68,356	71.8%	68.8%	7.0%	21.3%	0.1%	2.8%
Hi-Desert Medical Center	158	49,335	77.2%	25.1%	65.5%	7.3%	0.3%	1.9%
Kindred Hospital Ontario	91	32,198	96.9%	83.0%	0.0%	0.0%	0.0%	17.0%
Loma Linda University Medical Center	653	187,726	78.8%	23.8%	43.2%	31.1%	0.7%	1.2%
Mammoth Hospital	15	1,557	28.4%	16.1%	15.3%	56.5%	0.8%	11.4%
Northern Inyo Hospital	32	2,956	25.3%	49.4%	18.6%	24.1%	3.9%	3.9%
Riverside Community Hospital	364	86,360	65.0%	42.9%	19.7%	33.2%	0.6%	3.6%
San Antonio Community Hospital	254	65,318	70.5%	48.7%	10.7%	38.5%	0.0%	2.2%
San Gorgonio Memorial Hospital	48	16,603	65.0%	54.2%	17.8%	25.4%	0.3%	2.2%
Southern Inyo Hospital	37	11,861	87.8%	5.5%	87.3%	0.6%	0.2%	6.5%
Southwest Healthcare System – Murrieta	130	47,029	73.2%	49.0%	12.4%	32.4%	0.7%	5.5%
St. Mary Regional Medical Center	186	49,618	73.1%	54.7%	20.9%	22.1%	0.8%	1.4%
Sun Health Robert H. Ballard Rehab	60	14,283	65.2%	50.5%	22.2%	27.3%	0.0%	0.0%
Valley Plaza Doctors Hospital	41	2,527	16.9%	52.1%	25.8%	14.3%	0.0%	7.7%
Victor Valley Community Hospital	74	27,569	65.7%	30.9%	38.5%	22.6%	3.3%	4.6%
TOTAL	**5,731**	**1,506,107**	**68.4%**	**42.8%**	**29.2%**	**22.4%**	**2.6%**	**3.1%**

Source: Author's analysis of annual hospital report data for year-end 2003 from office of Statewide Health Planning and Development.

EXHIBIT 47. Inland Empire Physician Organizations, 2004 (includes Imperial, Riverside, and San Bernardino counties)

Physician Organization	Estimated Enrollment	Number of PCPs	Number of Specs	Number of Clinic Sites	Management Entity	Notes
Group Practice						
Beaver Medical Group	93,500	70	63	9	Epic Management LP (Beaver Medical Group)	Includes IPA type panel.
Desert Family Practice Associates	9,400	12	40	0	Primary Provider Management Company, Inc.	Includes IPA type panel.
Desert Valley Medical Group	14,800	16	109	6	Desert Valley Medical Group, Inc.	Self-managed
Family Practice Medical Group of San Bernardino	10,000	11	95	0	Family Practice Medical Group of San Bernardino, Inc.	Includes IPA type panel.
High Desert Primary Care Medical Group	17,100	17	68	2	High Desert Primary Care Medical Group, a California General Partnership	
Inland Faculty Medical Group	18,700	60	140	8	Arrowhead Medical Management Services, Inc. (Inland Faculty)	
Inland Healthcare Group, a Medical Corporation	26,100	26	167	0	Inland Health Organization of Southern California	Includes IPA type panel.
Lasalle Medical Associates	34,100	38	0	4	MV Medical Management	Independent MSO
Molina Healthcare of California	11,800	8	0	4	Molina Healthcare of California	
PrimeCare Medical Network	232,000	291	650	11	North American Medical Management California	Includes IPA type panel.
Riverside Medical Clinic	69,700	56	48	7	Riverside Medical Clinic, Inc.	
San Bernardino Medical Group	14,900	18	173	1	San Bernardino Medical Group, Inc.	
Southern California Permanente Medical Group	571,900	561	649	24	Southern California Permanente Medical Group	
United Family Care Medical Corporation	18,600	14	169	3	United Family Care, Inc, a Medical Corporation	
IPA						
Alpha Care Medical Group	23,900	47	196	0	Primary Provider Management Company	
Empire Physicians Medical Group	9,000	44	140	0	Primary Provider Management Company, Inc.	
Family/Seniors Medical Group	5,200	12	300	0	Meridian Health Care Management	
Hemet Community Medical Group	58,000	123	172	0	KM Strategic Management, LLC	
Heritage Provider Network, Inc.	47,100	186	170	4	Heritage Provider Network, Inc.	
Mission Medical Group	26,550	70	109	0	Primary Provider Management Company	
Physicians Health Network Medical Corp	15,700	55	147	0	Epic Management LP (Beaver Medical Group)	
Pro Med Health Network of Pomona Valley	8,900	79	50	0	Pro Med Healthcare Administrators	
Riverside Physician Network / Riverside Community Health Agency	51,000	87	208	12	Riverside Community Healthplan Medical Group, Inc.	
Riverside Family Health Medical Group	5,500	17	170	0	MedPoint Management, Inc.	
St. Mary Choice Medical Group, a Medical Corp	33,450	42	116	0	Desert Physicians Management, LLC	Old Corwin IPA and merger of St. Mary Medical Group and Choice Medical Group IPAs. Effective September 1, 2001 became self-administered.
Vantage Medical Group	96,300	166	490	0	Primary Provider Management Company, Inc.	
Medical Foundation						
Loma Linda University Health Care	30,600	168	250	8	Adventist Health Managed Care	Includes medical group.

Source: Adopted from Cattaneo & Stroud's medical group inventory, April 2004.

Network is one of the only southern California medical groups that retains aspects of the 1990s model of physician organization, management, and HMO contracting. It holds a Knox-Keene license with waivers. North American Medical Management, one of the few physician management companies left over from the 1990s, provides management services.

Health Plans

Based on the analysis reflected in Exhibit 13, about 64 percent of the population of the Inland Empire is enrolled in an HMO. By the estimates in this analysis, more than 2.3 million people belong to HMOs here. Kaiser Permanente is the largest HMO in the area with more than 620,000 lives. Blue Cross has about 365,000 HMO members here, and Blue Shield is third with about 283,000 lives.

These counties are a popular retirement destination, and Medicare managed care is still competitive in the area with eight or nine HMOs selling senior plans. About 54,000 of Kaiser's enrollees are in its Medicare HMO plan. PacifiCare has about 46,000 seniors in its Secure Horizons plan. Another Medicare HMO is Long Beach-based SCAN Health Plan, which was created as a Social HMO, combining Medicare benefits and other services to seniors. It has about 13,000 seniors in Riverside and San Bernardino.

Riverside and San Bernardino counties collaborate for Medi-Cal managed care in a two-plan model, and have a strong local initiative plan that works closely with the two county hospitals. The county plan, Inland Empire Health Plan, has more than 220,000 Medi-Cal members. Its provider network includes the two county hospitals, public health agencies, community health centers, and some of the large group practices in the area. Molina Medical Centers is the commercial plan. In 2004, Molina had about 92,000 Medi-Cal enrollees in those two counties.

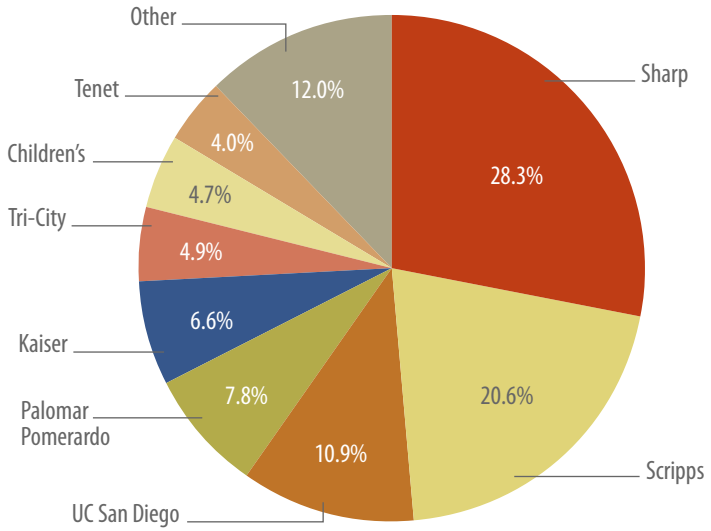
4.7 San Diego/Imperial Counties

This analysis looks at San Diego County and also Imperial County, a largely rural area to the east. As has been pointed out in past editions of this report, the San Diego area constitutes a distinctive and enclosed health care market. San Diego hospitals are mostly nonprofit organizations but without religious affiliation, unlike most of the nonprofit hospitals in the state. Its major provider systems — Sharp, Scripps Health, and the University of California – San Diego — are local and do not have significant ties to hospital systems in other parts of the state. In the past, interviewees have said that even the Kaiser system in the San Diego area is not like Kaiser in other parts of the state.

San Diego County has difficult challenges but also has important health care resources. Most San Diego employers are smaller businesses based in the area, and smaller businesses are usually less able to offer health benefits to their employees. About 600,000 people in San Diego County (15.0 percent) do not have health insurance, a lower uninsured rate than in some other parts of the state, but still a major problem. (The comparable rate in Los Angeles County is 20 percent.)

The region's hospital systems, to differing degrees, provide significant amounts of care to people without insurance. There is an active community health foundation that promotes community-based approaches to addressing health care issues, through grantmaking and by convening employers, providers, consumers, and government agencies to become part of the solution. San Diego is one of only two counties that has a competitive model for Medi-Cal managed care in which seven HMOs seek to enroll Medi-Cal recipients. All of these factors contribute to an optimistic sense that a community can be innovative and have a real impact on problems of health care access, cost, and quality.

EXHIBIT 48. Market Share for San Diego Area Hospital Systems, 2003



Source: Author's analysis of annual hospital report data for year-end 2003 from the Office of Statewide Health Planning and Development.

Overview of Hospitals

Exhibit 48 on the previous page shows the relative market share of the major hospital systems in the San Diego area in 2003. With 28.3 percent of the inpatient hospital days in the county, Sharp has the largest share, followed by the Scripps Health hospitals (20.6 percent), and the University of California – San Diego Medical Center (10.9 percent).

The Scripps system grew during the 1990s as several community hospitals affiliated with each other. Kaiser's single hospital in the area is also a major provider of care with 6.6 percent of the inpatient days. Earlier, Kaiser had explored constructing its own hospital in the northern part of the county. For now it has chosen to continue its working relationship with the Palomar Pomerado district hospitals.

Both Sharp and Scripps Health are closely tied to medical groups. (Those ties have not always been so close or cordial, particularly in the case of Scripps.) For example, Scripps Clinic has about 350 physicians in a medical foundation, and Scripps Health also provides management services to a 470-doctor IPA, San Diego Physicians Medical Group. Sharp has two large affiliated medical groups and provides management services to the Sharp Community Medical Group IPA.

Hospital districts operate four hospitals in the northern part of the county. The Palomar Pomerado district operates hospitals in Escondido and Poway. Tri City Medical Center in Oceanside is a district hospital as is Fallbrook hospital.

For-profit hospital systems have only a small presence here. Tenet owns the Alvarado Hospital Medical Center in San Diego. (This hospital and some of its administrators were recently the targets of federal investigations into certain payment practices.) HCA/Columbia owned the Mission Bay hospital in the 1990s and attempted a deal with the Sharp system that would have made it a major presence in the area. That proposed transaction stirred enormous controversy and was never completed.

Financial Results

Exhibit 49 the follows shows that hospitals in the area reported net income of $82.2 million in 2003, which was 2.4 percent of total revenue. In 2001 the hospitals reported average margins of 2.7 percent. In general, hospitals made money on operations and benefited from other revenues, including investment income and philanthropy.

The University of California – San Diego Medical Center lost $6.2 million on total revenues of $471.6, which includes disproportionate share hospital funds and county indigent care funds. The Sharp hospitals had net income of $27.6 million, which was 3.0 percent of total revenue. That was an improvement over net income of $19 million in 2000 but less than $34.0 million in 2001. The two Palomar Pomerado hospitals reported net income of $11 million or 3.9 percent of total revenue.

Occupancy

There is a significant amount of health care construction taking place in the San Diego area, including both hospital facilities and health centers. Clinics are trying to keep up with new population growth in places like Rancho Bernardo on the Interstate Highway 15 corridor to the north. As shown in Exhibit 50 on page 99, average 2003 occupancy rates for inpatient care in the San Diego area were 68.5 percent — slightly higher than in other parts of the state. The rate is also a few percentage points higher than for the comparable period in 2000.

The Palomar Pomerado hospital district will add new patient towers to both hospitals, thereby solving the seismic standard compliance issues at one of the hospitals and the capacity problems at the other, which is of relatively new construction. The hospitals have fairly close ties with Kaiser, which has deferred construction of a new north county hospital in favor of heavy use of the district hospitals and the specialists that practice there. Kaiser just completed the second phase of an ambulatory medical center in San Marcos near the district hospital, and has long-range plans for a third phase of expansion. Scripps Health has apparently shelved plans to build a medical center in San Marcos.

Occupancy rates are relatively higher at the Kaiser Foundation hospital (73.2 percent), the Scripps Health hospitals (71.2 percent), and Sharp hospitals (73.3 percent). Inpatient use rates at the University of California – San Diego Medical Center are slightly below average at 67.4 percent.

Payer Mix

On average, Medicare covered 40.4 percent inpatient days in 2003. Medicare is especially important to the Scripps hospitals, where it covers 45.5 percent of inpatient days. Medicare is also very important at Alvarado Medical Center, a Tenet hospital.

Medi-Cal covers an average of 25.6 percent of inpatient days in the area and paid for 406,400 inpatient days in 2003. Major providers of care for Medi-Cal patients include the Sharp hospitals (124,000 days), Children's Hospital (49,000) and the University of California – San Diego (41,000 days).

EXHIBIT 49. Revenues and Profitability for San Diego Area Hospitals, 2003

System/Hospitals	City	Total Charges	Net Patient Revenue	Total Revenue	Operating Expenses	Net from Operations	Net Income	% of Total Revenue
Kaiser Foundation*								
Palomar Pomerado		**$777,832,706**	**$274,579,755**	**$286,667,061**	**$275,531,084**	**$6,891,738**	**$11,040,636**	**3.9%**
Palomar Medical Center	Escondido	561,774,402	198,648,001	208,275,367	196,204,303	8,688,259	11,976,841	5.8%
Pomerado Hospital	Poway	216,058,304	75,931,754	78,391,694	79,326,781	– 1,796,521	– 936,205	– 1.2%
Scripps		**$2,625,594,118**	**$835,721,738**	**$865,671,508**	**$833,591,134**	**$27,014,058**	**$32,111,221**	**3.7%**
Scripps Green Hospital	La Jolla	443,986,020	149,739,490	159,091,934	147,106,780	11,985,154	11,985,154	7.5%
Scripps Memorial Hospital	Chula Vista	268,015,241	78,481,549	81,215,856	89,628,999	– 8,413,143	– 7,719,166	– 9.5%
Scripps Memorial Hospital	Encinitas	260,987,651	83,420,231	85,172,356	87,103,363	– 3,000,707	– 1,931,007	– 2.3%
Scripps Memorial Hospital	La Jolla	866,375,142	267,140,469	277,185,384	261,840,127	14,844,705	15,345,257	5.5%
Scripps Mercy Hospital	San Diego	786,230,064	256,939,999	263,005,978	247,911,865	11,598,049	14,430,983	5.5%
Sharp		**$3,107,781,877**	**$880,821,586**	**$908,753,521**	**$871,248,776**	**$23,395,874**	**$27,585,767**	**3.0%**
Sharp Cabrillo Hospital	San Diego	36,399,153	13,059,870	13,082,693	17,617,977	– 4,536,551	– 4,653,838	– 35.6%
Sharp Chula Vista	Chula Vista	559,181,320	136,002,085	138,898,713	140,846,175	– 4,032,102	– 2,612,456	– 1.9%
Sharp Coronado	Coronado	107,765,488	37,699,000	39,753,850	42,089,280	– 4,371,324	– 4,190,121	– 10.5%
Sharp Grossmont Hospital	La Mesa	1,067,603,533	292,896,848	299,025,395	284,075,928	9,880,428	10,968,419	3.7%
Sharp Mary Birch Hospital	San Diego	237,965,464	66,363,979	66,931,168	57,656,191	8,950,548	8,967,311	13.4%
Sharp Memorial Hospital	San Diego	1,098,866,919	334,799,804	351,061,702	328,963,225	17,504,875	19,106,452	5.4%
Alvarado Hospital	**San Diego**	**$793,576,924**	**$155,018,341**	**$158,758,128**	**127,380,120**	**$28,945,848**	**$28,352,432**	**17.9%**
UC San Diego Medical	**San Diego**	**$1,040,330,586**	**$433,809,972**	**$471,578,647**	**476,397,820**	**$58,734,734**	**$– 6,174,048**	**– 1.3%**
Other		**$2,013,085,462**	**$700,510,479**	**$773,283,552**	**781,708,943**	**$– 46,787,919**	**$– 10,725,708**	**– 1.4%**
Children's Hospital	San Diego	574,534,265	230,883,092	275,280,979	293,195,921	– 37,801,026	– 18,252,848	– 6.6%
Continental Rehab Hospital	San Diego	34,325,846	17,521,685	17,654,682	18,460,323	– 895,105	– 805,641	– 4.6%
El Centro Regional	El Centro	153,377,620	53,439,031	56,922,308	54,063,911	1,966,926	2,195,287	3.9%
Fallbrook Hospital District	Fallbrook	95,641,988	31,841,304	31,964,560	28,891,160	3,043,763	3,073,400	9.6%
Paradise Valley Hospital	National City	444,098,721	114,182,996	121,277,942	121,209,895	– 3,785,591	– 1,100,257	– 0.9%
Pioneers Memorial Hospital	Brawley	122,537,041	43,345,223	46,912,487	46,309,110	– 2,311,751	529,141	1.1%
Tri-City Medical Center	Oceanside	522,305,012	179,684,053	193,322,620	190,298,350	– 7,672,836	2,967,509	1.5%
University Community	San Diego	66,264,969	29,613,095	29,947,974	29,280,273	667,701	667,701	2.2%
TOTAL		**$10,358,201,673**	**$3,280,461,871**	**$3,464,712,417**	**$3,365,857,877**	**$98,194,333**	**$82,190,300**	**2.4%**

*Data for Kaiser hospitals is incorporated into Exhibit 40 with other southern California hospitals.

Source: Author's analysis of annual hospital report data for year-end 2003 from office of Statewide Health Planning and Development.

EXHIBIT 50. Inpatient Occupancy Rates and Payer Mix for San Diego Area Hospitals, 2003

System/Hospital	Staffed Beds	Inpatient Days	Occupancy	Medicare Share of Days	Medi-Cal Share of Days	Third Party Share of Days	County Indigent Share of Days	Other Payers Share of Days
Kaiser Foundation	**395**	**105,494**	**73.2%**	**43.9%**	**2.6%**	**52.4%**	**0.0%**	**1.1%**
Palomar Pomerado	**482**	**173,776**	**73.4%**	**39.0%**	**34.3%**	**19.5%**	**1.5%**	**5.8%**
Palomar Medical Center	303	109,785	72.8%	39.5%	31.4%	21.0%	2.1%	6.1%
Pomerado Hospital	179	63,991	74.3%	38.1%	39.3%	17.0%	0.5%	5.2%
Scripps	**887**	**326,545**	**71.2%**	**45.5%**	**14.5%**	**31.6%**	**2.8%**	**5.6%**
Scripps Green Hospital	110	38,044	62.0%	58.8%	0.6%	38.1%	0.0%	2.5%
Scripps Memorial Hospital – Chula Vista	124	45,280	81.6%	45.9%	30.6%	11.2%	4.1%	8.2%
Scripps Memorial Hospital – Encinitas	91	38,014	78.3%	55.7%	9.4%	28.6%	3.0%	3.3%
Scripps Memorial Hospital – La Jolla	282	103,085	79.3%	42.2%	5.3%	44.7%	1.2%	6.7%
Scripps Mercy Hospital	280	102,122	62.6%	39.8%	23.7%	26.2%	4.9%	5.4%
Sharp	**1,627**	**449,167**	**73.3%**	**40.5%**	**27.6%**	**26.1%**	**1.3%**	**4.6%**
Sharp Cabrillo Hospital	76	22,178	79.9%	57.6%	21.8%	14.3%	0.0%	6.3%
Sharp Chula Vista Medical Center	315	90,175	78.4%	43.6%	35.4%	14.5%	1.4%	5.1%
Sharp Coronado Hospital	175	51,038	68.5%	12.5%	67.0%	8.6%	0.1%	11.8%
Sharp Grossmont Hospital	433	112,273	71.0%	56.4%	17.6%	19.8%	2.3%	3.9%
Sharp Mary Birch Hospital For Women	166	41,161	67.9%	1.0%	35.8%	62.0%	0.1%	1.1%
Sharp Memorial Hospital	462	132,342	74.8%	45.0%	13.9%	36.9%	1.4%	2.7%
Alvarado Hospital Medical Center	**311**	**65,308**	**57.5%**	**59.8%**	**12.6%**	**21.2%**	**1.6%**	**4.7%**
UC San Diego Medical Center	**463**	**123,194**	**67.4%**	**26.0%**	**33.3%**	**28.6%**	**6.7%**	**5.4%**
Other	**1,211**	**344,100**	**60.6%**	**36.7%**	**36.1%**	**20.0%**	**1.3%**	**6.0%**
Children's Hospital – San Diego	301	78,135	71.1%	0.1%	62.3%	37.1%	0.0%	0.5%
Continental Rehab Hospital for San Diego	110	17,154	42.7%	88.4%	0.0%	11.6%	0.0%	0.0%
El Centro Regional Medical Center	107	26,832	68.7%	48.2%	23.2%	16.9%	4.8%	6.9%
Fallbrook Hospital District	89	31,577	61.8%	34.6%	41.2%	14.2%	0.0%	10.0%
Paradise Valley Hospital	197	71,744	65.3%	43.5%	41.5%	8.0%	2.6%	4.5%
Pioneers Memorial Hospital	99	19,295	53.4%	38.5%	31.3%	22.2%	5.6%	2.4%
Tri-City Medical Center	208	74,044	51.1%	53.0%	12.7%	24.8%	0.0%	9.6%
University Community Medical Center	100	25,319	69.4%	36.4%	43.6%	1.4%	1.6%	17.0%
TOTAL	**5,376**	**1,587,584**	**68.5%**	**40.4%**	**25.6%**	**26.9%**	**2.0%**	**5.1%**

Source: Author's analysis of annual hospital report data for year-end 2003 from office of Statewide Health Planning and Development.

Physician Organizations

Exhibit 51 provides information about 15 of the largest physician groups in San Diego. Scripps Clinic MD Group, a medical foundation, has about 350 doctors and 98,000 enrollees. A second foundation, Scripps Mercy Medical Group, is also affiliated with Scripps Health and has 19 physicians. Management services are provided by Scripps Clinic Health Plan Services, Inc., a foundation affiliated with Scripps Health, which has a Knox-Keene license with waivers. At the end of 2003, the Knox-Keene company reported 152,000 enrollees, mostly in commercial plans. (See Exhibit 6.) The Kaiser Permanente clinics in the area have about 930 doctors. Kaiser also uses outside doctors, particularly in the north county area and for certain specialties.

Health Plans

At the end of 2003, HMO penetration in San Diego was an estimated 53.4 percent, or 1.7 million members out of an estimated population of 3.14 million. (See the analysis for Exhibit 13.) That is lower than in the other major metropolitan areas of the state. The five largest health plans in San Diego County are statewide companies like Kaiser Permanente, PacifiCare, and Blue Cross. Local health plans — Sharp Health Plan and Community Health Group — have grown and play an important role in serving Medi-Cal enrollees, but have a smaller share of the market for employer health plans. The University of California – San Diego ran a Medi-Cal HMO plan until the end of 2003.

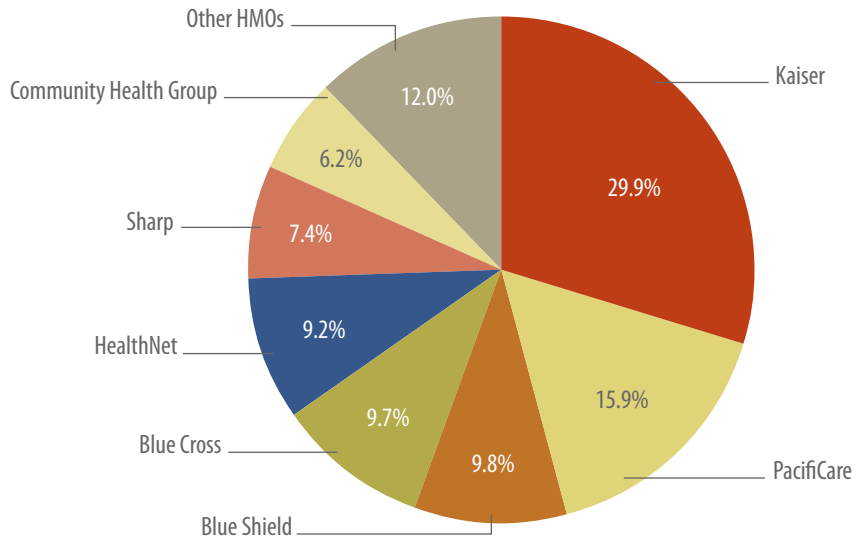
As shown in Exhibit 52 on the next page, Kaiser continues to be the largest HMO in San Diego, with an estimated 29.9 percent of the market. About 1.2 million residents in the area are enrolled in HMO commercial plans. Another 172,000 are in Medi-Cal managed care as of July 2004, split among six HMOs. Sharp Health Plan, one of the few remaining provider-sponsored HMOs

EXHIBIT 51. San Diego Physician Organizations, 2004 (includes San Diego and Imperial counties)

Physician Organization	Estimated Enrollment	Number of PCPs	Specs	Clinic Sites	Management Entity	Notes
Group Practice						
Centre for Health Care Medical Associates	26,900	25	144	4	Centre Care Management Co, LLC	Includes IPA type panel.
Graybill Medical Group, Inc.	500	26	70	4	Graybill Medical Group, Inc.	
Sharp Mission Park Medical Centers	56,900	58	399	9	Sharp Mission Park Medical Group, Inc.	Includes IPA type panel.
Sharp Rees-Stealy Medical Group, Inc.	146,800	97	221	17	Sharp Rees-Stealy Medical Group, Inc.	
Southern California Permanente Medical Group	464,200	411	523	22	Southern California Permanente Medical Group	
IPA						
Children's Physicians Medical Group	57,900	100	250	0	Children's Physicians Medical Group, Inc.	
Greater Tri-Cities IPA Medical Group, Inc.	14,400	32	110	0	Physicians Data Trust, Inc.	
Mercy Physicians Medical Group, Inc.	26,200	58	211	0	North American Medical Management CA	
Primary Care Associates Medical Group, Inc.	55,400	65	275	0	Primary Care Associates Medical Group, Inc.	
Sharp Community Medical Group, Inc.	169,000	232	637	0	Sharp Community Medical Group, Inc.	
San Diego IPA	3,250	39	479	0	Universal Care, Inc (HMO)	
San Diego Physicians Medical Group, Inc.	39,400	112	359	0	Southern California Physicians Managed Care Services, Inc.	
Medical Foundation						
La Maestra Family Clinic	5,550	15	200	2	La Maestra Family Clinic	
Scripps Clinic MD Group, Inc. / Scripps Medical Foundation / Scripps Clinic	98,000	100	250	13	Scripps Clinic Health Plan Services, Inc.	Includes medical group.
Scripps Mercy Medical Group, Inc. / Scripps Medical Foundation	13,800	19	0	2	Scripps Clinic Health Plan Services, Inc.	Includes medical group and IPA.
State/County Faculty/Staff						
UCSD Healthcare Network	35,000	63	500	12	UCSD Healthcare Network	

Source: Adopted from Cattaneo & Stroud's medical group inventory, April 2004.

EXHIBIT 52. Estimated Market Share for San Diego Area HMOs, 2003



Sources: Based on HMO annual statements and author's surveys of health plans. Where health plan did not respond to survey, commercial enrollment is based on author's estimates compared to results of Cattaneo & Stroud annual survey of health plan enrollment; Medi-Cal enrollment based on monthly enrollment reports from the Department of Health Services; Medicare enrollment based on quarterly enrollment reports posted by Center for Medicare and Medicaid Services on www.cms.hhs.gov.

in the state, had the second largest Medi-Cal enrollment in the area. Only Community Health Group is larger. Both Sharp and Universal Care are transitioning their Medi-Cal and Healthy Families members in the area to Molina Healthcare sometime in 2005. That will leave four HMOs competing for Medi-Cal managed care enrollment.

The Sharp hospitals continue to contract with health plans on a capitated basis, which makes them exceptional today in California. For a hospital, sponsoring a health plan and accepting capitation risk are two sides of the same coin. A provider organization that has skilled management and systems in place can succeed with risk arrangements. That is especially true in an environment where premiums are increasing faster than medical costs, which has generally been the case for the past few years in California. The different Sharp medical groups, including Sharp Rees-Steely and Sharp Community Medical Group, were invested in information systems and medical management practices designed for capitated payments. Sharp Health Plan has also been a key partner in an initiative to make employer-sponsored health coverage more accessible. This program, which leveraged grants to subsidize the premiums on a limited benefit health plan, has had a positive impact, helping to raise awareness of health insurance and to get coverage for more employed households.

According to data from the Centers for Medicare and Medicaid Services, 39.5 percent (143,000) of San Diego seniors are enrolled in one of four Medicare+Choice HMOs. The four still participating are PacifiCare, Kaiser Permanente, Health Net, and Blue Cross. Health Net and Blue Cross are small in San Diego, with fewer than 10,000 seniors each. PacifiCare is the largest with 76,000 seniors; Kaiser has about 52,000. Enrollment in senior plans in the area has declined by about 6,000 enrollees since 2002.

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