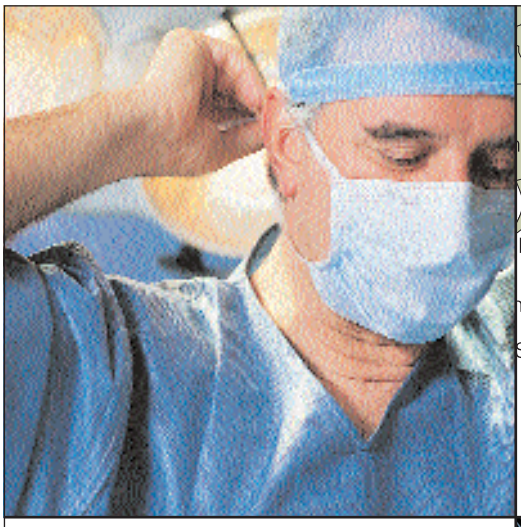
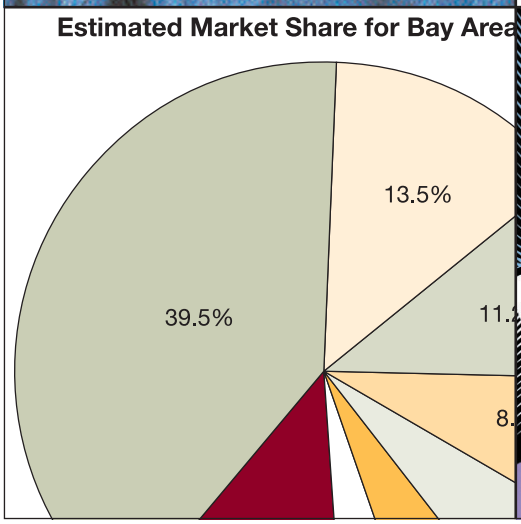
California HealthCare Foundation





California Health Care Market Report 2004

Prepared by Allan Baumgarten

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prepared for

THE CALIFORNIA HEALTHCARE FOUNDATION

Contents

ABOUT THIS REPORT

California is big, not just in geographic area or in population. It also has enormous resources and faces huge economic and social challenges. In health care, it has world class hospitals and physicians and innovative organizations. At the same time, it also has millions of people with no health insurance and is faced with the monumental task of maintaining a safety net for health care that is fraying under the strain of caring for so many people.

California's size is matched by its diversity—whether in geographic features, ethnic background of its people, or local economies. Yet bringing together all this diversity are unifying institutions such as major transportation systems, finance and human service programs operated by state agencies, and the networks of supermarkets and banks whose signs and teller machines are seen throughout the state. Similarly, while health care systems around the state have significant regional differences, they are linked by major organizations that provide health care or purchase and administer health benefit plans.

The *California Health Care Market Report 2004* is intended to be a resource for understanding the organizations that provide health care and purchase and administer health benefit plans in the state, and the market forces affecting them. This is the third annual edition of this report, known in its first two years as *California Managed Care Review.* Recognizing that the scope of this research goes beyond managed care organizations, the report was given a new title this year. The California HealthCare Foundation commissioned the report to provide a resource that would inform health policy debates by providing 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 presents a competitive analysis of data on health plans, hospital systems, and physician organizations. Most of the data are drawn from public sources, including the annual 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. The report examines the financial performance of health plans and hospitals and examines enrollment trends, measures of utilization, and effectiveness of care and patient satisfaction. Second, the author conducted 40 interviews with different leaders in and observers of the California market. These are in addition to 90 or so interviews conducted in preparing the two previous editions of this report. The new interviews, most of them in person, were conducted between November 2002 and June 2003. These interviews provided very helpful perspectives and a complementary context for the data. Interviewees are not quoted directly, but the author has gleaned their insights and placed them in the report as unattributed comments.

This edition of the report is organized into four major sections. The first section summarizes the findings of the research that went into this report. The next part provides an overview of organizations involved in purchasing health benefits, delivery of health care and administering health benefit plans. It focuses on the evolving business relationships that connect these organizations.

The third section of the report provides a detailed analysis of health plans in the state, examining trends in enrollment and net income, and comparing large HMOs on measures of utilization and effectiveness of care. Sidebars in this section benchmark California health plans with their counterparts in the eight other states where the author prepares similar market analyses: Colorado, Florida, Illinois, Michigan, Minnesota, Ohio, Texas, and Wisconsin.

In the fourth section, the report examines health market issues in major regions of 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, the market share of the largest health plans, and the finances and inpatient occupancy of hospital systems.

What Is Managed Care?

The Health Insurance Association of America, a Washington-based insurance industry group, describes managed care systems as 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. And they are less likely to pay providers using capitation contracts that created incentives for the providers to hold down utilization of care.

The managed care industry and HMOs have been the targets of strong negative rhetoric lately, not just in the news media but also in movies and on late night TV talk shows. The industry has shied away from the terms HMO and managed care, preferring alternatives like health plans, comprehensive care, or coordinated care.

1.0 OVERVIEW OF FINDINGS

Health care in California has been based on business and professional relationships that link hospitals, groups of physicians, health plans, and private and public purchasers of health benefits. In the world outside of the Kaiser Permanente system, purchasers paid the health plans and the health plans, in turn, passed premium dollars and insurance risk, and delegated responsibilities to the medical groups. Those relationships have been evolving in the past few years, but the direction of those changes was unclear. In the past year, their heading has become clearer. The circumstances described in last year's report as "relative calm" now appear as a significant challenge to key organizations. There has been a fundamental change in business relationships and in how economic power is held and used.

Here are some key findings in this report:

1. Hospitals and medical groups once were partners, but they are now more likely to be competitors whose economic interests are more in conflict than in alignment. Under the old model of health plan and provider relations, physician groups and hospitals shared risk. If the physicians held down hospital utilization, they shared any dollars left in the payment pools at the end of the year with the hospitals. During the late 1990s, however, those pools of dollars stopped growing and there was much less money left to divide. Through system building and more strategic negotiating, hospitals have used their expanded leverage to escape from risk-sharing contracts. And while the total dollars available from employer premiums for provider payments have increased, hospitals have placed themselves higher on the proverbial food chain and have generally benefited more than medical groups. The relationship between hospitals and medical groups is discussed in Section 2.5, Health Plan/Provider Relations.

2. Medical groups are further challenged by the declining demand for their core competence: managing the care of large numbers of patients enrolled in capitated HMO plans. As in other states, California HMOs have seen their enrollment decline with most of that leakage moving to PPOs and similar arrangements. Many groups report that they have fewer HMO patients and yet they are not well equipped to offset that loss by adding more patients with PPO coverage. They have found that the systems they built to serve capitated HMO patients are not well suited for tasks as basic as filing and collecting on claims for services provided. Their investments, whether in information systems or care management, have been based on managing monthly capitation payments, not on trying to maximize revenues from patients who have more provider choices. This issue is discussed in Section 2.4, Physician Organizations.

3. Variation in practice and performance has emerged as a key issue in payment systems, physician organization and how issues like patient safety are approached. Simply put, there is wide variation in how effectively physicians practice, the rate at which they perform certain procedures and how much they get paid. The introduction of tiered hospital networks with different HMO payment rates for each tier is a good example of how the variation issue can pose challenges. For example, can health plans actually identify the best performing physicians and hospitals? Are the methods used to evaluate providers transparent to those providers and understandable to consumers? Can health plan companies devise payment systems that reward those providers? These variation issues have led to efforts to develop standard measures of practice and performance. For example, the Pay for Performance initiative launched by the Integrated Healthcare Association seeks to tie a component of physician group compensation to achievement of certain clinical measures, enrollee satisfaction, and use of information technology. The issue of variation in practice and performance is discussed in Section 2.4 and tiering of hospitals is covered in Section 2.5.

4. Capacity of hospitals and physicians is now seen as limited instead of excessive, further strengthening providers' negotiating power. Until recently, hospital beds were seen as overbuilt and employers and state officials wondered whether market forces or regulation could somehow "rightsize" the system. Now inpatient capacity seems scarce, although that has as much to do with the available supply of nurses as with bricks and mortar. Hospitals have closed in recent years but hospital administrators say that they are unable to staff hospital units because of the shortage of nurses. Some consultants say that the constraint on capacity is an inefficient use of the available inpatient units. That is, hospitals do not move patients efficiently through and out, resulting in emergency rooms crowded with patients waiting for beds in the upstairs units. Capacity, in turn, has an impact on the prices that providers can charge. In the early days of HMO development, their analysts identified high potential markets as those with lots of (independent) specialists and plenty of hospital capacity. That surplus capacity would mean that providers would compete to have access to patients and allow the health plans to negotiate deep discounts on provider payment rates. Today, certain specialties and facilities are in short supply and they can set their prices much higher. Hospital systems are discussed in Section 2.3, physician groups in Section 2.4.

5. The largest health plans and the largest purchasers continue to have enormous impact on the market. Size is relative and a large HMO in most other states is considered small by California standards. California has five HMOs with 2 million or more enrollees, only a few other states have total HMO enrollment of 2 million. Whether it's loved or hated, Kaiser Permanente is what everything else is compared to. It has set the standard for investment in information systems, put recent public relations misteps behind, and is now challenging dominant local hospitals in several parts of the state. Its for-profit counterpart is Blue Cross of California, which continues to grow in California and to buy health plans in other states. Unlike Kaiser Permanente, Blue Cross has not built networks of clinics and hospitals. It is, however, highly invested in actuarial expertise, customized health plan design, and provider network management—assets that have helped it acquire and successfully manage Blue Cross plans in other states. CalPERS, the agency that purchases health benefits for 1.2 million people, is still viewed as the bellwether purchaser, but now tones of anxiety are mixed with the admiration: "If PERS can't hold down premium increases, how can anyone else?" 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, Trend Review.

6. Everyone talks about wanting more "transparency," but they all intend something different by that term. HMOs talk about the need for more *transparency* in the prices charged by providers or in the cost of drugs. They want consumers to know which hospitals are more expensive or the difference in cost between a name-brand drug and its generic equivalent. The hope is, if consumers can see the difference, they will respond appropriately. Hospitals use the term differently. They say they don't mind being evaluated by the health plans, so long as the assumptions and methods underlying the data analysis are *transparent* and not concealed inside the proverbial black box. For example, is a certain hospital's mortality rate in certain surgeries higher because the difficult cases from other hospitals are transferred there? If so, that should be built in to the analysis and comparison with other hospitals.

2.0 MARKET REVIEW: KEY ORGANIZATIONS

California has enormous health care resources including hospitals, physicians, and public health systems. It also faces significant challenges: a high proportion of the population without health insurance, a health care safety net that has frayed under the pressure of its task, and infrastructure that will require major investment in the coming years. The extent of this challenge has prompted leaders to once again propose mandating universal health coverage. 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.

2.1 Purchasers

Purchasers of health benefits, whether private employers or government agencies, play a crucial role in the markets for health care and health benefits. They have enormous power, but don't always understand how to use it or are reluctant to exercise their influence. They make important choices: who is eligible for coverage, what benefits and services should be covered, whether the members of their plan should be presented with incentives to use certain providers or to adopt certain lifestyles, and so on. Most attention of late has focused on the choice of which health plan or plans should be offered. In addition, as the cost of health benefits has soared, employers are making choices about how much of the cost should be shared with consumers and the specifics of how it should be shared. For example, should consumers pay more of the cost of insurance premiums, thus spreading that cost across all members of the group? Or should consumers pay higher co-payments for office visits and prescription drugs or satisfy a deductible before coverage applies, thus shifting more of the cost to those who are the heaviest users of care?

Shopping for health benefits is challenging—whether you run a hardware store in Modesto, operate a bank with hundreds of branches and thousands of employees, or run the state's Medi-Cal managed care initiatives, purchasing health care for millions of people. The budget for health benefits is understood to be limited, though not fixed. Recent premium increases have pushed those limits for many purchasers. For a few months, "defined contribution" was the buzzword, raising hopes (probably false) for employers that there were ways to limit the cost of their health benefits. Defined contribution was understood as a fixed amount provided to each employee to purchase health benefits. Employees that wanted to buy additional coverage

Purchasers of health benefits, whether private employers or government agencies, play a crucial role in the markets for health care and health benefits. They have enormous power, but don't always understand how to use it or are reluctant to exercise their influence.

✔ Both CalPERS and PBGH represent employers that in the aggregate have very large numbers of employees. Aggregating those employers and their employees has given them significant power in those negotiations—yet they nave not been immune to the same high premium increases that have frustrated other purchasers.

✔ Total enrollment in all CalPERS plans has hovered around 1.1 million in the past three years. In 2003, about 75% of enrollees were in HMOs, 21% in PPOs, and 4.7% in the association plans.

✔ Driving market share to two HMOs mitigated the premium increases somewhat, because Blue Shield was willing to accept a smaller increase in exchange for a larger share of the groups. However, the average increase was still about 18%.

✔ In the open enrollment for 2003, Blue Shield gained virtually all the CalPERS enrollees that had previously been in Health Net or PacifiCare.

or have access to more expensive providers would spend out of their own resources.

Interest in defined contribution has largely disappeared, while new buzzwords have emerged to describe health plans, such as "consumer choice," "consumer directed," or "consumer driven." These plans usually refer to arangements involving a health spending account for each employee to cover 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. Once that deductible has been satisfied, additional insurance applies.

Consumer driven plans all start from a premise that a central problem with today's health benefit plans is a lack of "consumer engagement." For example, some employers and consultants lament that some employees believe a $10 co-payment covers the entire cost of an $85 monthly prescription or a $225 office visit and procedure. If the consumer were paying more of these costs directly—either out of a health spending account or from their checking account—they would better understand the cost of care and why it is important to use a generic drug rather than a more expensive, brand-name prescription. The advocates and designers of consumer driven plans say that the obvious solution is to devise plans that create more consumer engagement.

As in previous editions, this report examines the current strategies of the two largest employer purchasers of health care, the California Public Employees' Retirement System (CalPERS) and the Pacific Business Group on Health (PBGH). Each operates a coalition of employers that sponsor benefit plans, negotiating health benefit plans with managed care companies. Both CalPERS and PBGH represent employers that in the aggregate have very large numbers of employees. Aggregating those employers and their employees has given them significant power in those negotiations—yet they nave not been immune to the same high premium increases that have frustrated other purchasers. (The state's Medi-Cal program is discussed in Section 3.4.)

For much of the 1990s, both CalPERS and PBGH successfully used their purchasing power to hold down premium increases, but by the end of the decade both were facing years of double-digit increases. CalPERS, especially, was rethinking its overall approach to group purchasing. As purchasing coalitions, both face the very real threat that participants will decide they will be better off, at least in the short term, by leaving the coalition and negotiating their own plans.

California Public Employees' Retirement System. The primary responsibility of CalPERS is administration of pension benefits for California state employees and investment of about $130 billion used to pay those benefits. However, it has gained prominence for its work in administering health benefit plans for state employees and for the employees of about 1,300 local government units across the state. It spends about $3.3 billion to purchase health benefits of 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 2003. Total enrollment in all plans has hovered around 1.1 million in the past three years. In 2003, about 75% of enrollees were in HMOs, 21% in PPOs, and 4.7% in the association plans.

HMOs. CalPERS was an early leader when it came to promoting HMO plans and offered 12 HMO plans in 1996. During the next few years it steadily reduced the number of plans offered, sometimes because HMOs folded or merged. Since 2000, it has chosen to do business with fewer HMOs in the hopes of holding down rate increases by driving market share to a smaller number of plans. In 2003, it offered only three HMOs and two self-funded PPO plans, for which Blue Cross provides administrative services. CalPERS also administers association plans for about 40,000 law enforcement personnel.

For the 2003 plan year, HMOs offered proposals to CalPERS that would have increased the premiums by as much as 41%. CalPERS decided to cut out PacifiCare and Health Net and essentially offer two HMOs in most of the state: Kaiser Permanente and Blue Shield. Blue Shield had only 60,000 members in CalPERS groups before 2002. Driving market share to two HMOs mitigated the premium increases somewhat, because Blue Shield was willing to accept a smaller increase in exchange for a larger share of the groups. However, the average increase was still about 18%. Exhibit 18, in the next section of the report, tracks the premiums of the CalPERS HMO and PPO offerings in recent years.

In the open enrollment for 2003, Blue Shield gained virtually all the CalPERS enrollees that had previously been in Health Net or PacifiCare. Its CalPERS enrollment went from 119,000 to 435,000, an increase of 267%. Kaiser Permanente gained only 5,000 net members from those groups.

PPOs. Enrollment in CalPERS' PPOs has grown steadily, which has created both challenges and opportunities. There were about 100,000 CalPERS enrollees in PPOs in 1996, which comprised about 11% of the total group. By 2003, PPO enrollment was 224,000 or 21% of total enrollment. Much of

the growth at first seemed to be due to 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. The price of the PPO plans increased significantly as the CalPERS board moved to make up deficits in the self-funded plans. In a self-funded arrangement, the employer has to maintain reserves that are adequate to pay claims as they are submitted. CalPERS saw its reserves dwindle and imposed hefty premium increases on those PPO plans to restore the reserves.

Another reason for PPO enrollment growth is the growing number of service areas in the state where no HMOs are contracting with CalPERS. In those areas, where the PPOs are the only option, the employers participating in CalPERS had to provide additional subsidies so those enrollees were not at a disadvantage. In negotiations with their unions, the different government units have 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 also been high, PPOs do provide an alternative approach to provider contracting and managing of benefits. For example, with a PPO the plan sponsor can often get more complete information on patients and their health care encounters because the plan sponsor is self-funded and the physician bills the PPO for each encounter and procedure. In contrast, California HMOs (and in turn, the plan sponsors) usually do not get full encounter data from the medical groups that they are paying on a capitated basis.

Future strategies. CalPERS has considered expanding its self-funded plans, even to the point of not using HMOs at all and placing all enrollees in self-funded plans. One advantage to that would be to get better data on utilization of members. Minnesota still uses HMOs to provide administrative services (network access, eligibility, enrollment, and claims payment)

- ✔ For 2004, CalPERS employers face average annual premium increases in the 16-18% range.
- ✔ CalPERS has been slower than other major employers to increase enrollee cost-sharing.
- ✔ A key issue facing CalPERS is whether to maintain statewide pricing for its health plans.
- ✔ The ability of CalPERS to hold on to its members throughout the state is a critical issue.

Exhibit 1

Enrollment in CalPERS Health Plan Options, 1996-2003: Active and Retiree Enrollment in Basic Plans

Health Plan	1996	1997	1998	1999	2000	2001	2002	June-03	Change 2002/2003	2003 Share
HMOs	**739,981**	**756,008**	**770,533**	**775,262**	**796,081**	**878,063**	**849,797**	**813,431**	**-4.3%**	**74.7%**
Kaiser Permanente	294,460	298,347	306,146	310,213	324,649	347,866	368,417	373,544	1.4%	34.3%
Health Net	201,886	199,258	202,805	207,018	215,544	223,344	162,924			0.0%
PacifiCare	103,014	101,866	99,788	99,592	107,164	130,936	175,574			0.0%
Blue Shield HMO*	31,267	37,508	42,746	45,317	44,766	59,478	118,566	435,164	267.0%	40.0%
CIGNA	35,023	31,388	30,541	27,336	27,709	29,232				0.0%
Aetna U.S. Healthcare	23,609	24,945	27,807	28,474	31,124	36,003				0.0%
Lifeguard	16,699	21,887	24,605	25,923	27,937	28,514				0.0%
Omni	14,609	18,560	19,976	15,187						0.0%
Maxicare	8,980	8,521	8,653	8,424	8,606	9,546				0.0%
Health Plan of the Redwoods	7,738	7,843	7,466	7,778	7,255	7,322				0.0%
National	2,696	5,885								0.0%
Universal Care					1,327	5,822	19,135			0.0%
Western Health Advantage							5,181	4,723	-8.8%	0.4%
PPOs	99,538	100,219	108,678	122,796	157,486	166,243	217,372	223,745	2.9%	20.6%
PERS Care	63,359	56,731	55,075	50,840	51,942	39,180	34,874	30,032	-13.9%	2.8%
PERS Choice	36,179	43,488	53,603	71,956	105,544	127,063	182,498	193,713	6.1%	17.8%
Association Plans	41,922	37,006	36,493	35,988	34,161	38,166	41,943	51,038	21.7%	4.7%
California Association of Highway Patrolman	15,240	16,403	17,261	17,940	18,638	20,401	21,852	22,879	4.7%	2.1%
California Correction and Peace Officers Association	17,933	12,860	11,764	10,974	9,695	9,426	9,637	17,121	77.7%	1.6%
Peace Officers Retirement Association of California	4,630	4,577	4,933	4,844	5,828	8,339	10,454	11,038	5.6%	1.0%
TOTAL	882,066	893,695	916,221	934,577	988,203	1,082,472	1,109,112	1,088,214	-1.9%	100.0%

Source: Author's analysis of CalPERS enrollment reports.

*According to Blue Shield, its enrollment in the CalPERS group is consistently higher than what appears in the CalPERS reports used to prepare this table. In June 2003, for example, Blue Shield reported enrollment of 459,626 compared to 435,164 in the CalPERS report. In 2002, the numbers were 123,642 and 118,566, respectively.

✔ PBGH was an early endorser of the Pay for Performance initiative developed by the Integrated Healthcare Association.

✔ PBGH disseminates comparative information on health plans—and now provider groups—through its HealthScope Web site—www.healthscope.org.

✔ PBGH added some new plan designs as options for member companies participating in the purchasing alliance.

for its state employees but decided to self-fund all of its benefit plans a few years ago. All the encounter data go into a data warehouse where the state can analyze patterns of utilization and relative cost of care at the physician level.

For 2004, CalPERS employers face average annual premium increases in the 16-18% range. The board approved some modest increases in enrollee cost-sharing in order to mitigate projected premium increases, but declined to adopt other staff proposals that would have more far-reaching impact. For example, the board did not approve a plan to develop regional rates that would have reflected the higher costs of hospitals and health plans in northern California, and it did not accept other proposals for higher enrollee co-payments for services.

CalPERS has been slower than other major employers to increase enrollee cost-sharing. That is largely due to battles with employee unions in past years over relatively small increases in prescription drug co-payments, for example. Like other employers, it tries to strike a balance between requiring all employees to absorb part of premium increases by setting their contribution higher, and putting more of the responsibility specifically on those employees who are regular users of care, in the form of co-payments and deductibles.

The move to fewer plan options apparently held down premium increases for 2004, at least when compared to the original proposals. Still, contracting with only two HMOs (except in the Sacramento area) also creates the risk of dependence on those two plans, the services they provide, and the prices they propose. CalPERS apparently sees the risks as outweighed by the potential for lower administrative costs, the opportunity to work more closely with two plans, and to link future payment rates to measures of quality.

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 utiliizers of care. CalPERS will also seek to moderate annual premium increases by entering into multi-year contracts with health plans, specifically Blue Shield. At this point, it expects to continue working with HMOs, although it is unlikely to add new plan options.

Absent from the CalPERS agenda for the future are some options that were considered in the past but rejected eventually. One example is moving to a system of direct contracting with medical groups, bypassing the HMO middleman. (In California "direct contracting" usually refers to an HMO bypassing medical groups and contracting with individual doctors or clinics, not to employers bypassing the HMOs.) In either case, one layer of administration would be passed over, which might provide some savings to the employer. After examining the experience of employers in Minnesota that use this approach, CalPERS concluded that it would require significant start-up costs to make the change and that the savings from reduced layers of administration would not be enough justify that investment.

Regional pricing. A key issue facing CalPERS is whether to maintain statewide pricing for its health plans. Local governments in southern California argue that their health care costs are lower than in the north, and so that they are effectively subsidizing those government units. There is a strong possibility that some of them will leave the coalition to negotiate coverage on their own. And if they are able to negotiate better deals, it is likely that their employees are younger and utilize less care than the average across all the CalPERS units. An exodus of groups would reduce the size and bargaining power of the CalPERS coalition, possibly resulting in even higher costs in future years. Other states, including Colorado, have sought to introduce some notion of regional pricing for their public employee plans. That has met with strong resistance from those employees who live in areas considered expensive and who would be asked to pay more for their coverage. In any event, the ability of CalPERS to hold on to its members throughout the state is a critical issue. In August 2003, it was announced that 27 local government units would withdraw from the CalPERS health benefit plans for 2004. Eight others will withdraw some of their employees. In total, an estimated 47,000 members and dependents would be affected by the change, or about 4% of the 1.1 million people enrolled in CalPERS health plans during 2003. PacifiCare and other health plans have announced that they will develop new plan designs to market to local government units.

Pacific Business Group on Health. The Pacific Business Group on Health (PBGH) is a national leader in involving employers in quality improvement and purchasing initiatives. Nearly 50 large companies are members of PBGH and many, though not all of them, purchase their employee health benefits through PBGH. It is a founding member of several collaboratives that are involved in collecting quality data on health plans and in surveying 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 have joined together to promote initiatives to

improve patient safety and quality of care in hospitals. See www.leapfroggroup.org/.) Similarly, PBGH was an early endorser of the Pay for Performance initiative developed by the Integrated Healthcare Association. However, its employer members have been hesitant to commit to paying additional premiums that would then be distributed to high-performing medical groups. The Pay for Performance initiative is described in Section 2.4.

Some major companies exited the PBGH buying coalition in recent years after mergers or relocation of corporate headquarters. Others decided that they could obtain better pricing, at least in the short-term, by negotiating their own deals with health plans. To extend the benefits of its purchasing expertise to smaller employers, PBGH took over administration of the state's health insurance purchasing pool, renamed it PacAdvantage, and is marketing it to small and medium employers.

PBGH disseminates comparative information on health plans—and now provider groups—through its HealthScope Web site—www.healthscope.org. While the site focuses on supporting the enrollment process for member companies, it also offers public access to most of its health plan information.

New plan designs. Beginning in 2003, PBGH added some new plan designs as options for member companies participating in the purchasing alliance. One of the new options is being offered through Definity, a Minneapolis-based company that organizes and markets "consumer choice" plans for employers. In the Definity model, the employer funds a medical spending account and offers a major medical insurance policy. The spending account may be $1,000 and the major medical policy may kick in after the enrollee has satisfied a $2,500 deductible. Depending on the employer's rules, the spending account can be used for non-covered benefits, such as Lasik eye surgery or complementary and alternative therapies. The gap between where the spending account is depleted and the major medical coverage begins is the responsibility of the consumer. The overall goal is to make consumers more careful about the kind of care they receive (to the extent they have choices) and to be more aware of the cost of care. These options supplement the current HMO and PPO offerings of those employers and do not replace them.

The University of Minnesota began to offer Definity two years ago alongside an HMO, a PPO, and the Patient Choice plan of competing health care systems. The early returns for that group shows that Definity got about 5% of the enrollment. And while some employers are concerned that the plan will attract mostly healthy employees who consume little care, the initial experience for some employers suggests that a mix of enrollees select that option. Health economists from the University of Minnesota have been studying the acceptance of these plans at the university and in other groups, and their preliminary reports suggest that some older members who are high utilizers of care think the consumer choice plan is well suited to their needs.

It is noteworthy that PBGH is trying to broaden the plan options available to its members—partly to give a boost to innovation, and partly in the hopes of moderating premium increases. CalPERS, on the other hand, has sought to contain cost increases by dividing its pool of enrollees into fewer segments.

2.2 Health Plans

Most Californians get their health benefits through their employers who in turn contract with health maintenance organizations (HMOs) and preferred provider organizations or arrangements (PPOs). (See the sidebar for a description of these two kinds of managed care plans.) California employers use HMOs more than their counterparts in other states. Even so, a growing number are now using PPO plans. According to the most recent Kaiser Family Foundation/HRET survey, 54% of employed Californians were in HMOs in 2002 and 30% were in PPOs. (Kaiser Family Foundation and Health Research and Educational Trust, California Employer Health Benefits Survey, 2002, February 2003.) A year earlier, 49% in California were in HMOs and 26% were in PPOs. (These numbers were restated in the Kaiser Family Foundation/HRET new report.) The national averages for 2002 were 26% in HMOs and 52% in PPOs.

The Knox-Keene Act, California's primary law governing HMOs, uses the term health care service plans. The California Department of Managed Health Care (DMHC), created in 1999, is the state's regulator of HMOs. It took over from the Department of Corporations in 2000. Advisory boards work with the DMHC on issues such as quality and health plan solvency.

The Department of Insurance regulates some California PPOs and indemnity insurance plans. From time to time legislators and others proposed that a single agency regulate all health insurance, but those proposals have not prevailed.

Under the Knox-Keene Act, the DMHC also licenses health plans that provide a managed health benefit limited to a single service, such as dental care, vision, mental health, or chiropractic. For example, there are 16 plans licensed for vision services, some of which double as dental plans. There are 10 single service plans for administering behavioral health benefits. This report focuses on HMOs that adminis-

Types of Managed Care Plans

Health Maintenance Organizations (HMOs): Prepaid plans that provide comprehensive care to enrollees. 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 (discounted) fee schedule 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. 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.

- ✔ 54% of employed Californians were in HMOs and 30% were in PPOs in 2002.
- ✔ Blue Cross of California is the largest administrator of PPO arrangements in the state.
- ✔ The number of plans doing commercial business in the state has dropped sharply, sometimes because of insolvency, sometimes through acquisition, and sometimes as in the case of United HealthCare, because of changes in core business strategies.
- ✔ The list of insolvent health plans has grown in the past year.

ter comprehensive health benefits and does not analyze those single-service plans.

California also issued health plan licenses to provider organizations that wanted to take full capitation risk. These were called Knox-Keene licenses with waivers. Several of those licensed plans failed spectacularly in 1998 and 1999, disrupting patients and providers alike. Some others later decided to go out of business, but five of those licensed plans are still in active operation. These are listed in the tables that follow as "Limited License Health Plans."

HMOs

Exhibit 2 presents an overview of the full-service 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.

The first group 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 Health Networks), Health Net, Kaiser Permanente, and PacifiCare. Most of these HMOs are investor-owned but a few are organized as not-for-profit organizations. While almost all of the HMOs serve commercial groups, a few do not contract with employers but only with the state for its Medi-Cal and Healthy Families programs.

The second category of health plans includes 14 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. The next section of the report provides additional details about HMOs serving the Medi-Cal population.

Finally, the third category of HMOs in Exhibit 2 is the provider-sponsored organizations that have a Knox-Keene license with waivers. Some of those are small or inactive. Five had enrollment in 2002, including three large groups operating in southern California: Heritage Provider Network, PrimeCare Medical Network, and Scripps Health Plan Services in San Diego.

The number of plans doing commercial business in the state has dropped sharply, sometimes because of insolvency, sometimes through acquisition, and sometimes, as in the case of United HealthCare, because of changes in core business strategies. Tenet Health closed National Med, its Modesto-area HMO last year. That was Tenet's only HMO plan and Tenet, like other hospital owners, decided that owning an HMO was not a helpful business strategy.

The list of insolvent health plans has grown in the past year. Health Plan of the Redwoods and Lifeguard both became insolvent and are in liquidation under state supervision. Early in 2002, Blue Shield had offered to buy Lifeguard, but that deal was never closed. These two insolvencies are in addition to three California HMOs that suffered severe financial problems in 2001 and went into receivership under the Department of Managed Health Care: Maxicare of California, Tower Health, and WATTSHealth. All three contracted with L.A. Care as subcontractors for Medi-Cal enrollees. Maxicare and Tower Health have since been liquidated, while WATTSHealth continues to operate, though in a smaller service area.

As of December 2002, 21.4 million Californians, or about 63% of the population, were enrolled in an insured HMO plan through a full-service health plans. (This analysis generally does not include enrollment in other kinds of managed care arrangements, such as PPOs. Note that many of the HMOs discussed here are also administering benefit plans with PPO networks.)

Exhibit 3 on page 14 shows the market share of California HMOs as of December 2002. Kaiser Permanente remains the largest plan in the state, with 30.5% of enrollees. Blue Cross is second largest, with 22.4%. PacifiCare, Health Net, and Blue Shield each have 9-10% of the market. Enrollment in Aetna Health and Prudential has declined. The two plans together once accounted for more than 5% of HMO enrollment in the state, but had only 2.7% in 2002.

At the end of 2002, the four largest HMOs had 72.9% of the HMO market. The sidebar on page 14 compares HMO 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 and falls in the middle. Other states have become less concentrated on the HMO side as some of the largest plans shift their emphasis away from insured HMO plans and toward PPO arrangements.

Long the largest HMO in the state, Kaiser Permanente continues to have enormous impact on the market. It has raised the bar for investment in administrative technology that supports medical practice. Last year it selected a vendor for electronic medical record systems and abandoned an in-house project in which it had invested heavily. It is adding clinical capacity and building new or replacement hospitals both to extend its geographic reach and

Exhibit 2

California HMOs at a Glance

Health Plan *(Web site)*	Headquarters	Owner/Manager/ Other Affiliation	Year Begun as an HMO	HMO Enrollment in December 2002	2002 Net Income (Loss) Margin	Historical Notes
Aetna Health of California *http://www.aetna.com*	San Ramon, CA	Aetna Health, Inc. Hartford, CT	1981	523,099	50,342,224 3.4%	Acquired Prudential Health Care in 1999
Blue Cross of California *http://www.bluecrossca.com*	Woodland Hills, CA	WellPoint Health Networks, Thousand Oaks, CA	1993	4,836,701	434,614,000 4.8%	Acquired membership of Omni Healthcare (Sacramento) in 1999
Blue Shield of California *http://www.blueshieldca.com*	San Francisco, CA	California Physicians' Service	1978	2,208,399	142,649,000 3.1%	Organized as California Physicians' Service; acquired CareAmerica in 1998
Care 1st Health Plan	Alhambra, CA		1995	196,616	8,175,456 3.8%	
Chinese Community Health Plan	San Francisco, CA		1987	10,734	823,013 2.1%	
CIGNA HealthCare of California *http://www.cigna.com*	Glendale, CA	CIGNA Healthcare, Inc., Philadelphia, PA	1978	634,568	-6,238,572 -0.5%	Formerly Ross Loos Health Plan and Equicor
Community Health Group *http://www.chgsd.com*	Chula Vista, CA		1985	95,817	-513,966 -0.5%	
Community Health Plan	Los Angeles, CA	Los Angeles County Department of Health Services	1985	162,089	17,084,021 10.8%	
Health Net *http://www.Health.net*	Woodland Hills, CA	Health Net (formerly Foundation Health Systems)	1979	2,116,364	135,720,519 2.6%	Merged with Foundation Health of California
Health Plan of the Redwoods *http://www.hpr.org*	Santa Rosa, CA		1980	0	-14,631,119 -21.9%	Also known as Keycare. Entered bankruptcy in 2002 and expects to liquidate by end of year
Inter Valley Health Plan *http://www.ivhp.com*	Pomona, CA		1979	37,651		
Kaiser Foundation Health Plan, Inc. *http://www.ca.kaiserpermanente.org*	Oakland, CA		1977*	6,567,050	-117,574,000 -0.7%	
Lifeguard, Inc. *http://www.lifeguard.com*	San Jose, CA		1978	0	22,299,339 2.4%	Entered bankruptcy in 2002 and expects to liquidate by end of year
Molina Healthcare of California *http://www.molinahealthcare.com*	Long Beach, CA	Molina Healthcare, Inc.	1994	286,180	13,384,359 4.1%	
National Med, Inc. *http://www.nationalhmo.com*	Modesto, CA	Tenet Healthcare Corporation	1985	0	-2,836,931 -4.8%	
On Lok Senior Health Plan *http://www.onlok.org*	San Francisco, CA		1999*	905	4,695,462 9.2%	
One Health Plan *http://www.onehealthplan.com*	San Jose, CA	Great- West Life Assurance Co., Englewood, CO	1996	59,015	377,851 0.2%	
PacifiCare of California *http://www.pacificare.com*	Cypress, CA	PacifiCare Health Systems	1975	1,929,076	86,955,920 1.4%	Acquired FHP which had acquired TakeCare in 1994
Prudential Health Care Plan of California	Woodland Hills, CA	Aetna Health, Inc., Hartford, CT	1990	62,678	14,406,854 46.1%	Aetna U.S. Healthcare acquired Prudential Health in 1999. Reported in 2002 under name AET Health
SCAN Health Plan *http://www.scanhealthplan.com*	Long Beach, CA		1984	54,245	35,049,451 11.3%	

Exhibit 2

California HMOs at a Glance, continued

Health Plan *(Web site)*	Headquarters	Owner/Manager/ Other Affiliation	Year Begun as an HMO	Enrollment in December 2002	2002 Net Income (Loss) Margin	Historical Notes
Sharp Health Plan *http://www.sharp.com*	San Diego, CA		1992	119,036	-4,622,073 -3.1%	
Sistemas Medicos Nacionales, S.A. de C.V.	San Diego, CA	Simnsa Health Care, Tijuana, Mexico	2000	11,764	257,092 2.8%	
UC San Diego Health Plan	San Diego, CA	Regents of the University of California	1997	12,151	-939,720 -6.3%	Acquired Comp Care Health Plan, a Medi-Cal Primary Care Case Management arrangement, in 1998.
Universal Care *http://www.universalcare.com*	Signal Hill, CA	Howard E. Davis	1985	355,204	-1,300,725 -0.3%	Includes enrollees absorbed from Great American Health Plan and Health Max America/HMO California
Valley Health Plan	San Jose, CA	Santa Clara County	1985	45,687	475,871 0.9%	Formed to serve Santa Clara County employ ees and retirees
WATTS Health (UHP Healthcare)	Los Angeles, CA	WATTS Health Foundation	1978	108,842	5,458,000 2.1%	State regulators took control in August 2001
Western Health Advantage *http://www.westernhealth.com*	Sacramento, CA	Sponsored by Mercy Healthcare Sacramento, NorthBay Healthcare System and the University of California Davis Health System	1997	60,347	207,896 0.2%	
County Organized Health Systems and Local Initiative Plans						
Alameda Alliance for Health *http://www.alamedaalliance.com*	Alameda, CA	Alameda County	1995	85,271	-153,374 -0.1%	
CalOptima *http://www.caloptima.org*	Orange, CA	Orange County Organized Health System	2000	240,045	20,765,919 2.9%	Formal name is Orange Prevention and Treatment Integrated
Central Coast Alliance for Health *http://www.ccah-alliance.org*	Santa Cruz, CA	Santa Cruz-Monterey Managed Medical Commission	2000	85,098	4,437,958 2.1%	
Contra Costa Health Plan *http://www.co.contra-costa.ca.us/depart/hsd/cchealthPages/insurance.html#cchp*	Martinez, CA	Contra Costa County Health Services Department	1973	59,187	99,731 0.1%	
Health Plan of San Mateo *http://www.hpsm.org*	S. San Francisco, CA	San Mateo Health Commission	1998	46,784	657,945 0.6%	
Inland Empire Health Plan *http://www.iehp.org*	San Bernardino, CA	Joint powers agreement agency created by San Bernardino and Riverside Counties	1996	241,258	6,789,985 2.6%	
Kern Health Systems	Bakersfield, CA		1996	74,712	11,838,825 13.5%	
L.A. Care (Local Initiative Health Authority) *http://www.lacare.org*	Los Angeles, CA	Local Initiative Health Authority for Los Angeles County	1997		22,299,339 2.4%	
Partnership Health Plan of California *http://www.partnershiphp.org*	Suisun City, CA	Solano-Napa Commission on Medical Care		74,656		Also serves Medi-Cal recipients in Yolo County
San Francisco Health Plan *http://www.sfhp.com*	San Francisco, CA	San Francisco Health Authority	1996	38,264	2,717,291 5.1%	
San Joaquin County Health (Health Plan of San Joaquin) *http://www.hpsj.com*	Stockton, CA	San Joaquin County Health Commission	1996	61,544	2,641,288 3.7%	
Santa Barbara Health Initiative *http://www.sbrha.org*	Goleta, CA	Santa Barbara County Special Healthcare Authority	2000	62,565	-3,516,343 -2.6%	

Exhibit 2

California HMOs at a Glance, continued

Health Plan *(Web site)*	Headquarters	Owner/Manager/ Other Affiliation	Year Begun as an HMO	Enrollment in December 2002	2002 Net Income (Loss) Margin	Historical Notes
Santa Clara Family Health Plan *http://www.scfhp.com*	San Jose, CA	Santa Clara County Health Authority	1996	74,524	5,979,847 6.7%	
Ventura County Health Care Plan *http://www.vchca.org/hcp/index.htm*	Ventura, CA	Ventura County	1996	10,612	-434,810 -3.2%	
Limited License Health Plans						
Cedars-Sinai Provider Plan, LLC	Los Angeles, CA	Cedars-Sinai Medical Center, Los Angeles	1998	636	113,868 23.0%	
Heritage Provider Network	Reseda, CA		1997	165,865	259,260 0.1%	
PrimeCare Medical Network	Ontario, CA	North American Medical Management, California	1998	241,714	978,370 0.4%	
Priority Plus of California	Fresno, CA		1985	0		Formerly Central Valley Health Plan
ProMed Health Care Administrators	Upland, CA	ProMed Health Services Company	1999	11,394	322,010 2.9%	
Scripps Clinic Health Plan Services	La Jolla, CA	Scripps Clinic	1999	151,755	184,954 0.1%	

*On Lok Senior Health Services commenced business in 1971, Kaiser in 1955

Source: Author's analysis of HMO annual statements, supplemented by Department of Managed Health Care, "Public Alpha Report," January 2002; Department of Managed Health Care, "Health Plan Financial Information," June 2001.

Other full service plans terminated in past three years: Tower Health, MaxiCare of California, United HealthCare of California, Great American Health Plan (San Diego), Greater Pacific (San Francisco), and HealthMax America.
Knox-Keene plans with waivers terminated in past two years: California Pacific Medical Group (San Francisco), FPA Medical Management (San Diego), MedPartners Provider Network (Long Beach), Monarch Plan, St. Joseph's Provider Network, THIPA Management Consultants (Torrance).

HMO Market Concentration

What portion of HMO enrollees in each state are enrolled in the four largest HMOs at the end of 2002 and 2001?

California	
2002	72.9%
2001	68.7%
Colorado	
2002	69.8%
2001	65.3%
Florida	
2002	54.8%
2001	57.7%
Illinois	
2002	74.5%
2001	68.0%
Michigan	
2002	56.6%
2001	56.9%
Minnesota	
2002	95.7%
2001	95.4%
Ohio	
2002	57.0%
2001	57.7%
Texas	
2002	48.7%
2001	53.7%
Wisconsin	
2002	48.0%
2001	49.5%

to challenge locally dominant hospital systems. Kaiser has closed or settled some embarrassing public relations issues, including very public disputes with the Department of Managed Health Care. In one case, Kaiser challenged the authority of the DMHC to impose a fine on the health plan because of quality issues in its Medicare plan. And it is beginning to respond to demand from employers for health benefit products that would include additional co-payments and deductibles to better compete with PPO products. Kaiser is looking at other benefit designs as well, including plans with medical spending accounts (MSAs). Adding MSAs would require Kaiser to replace the inadequate billing systems for hospital care provided at Kaiser's own facilities.

For all the changes Kaiser is considering in benefit design and enrollee cost-sharing, it is not inclined to change its provider network arrangements in California. Its plans in other parts of the country, on the other hand, are open to changes. For example, in the Washington, D.C. area, Kaiser plans to offer more options to go to physicians outside the Kaiser clinics. There it concluded that it needed additional network options to compete with the other health plans in the area.

WellPoint Health Networks, the parent of Blue Cross of California, has grown its California operation and continued its national expansion. 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 announced plans to acquire Cobalt, the Blue Cross Blue Shield United plan of Wisconsin. It also operates as UniCare in Texas where it acquired the Methodist Care HMO, a provider-sponsored health plan in Houston that decided to get out of the HMO business. WellPoint was rebuffed in its recent attempt to acquire CareFirst, the Blue Cross plan for Maryland, Washington, D.C., and Delaware. In general, WellPoint has retained much of the senior staff in its acquired health plans but will centralize certain accounting activities and other functions. It will apply its California expertise in actuarial, product design, and marketing to the acquired plans.

PPOs

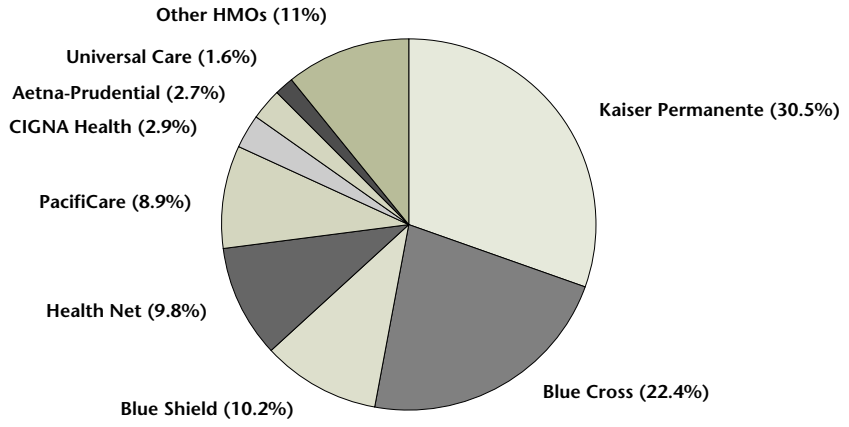
PPO plans can be divided into insured and self-funded arrangements. An employer buying an insured PPO plan pays premiums to an insurance company. Employees receive full benefits within the preferred provider network but can also receive care outside the network by paying additional co-payments and deductibles.

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, holding on to those funds and earning interest until it is time to pay the claims. It has more flexibility to design its benefit plans since self-funded plans are generally exempt from state laws mandating benefits. State insurance regulations can require that all insurance policies sold there include coverage for certain benefits, (e.g., chemical dependency inpatient care or infertility treatment), access to certain providers (such as

Exhibit 3

Market Share of California HMOs, December 2002



chiropractors), or coverage for dependents. By self-funding its benefit plan, a company can also simplify plan administration when it has locations in several different states. Some health plan companies, including United HealthCare and some of the Blue Cross plans, focus on that market segment and compete for business from those large employers that operate in more than one state.

Blue Cross of California is the largest administrator of PPO arrangements in the state. National managed care companies like Aetna Health and United HealthCare (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

Several things have changed for hospitals in California. Only a few years ago, there was general agreement that the state had surplus inpatient capacity. Now there is a significant amount of new construction underway, motivated by several factors. One is to comply with requirements that hospitals be able to withstand the next major earthquakes to hit the state. (California Senate Bill 1953, SB 1953, enacted in 1994.) Another is simple competition—a hospital system expands in order to challenge locally dominant hospitals. And while managed care helped to bring down hospital admissions and lengths of stay for many years, that trend has reversed. Now new hospitals are being built to meet a steady growth in inpatient hospital utilization rates. That increase—due to demographics and changes in the financial incentives facing physicians and hospitals, among other factors—is discussed in more detail later in Section 3.13, Utilization and Effectiveness of Care Measures.

Not long ago, California had hundreds of independent, community hospitals. Today, most hospitals in the state are part of groups of multiple hospitals. Some hospital groups are limited to California, while others are part of national hospital companies, both not-for-profit and investor-owned. There is wide variation in how these 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 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 a positive identification with the public, they can strengthen their hand in negotiations with managed care companies. Even in tightly integrated hospital systems, individual hospitals and the doctors that practice there 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.

A network of hospitals is more loosely affiliated than a hospital system, and usually maintains separate ownership and board governance for participating hospitals. They 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 came together, whether in integrated systems or loose networks, in order to regain economic power that's been 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 if they thought that payment was inadequate. Through system-building and more strategic negotiation, hospitals now tell managed care companies that the HMOs need them in order to sell insurance, either because of their geographic dominance or their brand name, 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 systemwide contracts to use all hospitals and services in the system or network. This has become less of an issue now than in the past, when HMOs wanted to be more selective in their contracting. Today their employer customers want access to broad networks of physicians and hospitals, and HMOs rarely object to contracting with lots of hospitals. And signing a contract is no guarantee that many members of an HMO will actually go to a certain hospital. That is still largely steered by the admitting patterns of the physicians.

Further, hospitals used their economic power to change the terms of contracts. Most of the major systems in California have limited their acceptance of risk by ending their participation in global capitation arrangements in which they and local med-

✔ Hospital systems, as compared to hospital networks, are more tightly integrated in some aspects of operation, such as ownership and administrative governance.

✔ A network of hospitals is more loosely affiliated than a hospital system, and usually maintains separate ownership and board governance for participating hospitals.

✔ Through system-building and more strategic negotiation, hospitals now tell managed care companies that the HMOs need them in order to sell insurance, either because of their geographic dominance or their brand name, or sometimes both.

- ✔ The three largest hospital systems in California are Catholic Healthcare West, Kaiser Permanente, and Tenet Health.
- ✔ Of the three largest systems, Catholic Healthcare West comes closest to a statewide presence.
- ✔ Kaiser provides most, though not all care, to its HMO members at its own facilities.
- ✔ Where Kaiser doesn't have its own hospital, it contracts with community hospitals for inpatient care.
- ✔ In 2001, the Kaiser hospitals reported net income of $481.9 million, up from $366.7 million a year earlier.

ical groups accepted risk for comprehensive medical care. As discussed below, this has changed the relationships of hospitals and physician groups. Hospital costs have been a major driver of rising health care costs; this leads to increased tension between doctors and hospitals as they compete for health plan payments.

As hospitals have used their renewed economic power to negotiate more favorable arrangements and payment rates with managed care plans, the health plans have sought to fire back. One strategy that they have used is to create financial incentives for consumers to use less expensive hospitals. This approach, known as tiered networks, is discussed in Section 2.5, Health Plan/Provider Relations.

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 2001. (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. More detailed information on the acute care hospitals, including their revenues, net income, occupancy and payer mix, is presented in Section 4.0.

The following analysis examines the hospital systems based on affiliations during 2001. System affiliations change through acquisitions and through decisions to end affiliations. Since 2001, several such changes have occurred. For example, Tenet Health has purchased two Los Angeles area hospitals from the Carondolet system and announced plans to close one of them. The Daughters of Charity Health System took back seven hospitals that were part of Catholic Healthcare West (CHW).

Dominant Hospital Systems. The size of hospital systems can be compared using several different measures. The analysis in this report uses a combination of three measures: inpatient hospital beds, inpatient hospital days, and net patient revenues, which is the amount that hospitals charge for services less the amount not collected because of discounts to Medicare, Medicaid, and insurers or due to uncompensated care provided to uninsured persons. 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 geo-

Exhibit 4

Largest California Hospital Systems at a Glance, 2001

System *(Web site)*	Locations	Staffed Beds	Inpatient Days	Inpatient Occupancy	Outpatient Visits	Net Patient Revenue	Net Income
Adventist *www.adventisthealth.org*	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) and Feather River Hospital (Paradise)	1,125	335,860	65.8%	1,144,350	600,032,986	30,601,387
Catholic Healthcare West *www.chwhealth.com*	47 - Bakersfield Memorial Hospital, California Hospital Medical Center (Los Angeles), Community Hospital of San Bernardino, Dominican Santa Cruz Hospital - Soquel, (Santa Cruz), 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 Hospital - Bakersfield, Mercy Hospital - Folsom, Mercy Hospital of 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, O'Connor Hospital (San Jose), Oak Valley District Hospital (Oakdale), Robert F. Kennedy Medical Center (Hawthorne), San Gabriel Valley Medical Center, Sequoia Hospital (Redwood City), Seton Medical Center (Daly City), Seton Medical Center - Coastside (Moss Beach), 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 (Lynwood), St.	8,789	1,919,074	60.0%	3,906,256	3,457,042,261	67,667,424

	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. Louise Health Center (Gilroy), St. Mary Medical Center (Long Beach), St. Mary's Medical Center - San Francisco, St. VIncent Medical Center (Los Angeles) and Woodland Memorial Hospital						
HCA: The Healthcare Company *www.hcahealthcare.com*	6 - Good Samaritan Hospital (San Jose), Las Encinas Hospital (Pasadena), West Hills Medical Center, Los Robles Regional Medical Center, Regional Medical Center (San Jose), San Jose Medical Center	1,034	305,424	58.6%	549,545	714,375,596	6,328,878
Kaiser Foundation *www.kaiserpermanente.org/ locations/california*	28 - Kaiser Foundation Hospitals in Anaheim, Bellflower, Fontana, Fresno, Geary (San Francisco), Harbor City, Kaiser, 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 (Sacramento), South San Francisco, Sunset (Los Angeles), Walnut Creek, West Los Angeles (Los Angeles), Woodland Hills, Vallejo, Baldwin Park and Chemical Dependency Program (Fontana)	5,899	1,421,258	66.0%	1,298,413	4,641,465,751	481,879,280
St. Joseph *www.stjhs.org*	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) and St. Mary Regional Medical Center (Apple Valley)	827	300,506	65.5%	427,006	646,100,417	11,767,106
Scripps *www.scrippshealth.org*	6 - Green Hospital of Scripps Clinic (La Jolla), Scripps Hospital - East County (El Cajon, now closed), Scripps Memorial Hospital - Chula Vista, Scripps Memorial Hospital - Encinitas, Scripps Memorial Hospital - La Jolla and Scripps Mercy Hospital (San Diego)	1,580	434,833	71.8%	692,645	688,173,292	33,962,878
Sharp *www.sharp.com*	8 - 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) and Sharp Memorial Hospital (San Diego)	1,373	334,952	66.8%	736,425	791,302,778	36,102,335
Sutter *www.sutterhealth.org*	24 - Alta Bates Medical Center (Berkeley), California Pacific Medical Center (San Francisco), Dameron Hospital (Stockton) Eden Medical Center (Castro Valley), El Camino Hospital (Mountain View), Laurel Grove Hospital (Castro Valley), Marin General Hospital (San Rafael), Memorial Hospital Modesto, Mills-Peninsula Medical Center (Burlingame), Novato Community Hospital, 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) and Sutter Tracy Community Hospital, St. Luke's (San Francisco)	2,645	686,558	65.4%	1,840,439	1,574,350,094	27,645,539
Tenet *www.tenethealth.com*	44 - 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, Desert Regional Medical Center (Palm Springs), Doctors Hospital of Manteca, Doctors Medical Center, Doctors Medical Center - Pinole, Doctors Medical Center - 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 and Whittier Hospital Medical Center	7,320	1,662,632	60.0%	3,159,150	3,559,806,054	626,211,749
University of California*	8-Medical Center at the University of California-San Francisco, Santa Monica - UCLA Medical Center, University of California, UCLA Medical Center, Los Angeles, UCLA Neuro-psychiatric Hospital (Los Angeles), UCSF Mt. Zion (San Francisco, now closed), University of California-San Diego Medical Center, University of California Davis Medical Center, Sacramento, University of California Irvine Medical Center (Orange)	2,946	764,160	69.4%	3,318,663	2,756,059,479	128,315,612

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 31, 2001. System affiliations reflect arrangements in 2001.

*Net income for certain University of California hospitals reduced by transfer of disproportionate share hospital funds.

✔ During 2001, Tenet's California hospitals had net income of $626.2 million on net patient revenue of $3.6 billion.

✔ Sutter has 24 hospitals with 2,645 staffed beds. It had net patient revenue in 2001 of $1.6 billion and net income of $27.6 million.

✔ A fundamental premise of managed care is that patients have incentives—and sometimes restrictions—to use certain providers.

✔ Kaiser does go outside the Permanente groups in some limited circumstances, such as to use certain specialists, for geographic access or when its capacity is inadequate.

graphic market for specialized pediatric care in children's hospitals might be different than the geographic market for other kinds of 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.

Using the three measures of inpatient beds, inpatient days, and net patient revenues, the three largest hospital systems in California are Catholic Healthcare West, Kaiser Permanente, and Tenet Health. Based on the 2001 data, CHW has the most inpatient beds and the most inpatient hospital days. However, Kaiser Permanente reported the highest net patient revenues (after discounts): $4.6 billion, compared to $3.6 billion at Tenet and $3.5 billion for Catholic Healthcare West.

All of the large hospital systems reported net income for 2001, though Tenet had the best results of the major systems. It had net income of $626.2 million on patient revenues of $3.6 billion.

Of the three largest systems, Catholic Healthcare West comes closest to a statewide presence. Catholic Healthcare West 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 has nine hospitals in the Los Angeles area and seven in the San Francisco Bay area, plus about 30 others scattered around the state with a total of about 8,800 inpatient beds. In 2001 it had net patient revenues of $3.9 billion and net income of $57.7 million (this includes the seven Daughters of Charity hospitals, recently taken back by the organization).

Kaiser provides most, though not all care, to its HMO members at its own facilities. Kaiser's 28 hospitals are mostly in the San Francisco Bay Area and Los Angeles, and it also has hospitals in places like Sacramento, Fresno, Santa Rosa, and San Diego. Where it doesn't have its own hospital, it 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). After a brief period during which it reduced its investment in new facilities and contracted out for more member care, it has now launched very ambitious plans to construct new facilities in the state. Kaiser plans major expansions to several of its hospital locations including Sacramento, and will build new hospitals in some communities where it has had difficulty in negotiating rates with a locally dominant hospital. In interviews with Kaiser leaders, they said that Kaiser's own analysis shows a very quick payback when comparing the cost of new facilities with the prices charged by some hospitals in the state.

In 2001, the Kaiser hospitals had net patient refvenues of $4.6 billion. They reported net income of $481.9 million, up from $366.7 million a year earlier. In its financial reports to the state, Kaiser combines the financial data for its northern California and southern California hospitals into two reports. Using that data, it is not possible to compare the net income of individual Kaiser hospitals.

Tenet Health is investor-owned and its corporate headquarters are in Santa Barbara, though its California operations are centered in Santa Ana. Most of Tenet's 44 California hospitals are in Los Angeles and Orange Counties, although it also has a few locations in other parts of the state. Most Tenet hospitals are smaller community facilities, but it also has acquired major teaching hospitals in California and in other states. During 2001, Tenet's California hospitals had net income of $626.2 million on net patient revenue of $3.6 billion.

Tenet Health operates more than 110 hospitals in 16 states and had net patient revenue of $11.2 billion in 2002. Among investor-owned hospital companies it is second to HCA: The Healthcare Company, which has 173 hospitals and $19.7 billion in net patient revenues. Until recently Tenet Health has been very successful and much loved by Wall Street analysts. However, it has been involved in a series of controversies, including one involving its hospital in Redding. Questions were raised about its practices in billing Medicare and individuals that 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. The Sutter hospitals are 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 2,645 staffed beds. It had net patient revenue in 2001 of $1.6 billion and net income of $27.6 million.

The other major investor-owned hospital in the state is HCA: The Healthcare Company (formerly Columbia/HCA). HCA has sold some of its properties in California and in other states. One result is that there is a new crop of investor-owned (for-profit) hospital companies doing business in the state, including Pacific Health Corporation. HCA's six California hospitals have about 1,000 staffed

beds. They reported net patient revenues of $714.4 million in 2001 and net income of $6.3 million.

Exhibit 4 groups the eight University of California medical centers, although they actually operate quite independently. (UCSF Mt. Zion ended inpatient operations.) They contract separately for managed care business and have separate budgets and profit and loss statements. When combined, the hospitals reported net income of $52.7 million on $2.9 billion in net patient revenue. As a group, the University of California hospitals combined reported the second highest number of outpatient visits, second only to Catholic Healthcare West hospitals.

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 said that they had their own clear ideas about how they would relate to health plans and how they should 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 those physicians provide almost all medical services to Kaiser enrollees. Kaiser does go outside the Permanente groups in some limited circumstances, such as to use certain specialists, for geographic access or when 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 the notion of exclusivity for now, but most of the other classic HMOs around the country are now tinkering with the Kaiser model by "renting" their physicians to other health plans or administrators. And, some Kaiser plans in other states have expanded their provider networks mainly through contracts with independent physicians.

Variations of the Kaiser model in California include a combination 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, began with staff clinics, but later sold those clinics and switched to contracting for physician services.

2. California Delegated Model. In the world outside of Kaiser, a different model predominates: HMOs contract with medical groups or independent practice associations (IPAs). This is called the California delegated model. The HMO agrees to pay a caputated (fixed) monthly rate for every enrollee who chooses that group as his or her primary care clinic, retaining some percentage of the premium for administrative costs and profit. (As discussed later in this section, those capitated payments are set aside in a series of "pools" for physician care; institutional care, including hospitals and skilled nursing facilities; prescription drugs; and out-of-area care.) The HMO delegates significant responsibility to the medical group, including functions like physician credentialing, claims payment, and medical management. The medical groups are not exclusive to any single health plan, although they may have been at one time. By being nonexclusive, 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 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 that reduce 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 recruit 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 people 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.

Tables in the fourth section of this report present additional information about the largest physician

- ✔ The HMOs delegate significant responsibility to medical groups, including functions like physician credentialing, claims payment and medical management.
- ✔ Many medical groups are heavily dependent the California delegated model. They have invested in medical management systems that keep specialty referrals within a limited network and that reduce hospital admissions and lengths of stay.
- ✔ Some of the established multi-specialty groups are growing and adding new primary care and specialty doctors.
- ✔ Group practices are very common in southern California but relatively rare in the northern part of the state.
- ✔ In this section the term "medical group" describes one of the six structures while "physicians group" is used more generally.

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 newly created **Department of Managed Health Care.**

· **The California Department of Managed Health Care (DMHC)** (www.dmhc.ca.gov) 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) , under Secretary Grantland Johnson, 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**. The Department of Health Services (www.dhs.ca.gov) , 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.

· **The Managed Risk Medical Insurance Board,** (known as 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.

organizations in each of the six regions. According to various sources, there are between 250 and 350 organized physician groups in California. Although the number of groups is large, many of them are very 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% of managed care enrollees.

Here are the six different structures in which physicians in California are organized. Note that the lines that separate medical groups and Independent Practice Association (IPAs) have blurred, sometimes suggesting that the distinctions are no longer 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 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. Specialists generally feel that they bring more revenues to the practice than primary care physicians and want to be compensated in a way that reflects their contribution. However, some of the established multi-specialty groups are growing and adding new primary care and specialty doctors. Others have cut back, spinning off their specialty physicians, therapists, and pharmacies.

Physicians are either employees or partners of the group and may practice at one or more group sites. They belong to a single medical group, and that entity handles all managed care contracting on their behalf. Some medical groups have added a "wrap-around" IPA group of physicians (described below) to extend their geographic reach and to add a source of revenue. That means that they contract with an IPA to provide certain administrative services. Medical group practices are very common in southern California but relatively rare in the northern part of the state. Prominent medical groups include Healthcare Partners in Los Angeles; Camino Medical Group, which is now affiliated with the Palo Alto Medical Foundation; San Jose Medical Group; Bright Medical Associates in the Los Angeles area; and Beaver Medical Group 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 in San Francisco; Alta Bates Medical Group in Oakland; Affinity Medical Group, Inc. (a "super"-IPA in the East Bay that includes three or four smaller IPAs); and Hill Physicians Medical Group, Inc. 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 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, but authorizes other structures in which a hospital can have close ties to physicians. The foundation integrated system through a hospital creates a foundation (a category of nonprofit corporation under California statute), 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 in the East Bay; Palo Alto Medical Foundation in the South Bay; Scripps Clinic in San Diego; and Adventist Health Southern California Medical Foundation.

California physicians and their groups also use two other types of organizations.

5. Management Service Organizations (MSOs). Many physician groups 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.

6. Knox-Keene Limited License plans. State law generally limits medical groups to capitation contracts with health plans where they accept risk only for the services that the group's physicians actually can provide. During the 1990s several physician groups decided they wanted to negotiate full-risk capitation contracts on their own with health plans where they would accept risk for inpatient hospital care as well as physician services. To accomplish this, they took HMO licenses known officially as *Knox-Keene plans with waivers* or "limited license health plans." After several of these HMOs failed, the Department of Corporations stopped issuing those licenses. As of April 2003, five limited license plans were still active, more or less: Cedars-Sinai Provider Plan (Los Angeles); Heritage Provider Network Inc. (Reseda); PrimeCare Medical Network (Ontario); ProMed Health (Upland); and Scripps Clinic Health Plan Service (San Diego).

Physician group finances. The 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. In the past five years, dozens of physician groups have gone out of business, some of them very well-known and well-established groups. Their failures caused significant disruption in patient-physician ties.

In response to the wave of 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;
- Timely claims payment.

The then-new 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. The California Medical Association (CMA) sued DMHC, claiming that the statute did not authorize 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 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, although the Department of Managed Health Care 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 that should be addressed in quality improvement measures, health plan payment systems, and organizing 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 are focusing 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. They hope that physicians would respond to financial incentives by improving their performance.

In the last year 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. 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. Selected HEDIS measures on commercial HMOs are reported in Section 3.3 of this report.) Other measures are related to enrollee satisfaction reported in Section 3.4. In 2004 all six of the health plans have agreed to pay performance bonuses to physician groups that meet the initiative's criteria. Each health plan will decide for itself how big the bonuses will be and exactly how they will be distributed. It appears that bonuses will be between 2% and 5% of the base payments.

· **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. 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 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).

Who Speaks for 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 **California Healthcare 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. It was a state hospital association and expanded to include physician organizations. 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.

· 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.

· The **National IPA Coalition** (NIPAC) (www.nipac.org) is a resource for physician organizations that manage risk contracts. It provides information, contacts, technical support, and advocacy. Headquartered in Oakland, NIPAC has 300 members in 33 states.

· 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. Established in 1961, the organization provides legislative and regulatory advocacy. Membership ranges from rural hospitals to large urban medical centers representing more than 38,000 licensed beds.

· Established in 1923, the **Healthcare Association of Southern California** (www.hasc.org) serves as a forum for three councils: Hospitals and Health Facilities Council, California Physician Groups Council, and Integrated Systems Council. The association provides technical and information services, as well as advocacy.

The Pay for Performance initiative has been greeted by physicians with enthusiasm mixed with a healthy dose of skepticism. How much money would be available for incentive payments and whether it would be all "new money" are among the questions that are still not 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.

The initiative 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 that 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 46 lists several Web sites where consumers can obtain comparative information about health plans and physician groups in California.

Future challenges for physician groups. Physician groups face a series of challenges going forward. First, many of them are seeing a decline in the number of capitated HMO patients. As will be seen in Section 3.0 of this report, 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 the patients don't come in. And there is some sense that consumers who carry a PPO card will elect away from the 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 and have threatened to terminate their contracts unless the 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.

IPAs continue to face uncertainty about their future 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.

Finally, there is the question about whether there is a threshold or optimal size for effective physician groups. They 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 patients will have a difficult time continuing; others suggest that the threshold size is even larger than that. The challenges of investing in infrastructure while having broad geographic presence has led to some consolidation of physician groups seeking to associate with larger health plan organizations. In one interesting development, Kaiser acquired some primary group clinics in northern California and seriously discussed acquisition of a large group practice in southern California. This is a departure from the past, when almost all of Kaiser's growth was internal, adding doctors to its clinics or adding new Permanente clinics.

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 hospital 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 that much.

Hospital and Physician Organizations. 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 partnering with physicians in the same way anymore. As was noted earlier, most hospital systems have used their increased leverage to negotiate new payment rates and methods with health plans. While there may still be an institutional care pool, hospitals are paid at much improved rates, effectively emptying out those pools at a much faster rate. That puts the hospitals at the top of the proverbial health care food chain. 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 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 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.

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.

HMO and Hospitals—Tiered Networks. As hospital systems have asserted their new economic power, HMOs have explored ways to regain some of that power. Several health plans have been trying to do that by returning to old managed care concepts such as steering patients to preferred providers and creating financial incentives for consumers to stay within limited networks.

In the past two years, major HMOs including PacifiCare, Health Net, and Blue Shield have introduced health benefit plans constructed around tiered networks of hospitals. These HMOs have designated certain hospitals as preferred, or on their "A list," based for now almost entirely on their fee schedules. Others that are more expensive, including academic health centers, don't get on the preferred list. (In one HMO's original design, only one Sacramento-area hospital was not on the preferred list—the University of California Irvine Medical Center.) If an enrollee is admitted to a preferred hospital, they receive full benefits. If they enter a non-preferred hospital they may be charged a co-payment of $100 to $400 per day.

The HMOs have said that they will incorporate quality measures in their method for tiering hospitals. In 2002, for example, Blue Shield said that hospitals could earn additional credit toward preferred status if they would participate in the Patients' Evaluation of Performance in California (known as PEP-C), sponsored by the California HealthCare Foundation, and by reporting to The Leapfrog Group on their progress toward meeting several standards for hospital safety and quality. (The Leapfrog Group and its initiatives are described in Section 2.1 in the discussion of purchaser initiatives.)

There is really not much new under the sun with hospital tiering. Health plans used to contract with fewer hospitals based largely on cost considerations. They would designate preferred hospitals and create financial incentives to use those hospitals and not others. And they certainly have set higher prices for some hospitals and lower prices for others. Still, some California hospitals have responded angrily to the current tiered hospital initiatives. They have challenged, among other things, the validity of the method used to rate hospitals and the lack of consultation with hospitals or with physicians. Others suggest that this is a strategy by health plans to fire back at hospital systems that have aggressively negotiated higher payment rates. The HMOs are saying, in effect, that we still can steer patients away from or toward your facilities based on your pricing.

News articles at the beginning of 2003 reported that about 70 small and medium businesses have signed up more than 20,000 employees for PacifiCare's tiered network product. Blue Shield didn't wait for employers to select its tiered network plan, but moved 1 million employees in small and medium groups into it.

High Performing Networks?

Experiments with tiered networks seem to miss a more fundamental issue: can health plans identify high-performing providers, assemble them in networks, and build benefits plans around them? At least one health plan (PacifiCare) says yes: that based on quality measures, it can design limited networks of high-performing physicians or medical groups. Such a network might include only 30% of the physicians in an area, not 90% as is typical today. Even if those high-performing doctors were paid more than their colleagues, it is possible that a health plan could profitably set the price for such a narrow network plan lower than other plans in the market.

HMO Enrollment Growth in 2002

California down 1.0%	21,757,646
Colorado down 12.0%	1,382,235
Florida down 8.3%	4,425,973
Illinois down 10.2%	2,029,392
Michigan down 3.1%	2,685,158
Minnesota up 4.7%	1,308,772
Ohio down 10.4%	2,216,151
Texas down 11.5%	3,186,571
Wisconsin down 3.6%	1,581,563

3.0 TREND REVIEW

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. This section of the report presents an analysis of enrollment and financial trends for California health plans. The data are generally from public sources, except that the HEDIS data are licensed through NCQA. A series of sidebars compares California health plans with their counterparts in the states where the author prepares market analyses.

Unfortunately, there is no comparable body of data on the finances, enrollment, or care utilization for other kinds of health plans (preferred provider arrangements, 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.

3.1 About This Analysis

This 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. (Previously, these statements were submitted to the Department of Corporations.) The tables in this section report data for health plan fiscal years ending in 2002. 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). Beginning in 2002, California moved away from using old NAIC forms and began to use new California reports. 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 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. Another source of supplementary data was 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.

To make the exhibits more useful, data on the seven or eight largest plans in the state are presented at the top. 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 (described under Physician Organizations in Section 2.4) are shown at the bottom of the table.

3.2 HMO Enrollment

Exhibit 5 shows enrollment in California HMOs at the end of 2002. Before reviewing the data it is useful to understand methodology issues affecting this analysis.

Methodology issues. 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, L.A. Care Health Plan, the local initiative plan run by Los Angeles County, subcontracts all its 800,000 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, L.A. Care is listed separately in some of the tables in this section, and its Medi-Cal enrollees are not included in the total row of those tables. The commercial HMO option for Los Angeles County Medi-Cal enrollees is Health Net, which in turn subcontracts out about 275,000 Medi-Cal enrollees to two other HMOs, Molina Medical and Universal Care. CalOptima, the county health system for Medi-Cal in Orange County, also contracts some of its enrollees to Blue Cross, Universal, and Kaiser Permanente. (Blue Cross ended its CalOptima contract in 2003.) Santa Clara Family Health Plan, operated by Santa Clara County, contracts out many of its Medi-Cal lives to Valley Health Plan (also operated by the county) and to Kaiser Permanente. According to the annual statements filed with DMHC, both the prime contractor and the subcontractor list those Medi-Cal enrollees. In this report,

Exhibit 5

Enrollment in California HMOs, 2001-2002

HMO	Commercial	Medicare	Medi-Cal/Healthy Families	TOTAL	2001	Change	% Change
Large HMOs							
Aetna Health	485,787	37,312	0	523,099	839,294	-316,195	-37.7%
Blue Cross of California	3,486,358	251,299	1,099,044	4,836,701	4,389,159	447,542	10.2%
Blue Shield of California	2,231,350	67,049	0	2,298,399	2,276,233	22,166	1.0%
CIGNA Healthcare	634,568	0	0	634,568	667,142	-32,574	-4.9%
Health Net*	1,665,221	101,317	349,826	2,116,364	2,211,253	-94,889	-4.3%
Kaiser Foundation	5,790,348	671,858	104,844	6,567,050	6,433,296	133,754	2.1%
PacifiCare	1,543,000	386,076	0	1,929,076	2,065,998	-136,922	-6.6%
Prudential Health Care	62,678	0	0	62,678	259,151	-196,473	-75.8%
Smaller HMOs							
Care 1st Health Plan	0	0	196,616	196,616	191,296	5,320	2.8%
Chinese Community Health Plan	6,132	4,602	0	10,734	8,686	2,048	23.6%
Community Health Group	29,088	0	66,729	95,817	89,614	6,203	6.9%
Community Health Plan	30,487	0	131,602	162,089	128,882	33,207	25.8%
Health Plan of the Redwoods	0	0	0	0	52,569	-52,569	-100.0%
Inter Valley Health Plan	20,797	16,854	0	37,651	69,183	-31,532	-45.6%
Lifeguard	0	0	0	0	223,253	-223,253	-100.0%
Molina Medical Centers	0	0	286,180	286,180	255,208	30,972	12.1%
National Med	0	0	0	0	36,430	-36,430	-100.0%
On Lok Senior Health Services	0	865	40	905	905	0	0.0%
One Health Plan	59,015	0	0	59,015	68,061	-9,046	-13.3%
SCAN Health Plan	0	52,223	2,022	54,245	46,676	7,569	16.2%
Sharp Health Plan	69,705	0	49,331	119,036	101,429	17,607	17.4%
Sistemas Medicos Nacionales	11,764	0	0	11,764	10,523	1,241	11.8%
UC San Diego	0	0	12,151	12,151	12,053	98	0.8%
Universal Care	143,249	412	211,543	355,204	317,211	37,993	12.0%
WATTSHealth Plan	8,368	15,848	84,266	108,482	113,762	-5,280	-4.6%
Western Health Advantage	42,236	2,797	15,314	60,347	54,967	5,380	9.8%
County Operated Health Systems and Local Initiatives							
Alameda Alliance for Health	2,178	0	83,093	85,271	74,909	10,362	13.8%
CalOptima*	0	0	240,045	240,045	212,133	27,912	13.2%
Central Coast Alliance	0	0	85,098	85,098	75,662	9,436	12.5%
Contra Costa Health Plan	14,001	732	44,454	59,187	55,574	3,613	6.5%
Inland Empire Health Plan	24,984	0	216,274	241,258	207,819	33,439	16.1%
Kern Health Systems	0	0	74,712	74,712	67,847	6,865	10.1%
L.A. Care (Local Initiative Health Authority)**	0	0	19,268	19,268	8,219	11,049	134.4%
Partnership Health Plan	0	0	74,656	74,656	70,267	4,389	6.2%
San Francisco Health Plan	0	0	38,264	38,264	34,146	4,118	12.1%
San Joaquin County Health	8,026	0	53,518	61,544	55,956	5,588	10.0%
San Mateo Health Commission	0	0	46,784	46,784	41,007	5,777	14.1%
Santa Barbara Regional Health	0	0	62,565	62,565	46,016	16,549	36.0%
Santa Clara Family Health Plan*	0	0	74,524	74,524	52,593	21,931	41.7%
Valley Health Plan	9,054	152	36,481	45,687	46,735	-1,048	-2.2%
Ventura County	10,612	0	0	10,612	9,978	634	6.4%
TOTAL 2002	**16,389,006**	**1,609,396**	**3,759,244**	**21,757,646**	**21,981,095**	**-1.0%**	**-223,449**
TOTAL 2001	17,200,303	1,543,036	3,237,756	21,981,095			
Change	-4.8%	3.5%	16.9%	-1.0%			
2002 % by Program	75.3%	7.4%	17.3%				
2000 % by Program	79.2%	7.5%	13.2%				
Limited License Plans and Other							
Cedars Sinai	6,873	0	0	6,873	636	6,237	980.7%
Heritage Provider Network	144,137	42,276	8,161	194,574	172,381	22,193	12.9%
L.A. Care (Local Initiative Health Authority)**	0	0	799,271	799,271	727,091	72,180	9.9%
PrimeCare Health Network	233,041	29,360	0	262,401	245,112	17,289	7.1%
ProMed Health Care Administrators	7,880	397	902	9,179	9,347	-168	1.8%
Scripps Clinics	133,642	18,113	0	151,755	174,013	-22,258	-12.8%

Source: Author's analysis of HMO annual statements, Report #4, Enrollment and Utilization Table. Based on fiscal years ending during 2002 and 2001.
* Health Net's enrollment is adjusted downward to reflect Medi-Cal enrollees in Los Angeles County that are subcontracted to Molina Healthcare (129,400) and Universal Care (146,900) as of December 2002. CalOptima subcontracts about 53,000 Medi-Cal enrollees to other HMOs. Santa Clara Family Health Plan subcontracts most of its lives to Valley Health Plan or Kaiser Permanente.
** L.A. Care subcontracts its 800,000 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.

- ✔ Total enrollment in California HMOs, including commercial Medicare, Medi-Cal and Healthy Families, declined by 1.0% in 2002, dropping by 223,400 to 21.7 million. Enrollment in commercial plans dropped by 4.8% or 810,000 lives.
- ✔ Enrollment in Medicare+ Choice plans has decreased in California as well as other states.
- ✔ The decline in commercial enrollment for California HMOs was partly offset by significant growth in Medi-Cal and Healthy Families HMO plans, which increased by 17.3% to 3.8 million.

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% 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 report self-funded enrollment on its HMO statements on a separate line, but does no longer. CIGNA's enrollment report includes enrollees in its FlexCare product, most of whom are in self-funded groups. In other states, regulators have directed CIGNA not to include self-funded FlexCare groups in its HMO statements.

Exhibit 5 shows that total enrollment in California HMOs, including commercial, Medicare, Medi-Cal, and Healthy Families, declined by 1.0% in 2002, dropping by 223,400 to 21.7 million. Enrollment in commercial plans dropped by 4.8% or 810,000 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, but they also show some increase on the HMO side as well. 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.

Overall enrollment in Medicare plans went up, although that is accounted for by the 193,000 enrollees in Medicare Supplement plans offered by Blue Cross and reported on its HMO statement for the first time in 2002. As will be seen later, enrollment in Medicare+Choice plans has decreased in California as well as other states. Plans left the market as seniors dropped out or never joined because of higher premiums, lower benefits, and overall instability for some plans. The decline in commercial enrollment for California HMOs was partly offset by significant growth in Medi-Cal and Healthy Families HMO plans, which increased by 17.3% to 3.8 million.

Of the largest health plans, Blue Cross, Blue Shield, and Kaiser Permanente reported enrollment growth in 2002. Blue Cross added more than 400,000 lives, while Kaiser Permanente added 134,000 lives. That is Kaiser's lowest enrollment growth in several years, but it is growth nonetheless. Blue Shield added commercial lives, including new lives from its contract with CalPERS. At the same time, Blue Shield's Medicare enrollment dropped by about 30,000 lives.

The other large plans lost enrollment in 2002. Aetna Health and its Prudential Health affiliate went from about 1.1 million in 2001 to 586,000 at the end of 2002. In a national strategy shift, Aetna has changed its focus from insured HMO groups to administration of self-funded groups and introduction of consumer choice model plans. However, those new plans have been very slow to gain acceptance. Aetna once had 84,000 seniors in Medicare HMO plans in California, but that number has dropped to 37,000. Aetna has ended Medicare plans in several of its key states. PacifiCare lost 6.6% of its enrollees in 2002, losing Medicare and commercial enrollment. Health Net saw a decrease in both its commercial and Medicare enrollment.

Three of the smaller commercial plans went out of business in 2002 and their enrollment dropped to zero: Health Plan of the Redwoods, Lifeguard, and National Med. Inter Valley Health Plan dropped most of its commercial enrollment in 2002 but continued its Medicare plans. Some of the smaller plans did gain enrollees, including Community Health Plan, Molina Medical Centers, and Western Health Advantage. Community Health Plan benefited by the demise of plans doing Medi-Cal business in Los Angeles.

All but one of the county Medi-Cal plans gained enrollment in 2002. Inland Empire Health Plan and CalOptima showed the largest gains. The overall trend has been steady growth, especially as the state's Medi-Cal rolls have grown. Almost all of the county plans now have more than 50,000 enrollees, seen by health plan managers and analysts as a threshold size for a health plan to effectively spread risk. In 2002, only two of the county plans had passed 100,000 enrollees, which some regard as a threshold size for gaining economic efficiencies.

Looking back, 2002 was the first year in recent memory where total HMO enrollment did not increase. As shown in *Exhibit 6,* enrollment in California HMOs grew steadily between 1995 and 2001, when it reached its peak. HMO enrollment in California was 15.9 million in 1995. It enjoyed a major increase in 1997 when the state more than doubled the number of Medi-Cal HMO enrollees. Note that some of the growth in recent years has reflected the fact that some Medi-Cal plans have received HMO licenses.

3.3 Medicare HMO Plans

The Medicare+Choice program was intended to give seniors numerous options for their federal Medicare coverage, mirroring the kind of options that were available to commercial groups: HMO, PPO, fee-for-service, and so on. Given Congress's intent to emphasize private market options in reforming Medicare, it is useful to review the experience of the Medicare+Choice program.

In the 1980s some HMOs began to offer plans for seniors, known generally as Medicare Risk plans. The HMOs contracted to provide comprehensive health care for seniors in exchange for a payment rate that was about 95% of the average cost of care for seniors in that state or county. In the 1990s, the Medicare Risk contracts were succeeded by the Medicare+Choice program, which was intended to provide seniors with many of the options available in the commercial market. HMOs initially embraced the program and began Medicare plans in numerous states. By 1999, there were about 20 HMOs offering Medicare+Choice plans in California. They offered significant supplemental benefits that were valued by seniors, including prescription drugs and hearing aids. Seniors could get these benefits in most cases with a small premium contribution.

California seniors joined Medicare HMOs in large numbers in the late 1990s. In some parts of the state, almost half of all seniors were in HMOs in 1999 and 2000. That was not the case in other states where the penetration rate barely broke 10%. In Michigan, for example, many retirees from the automobile industry had very rich retirement benefits, including full prescription drugs coverage, and few seniors were interested in Medicare HMOs during this period.

However, HMOs' enthusiasm for Medicare+Choice diminished as their profitability declined. Federal payment rate increases lagged behind the inflation in medical costs. 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 program as their provider networks began to fray or their plans began to lose money. 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 2003 provide an annual benefit limited to $1,500 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 risk from Medicare HMOs.

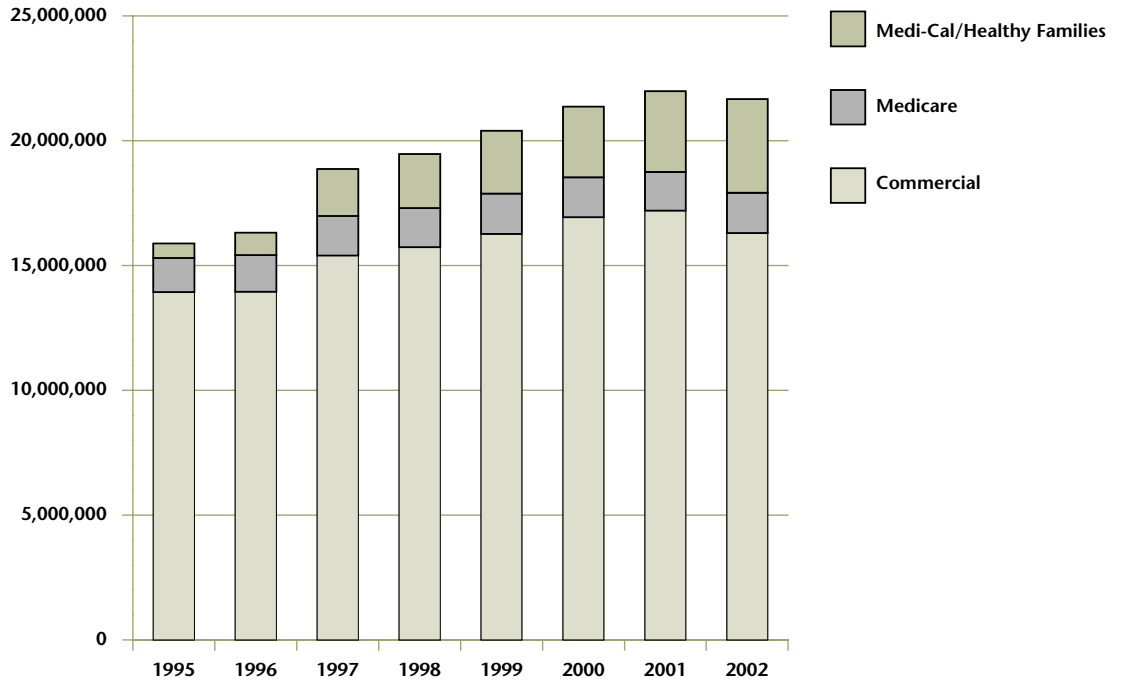
Exhibit 7 shows how enrollment in Medicare HMOs grew through 1999 but then began to decrease. Enrollment went from 1.4 million in 1995 to a peak of more than 1.6 million in 1999. Since then, enrollment has declined to less than 1.4 million in 2002.

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.

- ✔ In 2002. Blue Cross added more than 400,000 lives, while Kaiser Permanente added 134,000 lives.
- ✔ In a national strategy shift, Aetna has changed its focus from insured HMO groups to administration of self-funded groups and introduction of consumer choice model plans.
- ✔ All but one of the county Medi-Cal plans gained enrollment in 2002.
- ✔ 2002 was the first year in recent memory where total HMO enrollment did not increase.

Exhibit 6

Enrollment in California HMOs, 1995-2002



✔ As PacifiCare has withdrawn its Secure Horizons Medicare plan from some service areas, it has begun to market Medicare Supplemental plans to those seniors.

✔ Being dependent on Medicare meant relying on the federal government and how much or how little it chose to increase payments each year.

They 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.

Kaiser Permanente has been the largest Medicare HMO in California since it surpassed PacifiCare in 2000. Kaiser grew from 440,000 seniors in 1995 to 650,000 in 2002. PacifiCare used to have 600,000 seniors in its California Medicare plans, but that dropped in the past few years to 386,000. Stock analysts used to be concerned about PacifiCare's unbalanced portfolio of products and enrollees. Being dependent on Medicare meant relying on the federal government and how much or how little it chose to increase payments each year. It also meant that it was very difficult for HMOs to make money on senior plans as hospitals moved away from capitation arrangements. As PacifiCare has made efforts to diversify its portfolio of business, analysts and investors have approved, and the company's stock price has increased sharply in 2003. Analysts and investors approve of PacifiCare's efforts to diversify its portfolio of business, and the company's stock price increased sharply in 2003.

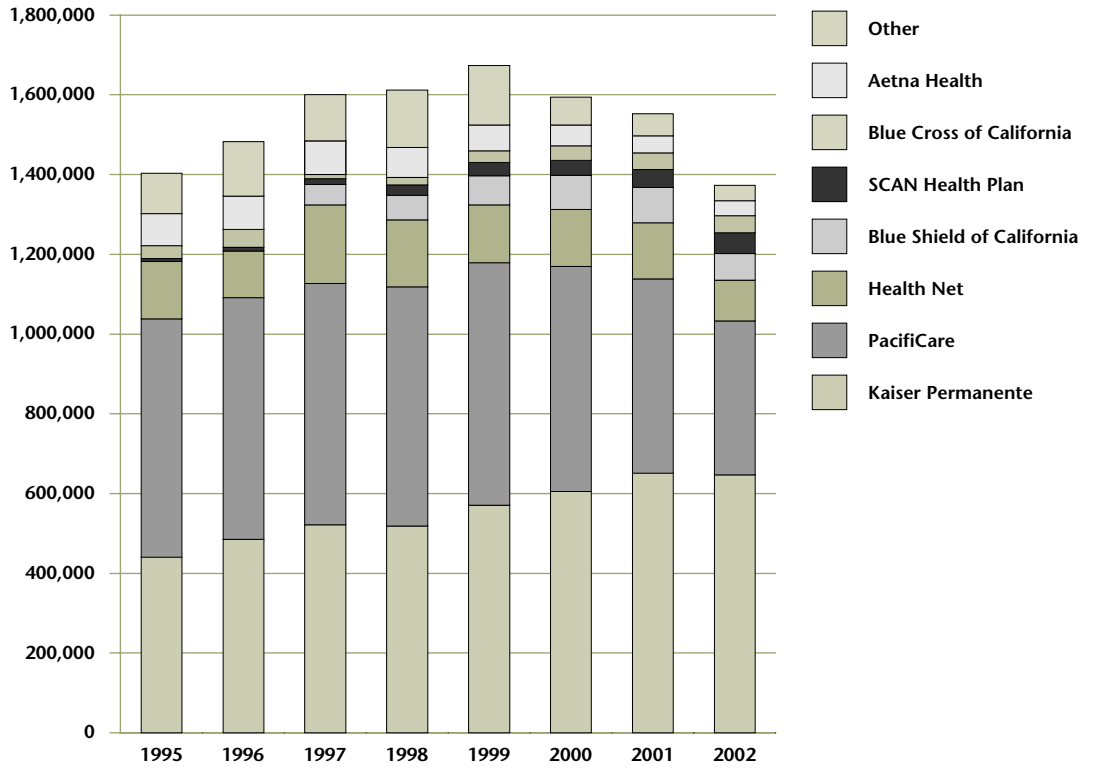
Using information from the Medicare.gov Web site, HMO availability, penetration, and payment rates in California counties were examined, based on data for 2001 and 2002. *Exhibit 8* compares Medicare HMO plans in 24 counties on these measures. Over 5 million Californians are age 65 or older, and in 2002 about 31% of all California seniors were enrolled in HMOs.

While the number of plans and senior enrollment have both declined in California, the change has been less dramatic here than in other states. For example, 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. (And there are even more plan options, since some HMOs offer different plans in many counties.) In Chicago, on the other hand, there is only one Medicare+Choice HMO available now. All the others have dropped out of that market.

The federal government sets payment rates for Medicare HMOs by starting with the average area per capita cost (AAPCC) formula. (The formula originally measured fee-for-service Medicare spending per recipient with a separate amount for each county.) When the formula was first developed, it was intended to capture historical costs of care at the county level. Since then it has been modified in numerous ways, including the introduction of risk adjustment, so that health plans that enroll seniors with greater health care needs will be rewarded with higher payment rates. The AAPCC for Los Angeles is the highest in the state. It will increase by

Exhibit 7

Enrollment in California Medicare+Choice HMOs, 1995-2002



2.2% (to $724) for 2004, as will the rates in several of the other urban counties.

Last year it was noted that three southern California counties had penetration rates over 45%: Riverside, San Bernardino, and San Diego. That has changed in the past year. Penetration has declined and now San Bernardino County, still the highest in the group, is down to about 43% of seniors enrolled in an HMO.

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 second 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 that follows are limited to Medi-Cal managed care enrollment, although *Exhibit 11* combines Medi-Cal managed care and Healthy Families enrollment as reported to the Department of Managed Health Care.

States introduced managed care arrangements for Medicaid to achieve several goals: improving access to physicians, improving continuity of care by emphasizing primary care, and saving money to the Medicaid program, or at least setting limits on the state's obligation. When patients have a primary care home, they will use the emergency room less 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 5-10% below

- ✔ More than 5 million Californians are age 65 or older, and in 2002 about 31% of all California seniors were enrolled in HMOs.
- ✔ 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.

Exhibit 8

Medicare+Choice Payment Rates, Plans and Penetration in Selected Counties

County	2003 AAPCC Rate	2004 AAPCC Rate	Rate Increase Over 2003	Number of HMOs in 2000*	Number of HMOs in 2003*	Seniors in HMOs, December 2002	Eligible Seniors	Penetration Rate
Northern & Central								
Alameda	661.92	676.48	2.2%	6	3	59,377	164,617	36.1%
Contra Costa	674.12	688.95	2.2%	7	4	48,238	125,382	38.5%
Fresno	564.10	592.29	5.0%	4	2	20,569	97,183	21.2%
Marin	603.51	616.79	2.2%	3	1	11,352	36,583	31.0%
Monterey	581.70	594.50	2.2%	0	0	297	45,171	0.7%
Napa	638.75	652.80	2.2%	2	1	6,763	22,642	29.9%
Placer	565.51	592.29	4.7%	4	4	17,550	39,681	44.2%
Sacramento	584.73	597.59	2.2%	5	4	66,791	164,850	40.5%
San Francisco	612.53	626.01	2.2%	7	3	35,178	122,881	28.6%
San Joaquin	564.10	592.29	5.0%	4	1	20,957	73,605	28.5%
San Mateo	564.10	592.29	5.0%	4	3	32,553	95,190	34.2%
Santa Clara	582.13	594.94	2.2%	5	4	63,095	177,466	35.6%
Santa Cruz	564.99	592.29	4.8%	1	1	4,374	29,076	15.0%
Solano	592.17	605.20	2.2%	2	2	15,609	44,322	35.2%
Sonoma	569.66	592.29	4.0%	4	1	17,402	65,804	26.4%
Stanislaus	564.10	592.29	5.0%	4	2	22,586	59,719	37.8%
Southern								
Kern	589.33	602.30	2.2%	6	5	27,436	80,895	33.9%
Los Angeles	707.96	723.54	2.2%	10	10	339,858	1,054,505	32.2%
Orange	653.29	667.66	2.2%	9	9	106,597	313,977	34.0%
Riverside	593.28	606.33	2.2%	10	8	91,665	222,368	41.2%
San Bernardino	606.05	619.38	2.2%	9	9	79,320	182,879	43.4%
San Diego	604.13	617.42	2.2%	6	4	147,593	360,182	41.0%
Santa Barbara	564.10	592.29	5.0%	3	3	12,416	57,751	21.5%
Ventura	584.77	597.63	2.2%	5	3	25,066	92,895	27.0%

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

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

✔ States addressing Medicaid shortfalls are largely limited to three approaches: reducing eligibility, reducing benefits, and reducing payments to providers.

what they believe 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. *Exhibit 9* shows that the number of Medi-Cal recipients in managed care has grown steadily. As of December 2002, there were more than 3.2 million Medi-Cal beneficiaries in managed care arrangements.

California began with two models: (1) *prepaid health plan* (PHP) arrangements where provider organizations did not accept significant risk for utilization, and (2) *a primary care case management* (PCCM) model, in which physicians and clinics played a role in overseeing patients' referrals to specialists and hospital admissions. They would usually be paid a few dollars extra per patient per month in exchange for keeping tabs on referrals and admissions. At the end of 2002, these programs still existed in only one or two counties, with fewer than 2,000 enrollees each. 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.

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: Two-Plan Model, County-Organized Health Systems and Geographic Managed Care. *Exhibit 10* shows enrollment by county in Two-Plan and County Organized Health System counties.

• *Two-Plan Model,* in which 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 (L.A. 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.

• *County-Organized Health Systems (COHS),* where a county authority, sometimes partnering with a nearby county, manages a health plan-like arrangement. Orange, Santa Barbara, Monterey, and Napa counties are examples. Some of those county

Exhibit 9

Enrollment in Medi-Cal Managed Care Arrangements, 1997-2002

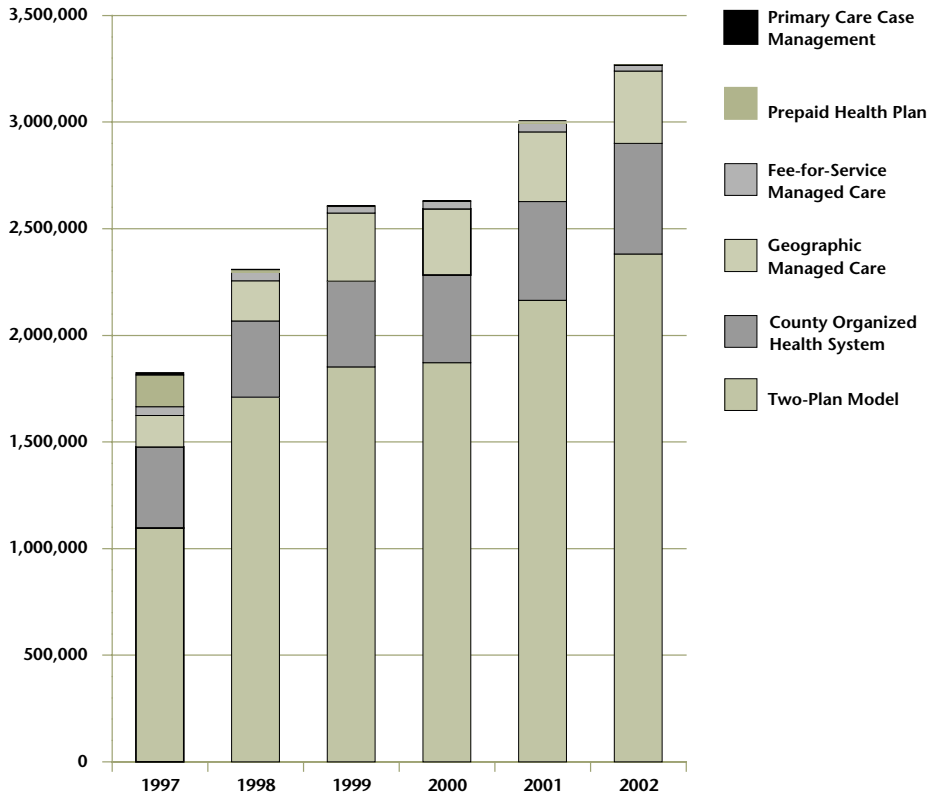


Exhibit 10

Enrollment in Medi-Cal Managed Care Plans for Counties, 2001 and 2002

County Organized Health Systems	Counties	2001 Enrollment	2002 Enrollment
CalOptima	Orange	238,474	270,670
Central Coast Alliance	Monterey and Santa Cruz	71,141	80,132
Partnership Health Plan	Napa, Solano and Yolo	70,256	72,958
Health Plan of San Mateo	San Mateo	38,412	42,405
Santa Barbara Regional Health Authority	Santa Barbara	44,636	48,558
Subtotal		**462,919**	**514,723**

Two-Plan System Counties

County	Plans	2001 Enrollment	2002 Enrollment	2002 Local Share
Alameda	Alameda Alliance	67,848	70,220	71.9%
	Blue Cross	27,688	27,481	28.1%
	County Total	**95,536**	**97,701**	
Contra Costa	Contra Costa Health Plan	40,368	41,684	86.1%
	Blue Cross	4,890	6,735	13.9%
	County Total	**45,258**	**48,419**	
Fresno	Blue Cross	119,378	125,322	81.1%
	Health Net	29,355	29,222	18.9%
	County Total	**148,733**	**154,544**	
Kern	Kern Health Systems	62,138	67,950	65.5%
	Blue Cross	31,328	35,840	34.5%
	County Total	**93,466**	**103,790**	
Los Angeles	L.A. Care*	738,153	814,461	60.4%
	Health Net*	484,306	532,928	39.6%
	County Total	**1,222,459**	**1,347,389**	
Riverside	Inland Empire Health Plan	86,603	96,624	71.5%
	Molina Medical Centers	34,689	38,478	28.5%
	County Total	**121,292**	**135,102**	
San Bernardino	Inland Empire Health Plan	117,643	127,875	71.8%
	Molina Medical Center	47,457	50,300	28.2%
	County Total	**165,100**	**178,175**	
San Francisco	San Francisco Health Plan	26,223	27,955	65.8%
	Blue Cross	14,907	14,532	34.2%
	County Total	**41,130**	**42,487**	
San Joaquin	Health Plan of San Joaquin	51,165	55,872	74.0%
	Blue Cross	16,366	19,674	26.0%
	County Total	**67,531**	**75,546**	
Santa Clara	Santa Clara Family Health*	46,405	60,580	71.6%
	Blue Cross	22,043	23,996	28.4%
	County Total	**68,448**	**84,576**	
Stanislaus	Blue Cross	26,391	35,224	100.0%
	County Total	**26,391**	**35,224**	
Tulare	Blue Cross	51,716	60,863	77.5%
	Health Net	16,796	17,662	22.5%
	County Total	**68,512**	**78,525**	
Two-Plan Subtotal	**All Enrollees**	**2,163,856**	**2,381,478**	
	County Plans	1,434,031	1,584,630	66.5%
	Commercial Plans	729,825	796,848	33.5%

Source: Author's analysis of Department of Health Services, Monthly Enrollment Report for December 2002

*In Los Angeles County, L.A. 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.

authorities also enroll Medicaid recipients with disabilities. Federal rules limit the percentage of a state's Medicaid managed care enrollees that can be in a county health system.

• *Geographic Managed Care (GMC),* where competing health plans vie for enrollees within a county, but there is no designated county government plan. GMC arrangements operate in Sacramento and San Diego Counties with five to seven HMOs competing.

There are eight counties in five county-organized health systems. In addition, 12 counties have a two-plan system (although one of them has only a single plan). In those counties, the county-sponsored plan has an average of two-thirds of the enrollees. In fact, in all two-plan counties the county-sponsored plan has a higher share of the enrollees. That is true even though there is significant overlap in the provider networks.

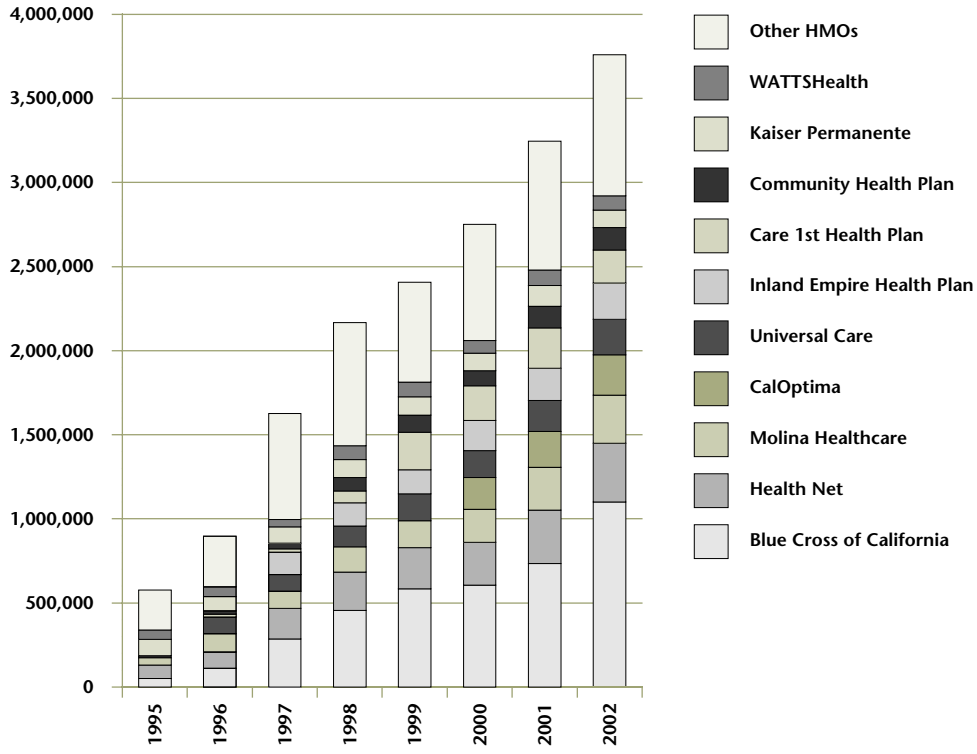
In 1997, there were about 1.1 million Medi-Cal recipients in two-plan arrangements. The two-plan arrangement in Los Angeles was implemented a year later, bringing two-plan counties to 2.4 million enrollees, or more than two-thirds of California's Medi-Cal managed care enrollees. About 518,000 enrollees were in the five County-Organized Health Systems at the end of 2002, and 367,000 were in the San Diego and Sacramento GMC arrangements.

Efforts to fix the state's budget deficit will slow the growth of both the Medi-Cal and Healthy Families programs. California and other states will benefit from a one-time infusion of federal funds in 2003, when Congress made a one-time increase in federal matching dollars. However, states addressing Medicaid shortfalls are largely limited to three approaches: reducing eligibility, reducing benefits, and reducing payments to providers. California had been planning expansions in eligibility for both Medi-Cal and Healthy Families. Under federal rules, there is very little room for states to do what private employers have been doing, namely increasing enrollee cost-sharing through co-payments and deductibles. A budget cut enacted in 2003 will reduce fees to providers. By requiring Medi-Cal recipients to go through a requalification process twice a year (instead of just once under current rules), some number of enrollees will fall off the rolls.

Exhibit 11 compares contracting HMOs on their Medi-Cal and Healthy Families enrollment between 1995 and 2002, based on their annual statements to the Department of Managed Health Care. Six plans have more than 200,000 enrollees, and three others have between 100,000 and 200,000 enrollees. Blue Cross reports almost 1.1 million enrollees in Medi-Cal plus a few thousand in Healthy Families, making it the largest plan by far. WellPoint Health Networks, 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

Exhibit 11

Enrollment in Medi-Cal HMO Plans, 1995-2002



amount of Medicaid business. If L.A. Care for Medi-Cal is excluded, CalOptima and Inland Empire Health Plan are the largest county-sponsored contractors for Medi-Cal and Healthy Families.

3.5 HMO Enrollment by Region

Exhibit 12 and *Exhibit 13* present two views of HMO enrollment and penetration by region. California health plan 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. As the Department of Managed Health Care develops new reporting requirements for HMOs, it would be helpful to researchers and others if supplemental reports with this information were available. Other researchers survey health plans to gather that information from health plans, but do not disclose information on individual HMOs.

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 L.A. Care.

Another source of enrollment data was reported by 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, but that affects only a small number of enrollees. The CMS reports do not exactly mirror 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.

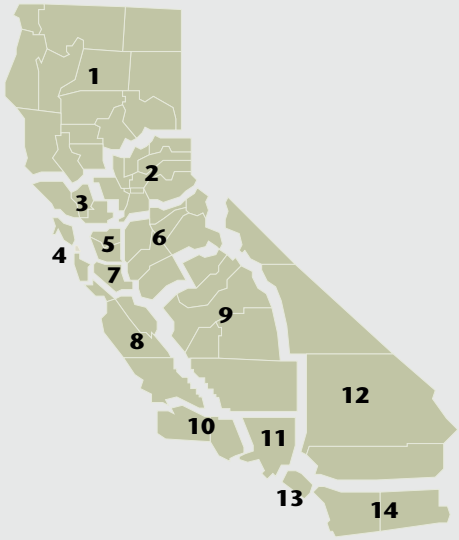
Enrollment in limited license health plans is not included in this analysis because of the double counting problem described earlier in this section. This analysis does not include some small demonstration projects in California, which account for only a few thousand enrollees.

County population figures are taken from the 2002 county population estimates. The counties are grouped into the 14 Health Service Area (HSA)

Exhibit 12

Estimated Health Plan Enrollment and Penetration by Region, 2002

Region	HSA	2002 Estimated HMO Enrollment	2002 Estimated Population	Estimated HMO Penetration
North	1	91,311	909,750	10.0%
Sacramento	2	1,491,294	2,156,620	69.1%
Sonoma Napa	3	667,533	1,007,800	66.2%
San Francisco Bay West	4	1,045,916	1,752,700	59.7%
East Bay Area	5	1,719,995	2,477,000	69.4%
Sierra Nevada	6	771,936	1,441,330	53.6%
San Jose	7	1,066,312	1,718,500	62.0%
Central Coast	8	280,417	981,500	28.6%
Central Valley	9	1,130,514	2,198,400	51.4%
Santa Barbara	10	584,922	1,193,500	49.0%
Los Angeles	11	6,436,913	9,902,700	65.0%
Inland Empire	12	2,360,346	3,520,400	67.0%
Orange	13	1,952,991	2,954,500	66.1%
San Diego	14	1,810,507	3,087,000	58.6%
	TOTAL	21,410,887	35,301,700	60.7%



Sources: Based on HMO annual statements, 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.hcfa.gov

regions used for state health planning. For ease of presentation in one of the tables, three regions in the Bay Area are combined. Los Angeles and Orange counties, which are separate HSAs, are likewise reported together.

At the end of December 2002, 60.7% of the state's 35.3 million residents were enrolled in an HMO for commercial, Medicare, Medi-Cal, or Healthy Families plans. That is down from 62% in 2001. In six regions of the state, HMO penetration is 65% or higher. The regions with the lowest penetration

Exhibit 13

Estimated HMO Enrollment by Region, 2002

HMO	North/ Sacramento 1,2	Napa-Sonoma 3	Bay Area 4,5,7	Sierra Nevada 6	Central Coast 8	Central Valley 9	Santa Barbara 10	Los Angeles-Orange 11,13	Inland Empire 12	San Diego 14	TOTAL
Aetna Health	38	3,638	83,614	17,128	1,634	1,680	13,215	198,876	95,354	109,532	524,711
Blue Cross	277,538	30,733	464,882	202,483	76,250	526,659	191,849	2,321,160	475,533	269,612	4,836,701
Blue Shield	256,394	52,178	347,257	81,542	43,225	128,822	76,721	861,662	231,208	129,389	2,208,399
CIGNA Healthcare	35,068	7,166	124,418	12,107	3,697	16,795	17,079	302,076	62,272	53,890	634,568
Health Net	184,100	83,575	401,354	78,940	28,060	120,239	80,306	811,250	165,170	163,371	2,116,364
Kaiser Permanente	620,619	381,620	1,818,099	229,521	13,502	209,438	68,164	1,850,226	618,668	495,390	6,305,247
PacifiCare	126,972	24,879	208,514	86,762	28,003	46,325	63,130	757,658	281,134	305,700	1,929,076
Prudential Health Care	766	0	8,582	0	0	0	0	36,320	9,195	7,816	62,678
Care 1st Health Plan	0	0	0	0	0	0	0	196,616	0	0	196,616
Chinese Community Health Plan	0	0	10,865	0	0	0	0	0	0	0	10,865
Community Health Group	0	0	0	0	0	0	0	0	208	93,403	93,611
Community Health Plan	0	0	0	0	0	0	0	162,089	0	0	162,089
Inter Valley Health Plan	0	0	87	0	0	0	0	18,441	18,924	12	37,464
Molina Medical Centers	23,689	0	0	0	0	0	0	155,559	106,932	0	286,180
National Med	0	0	0	0	0	0	0	0	0	0	0
On Lok Senior Health Services	0	0	865	0	0	0	0	0	0	0	865
One Health Plan	1,391	1,381	13,926	1,905	938	781	482	23,681	3,987	10,542	59,015
SCAN Health Plan	0	0	0	0	0	0	16	39,862	11,476	39	51,393
Sharp Health Plan	0	0	0	0	0	0	0	0	896	124,503	125,399
Sistemas Medicos Nacionales	0	0	0	0	0	0	0	0	0	10,612	10,612
UC San Diego	0	0	0	0	0	0	0	0	0	12,151	12,151
Universal Care	10	13	4	3	10	5,063	783	289,652	35,125	24,532	355,195
Santa Clara County Valley Health Plan	0	0	45,687	0	0	0	0	0	0	0	45,687
Ventura County	0	0	0	0	0	0	10,612	0	0	0	10,612
WATTSHealth Plan	0	0	0	0	0	0	0	105,462	3,006	13	108,481
Western Health Advantage	56,020	7,713	0	0	0	0	0	0	0	0	63,733
County Health Plans											
Alameda Alliance for Health	0	0	85,271	0	0	0	0	0	0	0	85,271
CalOptima	0	0	0	0	0	0	0	240,045	0	0	240,045
Central Coast Alliance	0	0	0	0	85,098	0	0	0	0	0	85,098
Contra Costa Health Plan	0	0	59,187	0	0	0	0	0	0	0	59,187
Inland Empire Health Plan	0	0	0	0	0	0	0	0	241,258	0	241,258
Kern Health Systems	0	0	0	0	0	74,712	0	0	0	0	74,712
L.A. Care (Local Initiative Health Authority)	0	0	0	0	0	0	0	19,268	0	0	19,268
Partnership Health Plan	0	74,656	0	0	0	0	0	0	0	0	74,656
San Francisco Health Plan	0	0	38,264	0	0	0	0	0	0	0	38,264
San Joaquin County Health	0	0	0	61,544	0	0	0	0	0	0	61,544
San Mateo Health Commission	0	0	46,784	0	0	0	0	0	0	0	46,784
Santa Barbara	0	0	0	0	0	0	62,565	0	0	0	62,565
Santa Clara Family Health Plan	0	0	74,524	0	0	0	0	0	0	0	74,524
TOTAL	1,582,605	667,553	3,832,183	771,936	280,417	1,130,514	584,922	8,389,904	2,360,346	1,810,507	21,410,887

rates are the far north and the central coast, including the Santa Cruz and Monterey areas. The northern part of the state generally does not have HMOs for Medi-Cal. The central coast does use county-sponsored HMOs for Medi-Cal, but the hospitals and physician groups in the region have historically been very 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 northern California, the Inland Empire, and San Diego. Blue Cross is the largest in central California and 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% 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 a bigger percentage of premium revenues. Employers wonder why their premiums increase so fast. Consumers ask questions about executive compensation and about what revenues are returned to shareholders.

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). Also note that statutory rules may vary from state to state. For example, some states might require that certain investments or receivables of a certain age be classified as long-term assets because they are not easily converted to cash. Under GAAP, the same investments might be classified as current assets.

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. 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.

In general, HMOs had stronger profits in 2002 than in 2001. As shown in *Exhibit 14*, California HMOs had net income (after taxes and including investment income) of $827.1 million in 2002, or 1.6% of revenues of $51.5 billion. HMOs had net income on operations of $1.285 billion in 2002, before investment income and income taxes. They reported investment income of $78.2 million and paid income taxes of $534.8 million. On average, the HMOs had net income of $3 per member per month. In 2001, by comparison, HMOs reported net profits after taxes (and including investment income) of $553 million, or 1.2% on revenues of $46.6 billion.

Among the largest health plans, Blue Cross, Blue Shield, Health Net, and PacifiCare all had strong net income. As in past years, Blue Cross had the highest net income, $434.6 million or 4.8% on revenues of $9.1 billion. A year earlier, Blue Cross had net income of $176.2 million, or 2.5% of revenues. Blue Shield increased its net income from $41 million in 2001 to $87 million in 2002, and Health Net improved from $101 million to $135 million.

On the other hand, Kaiser Permanente reported a net loss of $117.6 million in 2002. It had a small loss on its general operations but reported losses of $104 million on its investments. It also wrote off on its 2002 financial statements a significant investment on its automated patient record system that it abandoned in favor of a vendor system. A year earlier it reported net income of $120.2 million.

Among smaller HMOs, 10 reported net income in 2002. SCAN Health Plan in Long Beach, a special health plan for seniors, had 2002 net income of $35 million, compared to $6.9 million in 2001.

Two HMOs that became insolvent reported large losses in 2002: Lifeguard lost $52 million while Health Plan of the Redwoods lost $14.6 million.

The county-sponsored Medi-Cal HMOs have generally had strong results in recent years, but their net income declined in 2002. As a group they reported net income of almost $75 million in 2002. Kern Health System had net income of $11.8 million, or 13.5% of revenues. CalOptima and L.A. Care both reported more than $20 million in net income. Two county HMOs—Alameda Alliance for Health and Santa Barbara Health Authority—both lost money in 2002. Alameda Alliance had net income of $36.4 million in the previous four years.

The largest investor-owned HMOs in California pay a large amount in federal income taxes. Blue Cross paid $434.6 in 2002 income taxes. Health Net paid $94.2 million and PacifiCare paid $62.1 million.

HMO Net Income

How much did HMOs make from underwriting and investments? What percentage is that of total underwriting revenues?

California	$827,101,884	1.6%
Colorado	$102,067,854	2.8%
Florida	$134,968,998	1.0%
Illinois	$77,065,058	1.2%
Michigan	$63,845,947	1.1%
Minnesota	$65,619,336	1.6%
Ohio	$110,296,018	2.4%
Texas	$35,328,624	0.4%
Wisconsin	$63,231,735	1.6%

Exhibit 14

Net Income for California HMOs, 2002

Large HMOs	Revenue	Net Income (Loss) Pre-Tax	Taxes Paid	Net Income (Loss) After Tax	Margin	Net Income (Loss) Per Member Per Month	Profits (Losses) 1998-2002
Aetna Health	1,461,768,100	71,977,886	21,635,662	50,342,224	3.4%	6.71	23,407,877
Blue Cross	9,107,629,000	739,195,000	304,581,000	434,614,000	4.8%	7.78	1,426,289,000
Blue Shield	4,575,066,000	177,474,000	34,825,000	142,649,000	3.1%	5.25	258,951,000
CIGNA Health	1,293,103,910	-3,384,337	2,854,235	-6,238,572	-0.5%	-0.81	68,900,731
Health Net	5,220,620,598	229,940,872	94,220,353	135,720,519	2.6%	4.86	518,257,426
Kaiser Foundation Health Plan	16,970,874,000	-117,574,000	0	-117,574,000	-0.7%	-1.50	280,704,000
PacifiCare	6,143,814,844	149,058,114	62,102,194	86,955,920	1.4%	3.62	781,538,782
Prudential Health	31,257,260	16,194,144	1,787,290	14,406,854	46.1%	11.24	50,973,139
Smaller HMOs							
Care 1st	216,379,427	13,721,282	5,545,826	8,175,456	3.8%	3.42	14,520,793
Chinese Community	39,248,531	1,406,631	583,618	823,013	2.1%	6.80	2,009,938
Community Health Group	104,586,042	-513,966	0	-513,966	-0.5%	-0.46	9,405,065
Community Health Plan	157,926,346	17,084,021	0	17,084,021	10.8%	9.84	27,793,795
Health Plan of the Redwoods	66,787,685	-14,631,119	0	-14,631,119	-21.9%		-20,129,043
Inter Valley Health Plan	0	0	0	0		0.00	-5,626,937
Lifeguard	300,048,421	-52,041,930	0	-52,041,930	-17.3%	-29.89	-86,143,482
Molina Healthcare	323,448,405	21,358,422	7,974,063	13,384,359	4.1%	4.05	55,550,053
National Med	58,840,244	-4,519,482	-1,682,551	-2,836,931	-4.8%		-11,641,153
On Lok Senior Health	51,054,376	4,695,462	0	4,695,462	9.2%	447.40	15,382,851
One Health	158,792,283	736,633	358,782	377,851	0.2%	0.51	53,915,631
Scan Health Plan	309,832,618	35,050,251	800	35,049,451	11.3%	58.42	15,365,274
Sharp Health Plan	147,097,073	-4,622,073	0	-4,622,073	-3.1%	-3.47	-3,983,868
Sistemas Medicos Nacionales	9,090,708	531,680	199,149	257,092	2.8%	7.81	-4,031,374
UC San Diego Health Plan	14,954,395	-939,720	0	-939,720	-6.3%	-6.43	-6,908,004
Universal Care	432,441,722	-2,289,775	-989,050	-1,300,725	-0.3%	-0.31	-5,277,599
Valley Health	55,343,261	475,871	0	475,871	0.9%	0.85	7,492,724
Ventura County	13,687,311	-434,810	0	-434,810	-3.2%	-3.50	-478,134
Watts Health	265,147,000	5,458,000	0	5,458,000	2.1%	3.96	-1,100,000
Western Health Advantage	104,048,786	207,896	0	207,896	0.2%	0.31	-4,669,041
County Plans							
Alameda Alliance for Health	115,324,225	-153,374	0	-153,374	-0.1%	-0.16	36,594,387
CalOptima	715,301,668	20,765,919	0	20,765,919	2.9%	6.25	67,322,378
Central Coast Alliance	207,077,500	4,437,958	0	4,437,958	2.1%	4.53	23,801,703
Contra Costa Health Plan	112,725,107	99,731	0	99,731	0.1%	0.15	1,739,461
Inland Empire Health Plan	263,475,161	6,789,985	0	6,789,985	2.6%	2.50	22,356,377
Kern Health System	88,010,271	12,570,995	0	11,838,825	13.5%	13.68	53,221,904
L.A. Care (Local Initiative Health Authority)	934,462,176	22,299,339	0	22,299,339	2.4%	2.43	54,146,517
Partnership Health Plan						0.00	0
San Francisco Health Plan	52,880,543	2,717,291	0	2,717,291	5.1%	6.30	22,349,784
San Joaquin County Health	71,113,587	2,641,288	0	2,641,288	3.7%	3.73	28,903,017
San Mateo	113,582,661	657,945	0	657,945	0.6%	1.24	-14,802,917
Santa Barbara	137,368,526	-3,516,343	0	-3,516,343	-2.6%	-6.04	-1,549,035
Santa Clara Family Health Plan	88,987,621	5,979,847	0	5,979,847	6.7%	7.79	3,477,464
Limited License Plans							
Cedars Sinai	494,458	113,868	0	113,868	23.0%		344,660
Concentrated Care Inc	1,173,138	1,141,868	0	1,141,868	97.3%		5,627,058
Heritage Provider Network	383,606,993	362,459	103,199	259,260	0.1%	0.11	927,385
PrimeCare Medical Network	256,437,298	1,454,779	476,409	978,370	0.4%	0.32	870,677
ProMed	11,007,320	1,076,628	254,618	322,010	2.9%	3.08	610,207
Scripps Clinic	278,780,840	185,754	800	184,954	0.1%	0.10	35,445,541
TOTAL	51,464,697,439	1,363,240,890	534,831,397	827,101,884	1.6%	3.02	3,801,856,011

Source: Author's analysis of HMO annual statements, Report #2.Statement of Revenues, Expenses and Net Worth

As *Exhibit 15* shows, some of the large HMOs had consistently strong earnings in the past six years. Overall, California HMOs had net income of $3.8 billion from 1998 to 2002. The industry line has generally mirrored the results for Blue Cross since 1998. When the results for Blue Cross declined in 2001, the industry line followed.

3.7 Premium Revenue Trends

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, they may try to raise 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. 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.

The analysis in this section approaches 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 comparison states. Third, an exhibit presents data on premiums paid for commercial HMO and PPO plans organized through CalPERS.

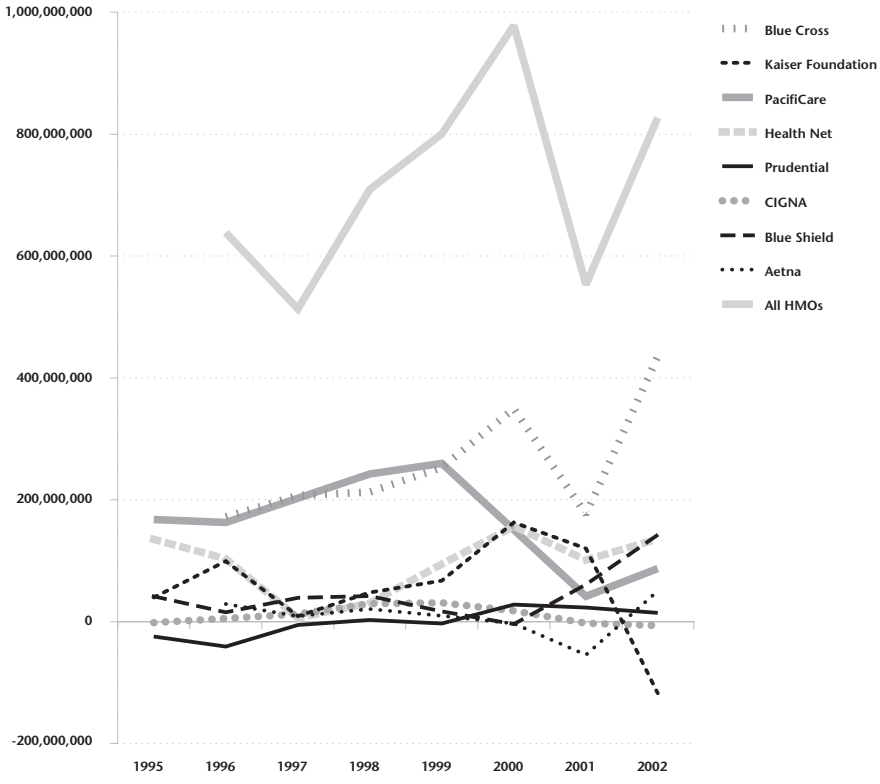
Premium revenue collected is a measure of revenue yield. That is different from a trend analysis in which employers are surveyed or rate filings are examined to determine what the "sticker price" is for health benefits. The format of the HMO annual statements in California makes this analysis somewhat imprecise because the statements do not separate out revenues and expenses for different lines of business. Thus, it is not clear if all premium revenues reported are for commercial business. And, 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.

As shown in *Exhibit 16,* the average commercial premium revenue, per-member per-month, increased by 15.6% in 2002, from $143.11 to $165.50. A year earlier the average increase for California HMOs was 8.3%.

Exhibit 17 compares the premium revenue trend in California with the trend in eight comparison states where the author publishes annual market analyses.

Exhibit 15

Net Income After Taxes of Largest California HMOs, 1995-2002



HMO Premium Trend

On average, how much did HMOs collect in premium revenues per-member per-month on their commercial plans? How much did that increase over 2001?

California up 15.6%	$165.50
Colorado up 20.5%	$189.55
Florida up 19.3%	$197.35
Illinois up 15.0%	$179.02
Michigan up 15.8%	$192.12
Minnesota up 9.9%	$208.97
Ohio up 19.8%	$204.11
Texas up 14.0%	$189.32
Wisconsin up 14.7%	$219.63

✔ Even with recent increases, California HMOs collect less on average than their counterparts in these other states.

✔ By increasing the amount of enrollee cost-sharing, the HMO can offer the employer a smaller premium increase.

Even with recent increases, California HMOs collect less on average than their counterparts in these other states. HMOs in the comparison states have had two or three years of double-digit increases. 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 below-average premium revenue trend. In those states, the HMO can offer a renewal quote of 14%, for example, then suggest that the employer adopt a plan design that includes a co-payment for each day of a hospital stay. By increasing the amount of enrollee cost-sharing, the HMO can offer the employer a smaller premium increase.

CalPERS had very good success in negotiating low rate increases during much of the 1990s, but that

Exhibit 16

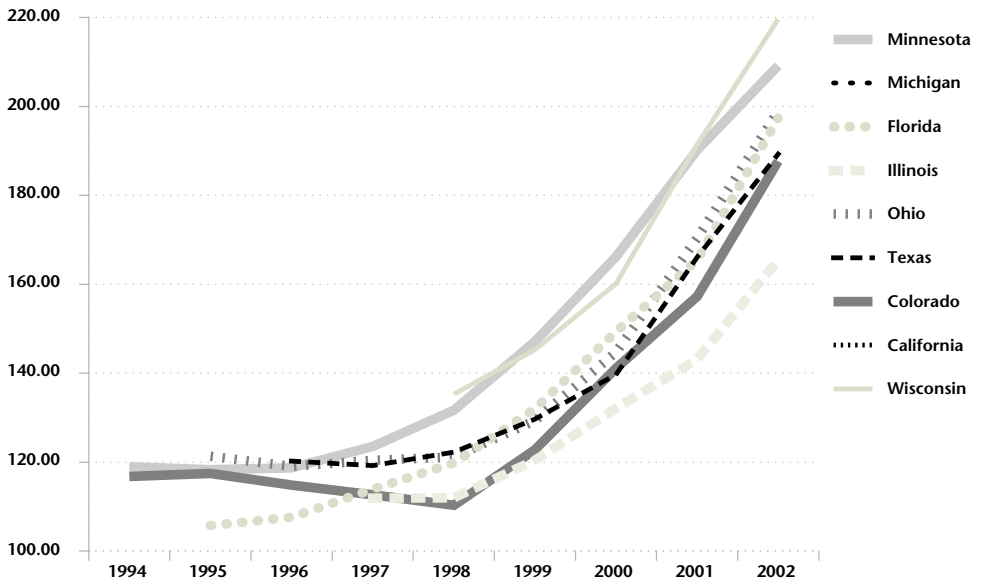
California HMO Commercial Premium Revenue, Per-Member Per-Month, 1997-2002

Large HMOs	1997	1998	1999	2000	2001	2002	Increase 2002/ 2001
Aetna Health	112.93	112.53	115.44	124.36	139.30	152.42	9.4%
Blue Cross	108.25	112.91	121.77	132.68	152.09	183.86	20.9%
Blue Shield	104.23	108.43	117.86	137.49	122.47	146.33	19.5%
Health Net	111.08	116.74	124.91	133.10	155.34	184.92	19.0%
Kaiser Permanente	112.54	112.61	122.07	133.96	144.78	163.44	12.9%
PacifiCare	135.37	109.99	116.74	123.58	135.29	149.92	10.8%
Prudential Health Care	109.74	111.68	117.43	137.22	151.86		
Smaller HMOs							
Chinese Community Health Plan	125.66	135.55	117.44	124.99	127.05	151.61	19.3%
Health Plan of the Redwoods	108.75	113.19	120.20	131.44	189.14		
Lifeguard	114.20	119.38	124.26	137.42	140.82	162.81	15.6%
National Med	105.44	102.59	107.35	113.63	145.27		
One Health Plan	117.08	132.78	153.23	142.08	155.68	146.81	-5.7%
Sharp Health Plan	133.88	103.85	107.49	107.53	82.63	89.62	8.5%
Universal Care	86.69	65.41	86.93	95.65	101.45	135.27	33.3%
Western Health Advantage		149.19	103.36	111.84	141.86	139.41	-1.7%
TOTAL	111.91	112.00	120.49	132.11	143.11	165.50	15.6%
Average increase		0.1%	7.6%	9.6%	8.3%	15.6%	

Source: Author's analysis of HMO annual statements, Reports #2 and #4.

Exhibit 17

HMO Commercial Premium Revenue Trends in California and Selected States



has not been the case recently. As *Exhibit 18* shows, family premiums for CalPERS participants selecting HMO plans will increase about 18% for 2004, on top of increases in the 16-19% range for 2003. Western Health Advantage will get a higher increase, although starting from a much lower base than the other HMOs. The exact amount of the employee contribution depends on what the different agencies have negotiated with their collective bargaining units. CalPERS has also raised the premiums for its PPO plans by 18% for 2004 and by 16% for 2003. It needed to build up reserves that were becoming too low to pay anticipated claims.

3.8 HMO Medical Loss Ratios

One tool used by analysts to assess the financial condition of an HMO is to measure the spread between insurance premiums and medical costs. 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. And 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 comparing HMOs. Still these 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 19 compares California HMOs on their medical loss ratios from 1997 to 2002. The average in 2002 was 89.2%, down from 90.5% in 2001. In the past few years, reductions in medical loss ratios have been reflected in higher net income and vice versa. In 2001, for example, the average loss ratio increased by two percentage points. That doesn't sound like a big difference, but it is an important reason for the reduced profitability of the industry in 2001. In turn, the industry showed improved

- ✔ The average medical loss ratio 2002 was 89.2%, down from 90.5% in 2001.
- ✔ In the past few years, reductions in medical loss ratios have been reflected in higher net income and vice versa. In 2001, for example, the average loss ratio increased by two percentage points.

Exhibit 18

Family Premiums for Active CalPERS Participants in HMO and PPO Plans, 1996-2004

HMOs	1996	1997	1998	1999	2000	2001	2002	2003	2004	Increase 2002/2003	Increase 2003/2004
Kaiser Permanente*	393.94	376.87	486.96	428.57	478.56	525.75	563.32	673.95	794.09	16.4%	17.8%
Blue Shield HMO	406.00	394.00	409.71	442.28	479.87	523.04	563.32	694.86	819.57	18.9%	17.9%
Western Health Advantage								543.14	729.07		34.2%
Health Net	384.80	384.80	403.66	427.48	469.67	512.88	534.25				
PacifiCare	407.60	407.60	417.79	428.05	453.73	489.24	534.25				
Health Plan of the Redwoods	395.00	395.00	409.04	431.52	476.83	517.84	537.11				
Universal Care					419.87	434.15	438.39				
Aetna Health	406.80	406.80	420.14	436.11	464.46	504.40					
CIGNA	398.06	398.06	410.41	424.77	448.48	481.78					
Lifeguard	413.91	413.91	437.38	457.84	507.81	558.08					
Maxicare	390.00	390.00	391.74	415.24	431.60	460.33					
PPOs											
PERS Care	666.00	666.00	705.00	710.00	764.00	892.00	1,167.00	1,425.00	1,416.40	18.1%	-0.6%
PERS Choice	408.00	400.00	416.00	426.00	452.00	556.00	647.00	770.00	908.47	16.0%	18.0%
Association Plans											
CCPOA - North								725.19	834.25		15.0%
CCPOA - South								654.65	693.31		5.9%
CCPOA - SLO								828.66			
California Association of Highway Patrolman	469.88	469.88	469.88	469.88	488.68	579.60	671.17	798.02	909.00	15.9%	13.9%
California Correction and Peace Officers Association	379.00	449.27	492.12	515.18	531.89	550.81	571.13				
Peace Officers Retirement Association of California	489.62	489.62	499.00	518.00	549.00	599.00	699.00	847.00	931.00	17.5%	9.9%
State Contribution	**410.00**				**452.00**	**452.00**	**452.00**				

* Through 1997, Kaiser Permanente charged slightly different rates in northern California and in southern California.

Exhibit 19

Medical Loss Ratios for California HMOs (Entire Plan), 1997-2002

Large HMOs	1997	1998	1999	2000	2001	2002
Aetna Health	89.3%	86.4%	87.0%	88.5%	94.2%	86.2%
Blue Cross of California	76.5%	77.9%	77.4%	76.4%	80.3%	78.9%
Blue Shield	78.7%	81.5%	84.0%	84.5%		83.5%
Cigna HealthCare	85.4%	83.5%	82.5%	82.7%	83.3%	84.6%
Health Net	85.9%	87.9%	86.4%	84.6%	87.8%	86.3%
Kaiser Permanente	96.3%	97.9%	96.4%	96.3%	96.0%	97.7%
PacifiCare	84.5%	84.3%	84.7%	88.1%	91.1%	88.4%
Prudential Health Care	85.5%	88.0%	87.6%	81.7%	66.0%	41.8%
Smaller HMOs						
Care 1st Health Plan	75.5%	82.8%	84.6%	86.0%	83.9%	85.8%
Chinese Community Health Plan	76.4%	80.0%	80.9%	81.0%	81.8%	84.6%
Community Health Group	78.1%	78.1%	86.1%	81.6%	84.4%	89.4%
Community Health Plan	93.6%	93.6%	92.8%	89.5%	89.7%	81.0%
Health Plan of the Redwoods	99.2%	89.7%	89.0%	89.7%		112.4%
Inter Valley Health Plan	87.0%	88.6%	88.2%	87.8%	91.3%	
Lifeguard	93.8%	85.0%	84.2%	85.3%	89.9%	89.4%
Molina Medical Centers	93.2%	87.9%	80.5%	77.8%	80.7%	83.0%
National Med	92.0%	93.1%	90.8%	99.2%		95.9%
On Lok Senior Health			87.5%	83.2%	84.9%	84.9%
One Health Plan	73.9%	65.0%	54.5%	68.4%	88.6%	86.9%
Scan Health Plan	79.6%	79.2%	81.2%	84.8%	88.5%	81.2%
Sharp Health Plan	85.5%	87.3%	91.4%	92.1%	95.2%	95.0%
SIMNSA				61.5%	81.2%	81.2%
UC San Diego Health Plan			85.5%	92.5%	89.9%	91.3%
Universal Care	86.7%	88.9%	89.2%	88.2%	94.4%	91.9%
Valley Health Plan				87.6%	89.5%	89.7%
Ventura County	95.3%	89.2%	89.3%	89.8%	90.3%	93.3%
WATTSHealth Foundation	77.6%	82.1%	82.5%	86.3%		84.3%
Western Health Advantage	88.0%	86.1%	84.3%	84.7%	87.4%	88.0%
County Plans						
Alameda Alliance for Health	71.7%	71.7%	79.3%	78.0%	102.4%	94.0%
CalOptima				90.0%	93.9%	93.5%
Central Coast Alliance	86.3%			90.8%	88.1%	92.4%
Contra Costa County Medical Services	93.3%	93.6%		91.6%	95.8%	92.5%
Inland Empire Health Plan	84.3%	85.8%	89.3%	90.4%	90.7%	89.5%
Kern Health Systems	72.9%	72.8%	67.9%	76.9%	80.1%	79.3%
LA Care (Local Initiative Health Authority)	85.1%	93.9%	94.7%	95.2%	94.4%	94.2%
San Francisco Health Plan	87.4%	84.0%	86.8%	88.4%	86.7%	86.1%
San Joaquin County Health	79.4%	75.3%	79.4%	79.2%	84.0%	84.8%
San Mateo Health Commission		92.3%	81.5%	98.7%	102.0%	91.3%
Santa Barbara Health Authority					95.1%	95.3%
Santa Clara Family Health Plan	87.4%	84.1%		75.2%	83.1%	82.6%
Limited License Plans						
Heritage Provider Network	84.9%	93.7%	93.7%	96.7%	97.3%	99.1%
PrimeCare Medical Network	97.5%	91.6%		96.6%	95.3%	87.5%
Scripps Clinic				96.5%	97.5%	95.9%
TOTAL	87.6%	88.4%	87.8%	88.2%	90.5%	89.2%

profitability in 2002, a year when medical loss ratios declined on average by 1.3%.

As in past years, Kaiser Permanente reports the highest loss ratio of the largest HMOs. This is partly the result of how it allocates expenses between the Medical-Hospital and Administration categories. For example, some HMOs say that the expense of 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. Some HMOs in Minnesota, wanting to show high medical costs and low administrative costs, took the costs of any staff that had contact with providers, such as network management or contracting staff, and allocated those expenses to the Medical-Hospital category.

Among the largest plans, Blue Cross has consistently shown the lowest medical loss ratio, below 80% in every year but one. (Prudential Health is ignored since Aetna is transitioning Prudential out of business.) Again, note that Blue Cross' net income dropped in the year that its medical loss ratio increased to 80.3%. PacifiCare had medical loss ratios of 84-85% from 1997 to 1999, but has had ratios between 88% and 91% since then.

Two years ago, four of the county-sponsored Medi-Cal plans had medical loss ratios below 80%. Many of them have seen their ratios increase in 2001 and 2002, and now only Kern Health Systems has a ratio below 80%. Some county health systems provide safety net providers with end-of-year bonuses, sharing surpluses that have built up in the year. That can be seen as a medical expense or an administrative expense.

3.9 Capitation Payments

Exhibit 20 compares selected HMOs on their use of capitation in 2002. In California, a high proportion of medical expenses are paid to providers through capitation arrangements. While most physician groups are interested in continuing to accept and manage capitation, hospitals have changed their contracts in the past two to three years. This year's report analyzes capitation payments using data from the revised revenue and expense statement that was introduced in 2002 for California HMOs. That statement includes three new lines 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 2002 numbers may not be comparable to the numbers reported in previous editions of this report. In past reports, the analysis of capitation payments was based on the calculation that HMOs made to report their compliance with the state's Tangible Net Equity (TNE) requirements. The calculation of TNE under California law assumes that an HMO that capitates most of its medical expenses can justify lower reserves and vice versa. Also, the analysis of California HMO data in this report may not be comparable to what is reported in comparison states. In other states that use the 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.

Using the information from the new revenue and expense statement, *Exhibit 20* shows that, on average, HMOs paid 37.3% of their medical expenses through capitation. 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 some measure of risk to hospitals. There is a good deal of variation in the extent to which California HMOs use capitation. Some large HMOs such as Health Net report capitating almost half of their medical expenses. Blue Cross is at the low end, at less than 15% of its medical expenses capitated. Kern Health System reports zero use of capitation. L.A. Care reports virtually 100% of its medical expenses paid through capitation, but that involves payments to licensed HMOs, not directly to medical groups or IPAs.

Going forward, it will be interesting to compare the use of capitation by California HMOs. In interviews with health plans and hospitals, it was clear that they see less use of capitation, particularly in hospital contracts.

3.10 Prescription Drugs

A key component of HMO medical expenses is outpatient prescription drugs. It is frequently cited as a key cost driver in overall health costs and for insurance premiums, and in recent years was seen as the single most important driver of health care cost increases. However, recent research from the Center for Studying Health System Change indicates that inpatient hospital care has supplanted prescription drugs as the biggest driver of health care costs. The cost of inpatient hospital care (discussed in Section 3.13) has increased sharply because of higher rates of utilization and much 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

What Is Capitation?

The goal of capitation is for the provider to have a financial stake in using 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.

HMO Capitation

What percentage of the dollars paid to providers were through capitation arrangements in 2001 and 2002?

California*

2002 37.3%
2001 %

Colorado

2002 18.2%
2001 22.4%

Florida

2002 20.8%
2001 20.5%

Illinois

2002 27.9%
2001 35.7%

Michigan

2002 33.4%
2001 39.3%

Minnesota

2002 14.0%
2001 23.7%

Ohio

2002 10.4%
2001 12.6%

Texas

2002 15.6%
2001 21.3%

Wisconsin

2002 36.9%
2001 35.9%

* Methodology for calculating capitation use in California is different from other states and was different in 2001 and 2002.

now become available. In other cases, popular drugs are now available over the counter and not paid for under health benefit plans.

In the 2002 edition of this report, HEDIS data were used to compare commercial plans on their prescription drug expenses. This year's report includes that analysis and the prescription drug expense data now reported in the HMO annual statements.

Exhibit 21 shows outpatient prescription drug expenses for HMO plans based on those two sources. Across all lines of business, the upper half of the exhibit shows that HMOs spent $3.7 billion on outpatient

Exhibit 20

Use of Capitation by California HMOs, 2002

Large HMOs	Capitated Medical Expenses	Total Medical Expenses	% In Capitation
Aetna Health	451,579,862	1,244,836,480	36.3%
Blue Cross of California	1,069,745,000	7,183,037,000	14.9%
Blue Shield of California	771,536,000	3,780,100,000	20.4%
CIGNA Healthcare	349,330,898	1,089,128,412	32.1%
Health Net	2,103,514,325	4,470,913,304	47.0%
Kaiser Foundation	7,773,891,000	16,677,567,000	46.6%
PacifiCare	2,125,542,054	5,406,653,578	39.3%
Smaller HMOs			
Health Plan of the Redwoods	13,987,459	74,598,327	18.8%
Care 1st Health Plan	76,819,927	185,133,855	41.5%
Chinese Community Health Plan	13,350,917	33,081,353	40.4%
Community Health Group	16,944,227	92,663,668	18.3%
Community Health Plan	63,458,398	126,313,959	50.2%
Lifeguard	7,187,187	267,623,824	2.7%
Molina Medical Centers	88,455,293	267,836,098	33.0%
National Med	19,308,023	55,422,851	34.8%
On Lok Senior Health Services	6,985,150	42,996,719	16.2%
One Health Plan	17,861,618	136,200,143	13.1%
SCAN Health Plan	99,129,529	251,560,755	39.4%
Sharp Health Plan	40,394,693	139,475,587	29.0%
Sistemas Medicos Nacionales	1,899,484	7,378,312	25.7%
UC San Diego	2,730,487	13,474,384	20.3%
Universal Care	124,446,920	397,074,605	31.3%
Ventura County	567,837	12,650,578	4.5%
WATTSHealth Foundation	70,684,000	222,817,000	31.7%
Western Health Advantage	37,511,122	91,544,613	41.0%
County Plans			
Alameda Alliance for Health	34,363,006	105,774,520	32.5%
CalOptima	185,849,518	661,717,524	28.1%
Central Coast Alliance	8,672,824	190,222,662	4.6%
Contra Costa Health Plan	5,455,468	104,042,184	5.2%
Inland Empire Health Plan	87,328,429	234,733,711	37.2%
Kern Health Systems	0	68,548,435	0.0%
LA Care	870,136,894	876,847,745	99.2%
San Francisco Health Plan	19,922,939	45,260,940	44.0%
San Joaquin County Health	9,254,967	59,224,854	15.6%
San Mateo Health Commission	5,433,400	102,452,029	5.3%
Santa Barbara	3,893,883	130,093,876	3.0%
Santa Clara Family Health Plan	36,261,633	72,771,891	49.8%
Santa Clara County Valley Health Plan	30,994,747	49,197,517	63.0%
TOTAL	17,096,530,245	45,855,261,030	37.3%

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

prescription drugs in 2002, which was $13.72 per-member per-month. The range among plans is quite wide and may reflect inconsistency in reporting. One Medi-Cal HMO reported an average PMPM of less than $7 while two others reported spending more than $40 PMPM.

✔ HMOs spent $3.7 billion on outpatient prescription drugs in 2002, which was $13.72 per-member per-month. The range among plans is quite wide and may reflect inconsistency in reporting.

Exhibit 21

Outpatient Prescription Drug Expense for Commercial Health Plans, 2002 (Part 1)

HMO	Prescription Drug Expenses	Expenses Per Member Per Month
Larger HMOs		
Aetna Health	173,624,260	23.15
Blue Cross of California	1,168,540,000	20.92
Blue Shield of California	557,506,000	20.51
CIGNA Healthcare	119,710,009	15.63
Health Net	589,164,732	21.08
Kaiser Foundation	34,397,000	0.44
PacifiCare	491,390,246	20.48
Prudential Health Care	83,276	0.06
Smaller HMOs		
Care 1st Health Plan	17,505,072	7.32
Chinese Community Health Plan	2,831,396	23.38
Community Health Group	15,829,249	14.03
Community Health Plan	14,212,504	8.18
Lifeguard	12,792,121	7.35
Molina Medical Centers	31,628,147	9.57
National Med	8,121,103	32.65
On Lok Senior Health Services	1,327,180	126.46
One Health Plan	0	0.00
SCAN Health Plan	26,329,508	79.69
Sharp Health Plan	21,920,405	16.45
Sistemas Medicos Nacionales	2,114,118	64.22
UC San Diego	2,366,644	16.19
Universal Care	55,122,233	13.31
Ventura County	2,317,826	18.66
WATTSHealth Foundation	15,480,000	11.22
Western Health Advantage	16,381,573	24.28
County Health Plans		
Alameda Alliance for Health	11,360,612	11.70
CalOptima	139,638,410	42.03
Central Coast Alliance	43,747,747	44.70
Contra Costa Health Plan	18,427,468	26.87
Inland Empire Health Plan	18,641,829	6.86
Kern Health Systems	13,257,892	15.32
L.A. Care (Local Initiative Health Authority)	271,992	0.03
San Francisco Health Plan	7,826,322	18.16
San Joaquin County Health (Health Plan of San Joaquin)	11,693,480	16.52
San Mateo Health Commission (Health Plan of San Mateo)	33,713,270	63.37
Santa Barbara	38,104,184	65.40
Santa Clara Family Health Plan	6,612,226	8.61
TOTAL	3,729,857,926	13.72

Source: Author's analysis of HMO annual statements, Report #2. Statement of Revenues, Expenses and Net Worth

Outpatient Prescription Drug Expenses for Commercial HMOs 2002 (HEDIS data) (Part 2)

HMO	Prescriptions	Prescriptions Per Member Per Year	Prescription Expenses	Average Cost of Prescriptions Per Member Per Month 2002	2001	2000
Aetna Health	4,260,036	8.20	NR	NR	NR	NR
Blue Cross of California	13,280,460	8.61	719,409,843	38.85	23.14	21.13
Blue Shield of California	6,855,062	8.35	296,270,678	30.08	NR	NR
CIGNA HealthCare	3,654,352	7.10	151,809,493	24.57	21.59	21.75
Health Net	13,150,370	9.31	559,480,014	33.01	28.78	25.99
Kaiser Foundation - Southern California	25,884,863	10.68	572,542,016	19.69	17.43	16.80
Kaiser Foundation - Northern California	28,892,998	11.80	634,269,131	21.58	18.82	15.27
PacifiCare	12,837,174	8.85	533,048,989	30.63	26.36	17.61
US Median		10.01		38.41	32.45	29.11

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.

✔ In 2002, HMOs reported spending $4.2 billion in administrative costs. On average, they spent 8.1% of their revenues on administration, and $15.38 per-member per-month.

✔ The average per-member per-month amount has increased—it was $14.23 in 2000.

The lower portion of the exhibit uses 2002 HEDIS data for commercial plans only and compares the PMPM calculated from that data with the PMPM for 2000 and 2001. PacifiCare showed the biggest increase, up by almost half in two years.

3.11 Administrative Expenses

HMO administrative expenses include compensation, marketing, and office expenses. As noted above, some HMOs that want to report lower medical loss ratios might report higher administrative expenses. *Exhibit 22* 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 2002, HMOs reported spending $4.2 billion in administrative costs. On average, they spent 8.1% of their revenues on administration, and $15.38 per-

Exhibit 22

Administrative Expenses for California HMOs (Entire Plan), 2002

Large HMOs	Administration Expense	As a % of Revenues	As a % of Expenses	Per Member Per Month
Aetna Health	144,953,734	9.9%	10.4%	19.33
Blue Cross of California	1,185,397,000	13.0%	14.2%	21.22
Blue Shield of California	617,492,000	13.5%	14.0%	22.72
CIGNA Healthcare	207,359,835	16.0%	16.0%	27.07
Health Net	519,766,422	10.0%	10.4%	18.60
Kaiser Foundation	410,881,000	2.4%	2.4%	5.23
PacifiCare	588,103,152	9.6%	9.8%	24.51
Smaller HMOs				
Care 1st Health Plan	17,524,290	8.1%	8.6%	7.33
Chinese Community Health Plan	4,760,547	12.1%	12.6%	39.31
Community Health Group	12,436,340	11.9%	11.8%	11.03
Community Health Plan	14,528,366	9.2%	10.3%	8.36
Health Plan of the Redwoods	6,820,477	10.2%	8.4%	
Lifeguard	84,466,527	28.2%	24.0%	48.51
Molina Medical Centers	34,253,885	10.6%	11.3%	10.36
National Med	7,936,875	13.5%	12.5%	
On Lok Senior Health Services	1,997,845	3.9%	4.3%	190.36
One Health Plan	21,855,507	13.8%	13.8%	29.32
Sharp Health Plan	12,243,559	8.3%	8.1%	9.19
Sistemas Medicos Nacionales	1,180,716	13.0%	13.8%	35.86
UC San Diego	2,419,731	16.2%	15.2%	16.55
Universal Care	37,656,892	8.7%	8.7%	9.09
Ventura County	1,471,543	10.8%	10.4%	11.85
SCAN Health Plan	23,221,612	7.5%	8.5%	70.28
WATTSHealth Foundation	36,872,000	13.9%	14.2%	26.72
Western Health Advantage	12,296,277	11.8%	11.8%	18.23
County Health Plans				
Alameda Alliance for Health	9,703,079	8.4%	8.4%	10.00
CalOptima	32,818,225	4.6%	4.7%	9.88
Central Coast Alliance	12,416,880	6.0%	6.1%	12.69
Contra Costa Health Plan	8,583,192	7.6%	7.6%	12.51
Inland Empire Health Plan	21,951,465	8.3%	8.6%	8.08
Kern Health Systems	6,890,841	7.8%	9.1%	7.96
L.A. Care	35,315,092	3.8%	3.9%	3.84
San Francisco Health Plan	4,902,312	9.3%	9.8%	11.37
San Joaquin County Health	9,247,445	13.0%	13.5%	13.06
San Mateo Health Commission	10,472,687	9.2%	9.3%	19.69
Santa Barbara	10,790,993	7.9%	7.7%	18.52
Santa Clara Family Health Plan	10,235,883	11.5%	12.3%	13.33
Santa Clara County Valley Health Plan	5,669,873	10.2%	10.3%	10.07
TOTAL	4,191,448,162	8.1%	8.4%	15.38

member per-month. Administrative costs were 8.4% of total expenses. The average ratio has gone down, although the average per-member per-month amount has increased—it was $14.23 in 2000. Kaiser Permanente reported exceedingly low administrative expenses for 2002—only $5.23 per member per month and only 2.4% of revenues. That was consistent with what it reported in previous years.

3.12 HMO Net Worth

With five California HMOs recently becoming insolvent, only one of which is still operating, attention has been focused on state standards for 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

Exhibit 23

California HMO Net Worth, 2001-2002

HMO Large HMOs	2001 Net Worth	2002 Net Worth	Change	Weeks of Net Worth	Net Worth Per Enrollee
Aetna Health	73,033,506	125,514,760	52,481,254	4.70	239.94
Blue Cross of California	886,880,000	1,042,880,000	156,000,000	6.48	215.62
Blue Shield	605,344,000	740,120,000	134,776,000	8.75	335.14
CIGNA Healthcare	45,149,989	43,512,580	-1,637,409	1.75	68.57
Health Net	500,585,310	487,303,979	-13,281,331	5.08	230.26
Kaiser Permanente	1,336,058,000	916,746,000	-419,312,000	2.79	139.60
PacifiCare	293,507,453	320,827,287	27,319,834	2.78	166.31
Smaller HMOs					
Care 1st Health Plan	22,768,955	30,944,411	8,175,456	7.94	157.39
Chinese Community Health Plan	3,578,964	4,401,977	823,013	6.05	410.10
Community Health Group	21,382,004	20,868,038	-513,966	10.32	217.79
Community Health Plan	5,046,291	37,935,566	32,889,275	14.01	234.04
Health Plan of the Redwoods	0	-18,443,147	-18,443,147	-11.78	
Inter Valley Health Plan	-5,169,574	-7,635,559	-2,465,985		-202.80
Lifeguard	9,516,525	-42,851,267	-52,367,792	-6.33	
Molina Medical Centers	34,006,157	26,390,516	-7,615,641	4.54	92.22
On Lok Senior Health	23,580,065	28,695,747	5,115,682	32.19	31,708.01
One Health Plan	18,776,745	19,099,861	323,116	6.28	323.64
SCAN Health Plan	19,932,320	53,270,228	33,337,908	10.08	982.03
Sharp Health Plan	4,311,875	4,592,743	280,868	1.57	38.58
SIMNSA Health Plan	1,008,435	1,134,624	126,189	6.89	96.45
UC San Diego Health Plan	2,123,784	1,802,622	-321,162	5.90	148.35
Universal Care	3,507,382	7,212,326	3,704,944	0.86	20.30
Ventura County	1,593,323	1,141,082	-452,241	4.20	107.53
WATTSHealth Foundation (UHP Healthcare)	1,171,000	-11,029,000	-12,200,000	-2.21	-101.67
Western Health Advantage	1,372,554	1,573,850	201,296	0.79	26.08
County Health Plans					
Alameda Alliance for Health	45,305,528	45,152,154	-153,374	20.33	529.51
CalOptima	126,658,062	147,423,982	20,765,920	11.04	614.15
Central Coast Alliance	32,270,843	36,708,799	4,437,956	9.42	431.37
Contra Costa Health Plan	5,285,098	5,458,061	172,963	2.52	92.22
Inland Empire Health Plan	18,644,461	25,434,448	6,789,987	5.15	105.42
Kern Health Systems	49,784,056	61,622,881	11,838,825	42.48	824.81
L.A. Care	39,625,193	61,924,533	22,299,340	3.53	3,213.85
San Francisco Health Plan	8,693,280	11,410,571	2,717,291	11.83	298.21
San Joaquin County Health	29,319,670	31,960,958	2,641,288	24.27	519.32
San Mateo	14,663,379	15,321,326	657,947	7.06	327.49
Santa Barbara	16,675,219	13,158,876	-3,516,343	4.86	210.32
Santa Clara Family Health Plan	13,692,666	17,867,946	4,175,280	11.19	239.76
Santa Clara County Valley Health Plan	3,175,527	3,651,399	475,872	3.46	79.92
TOTAL	4,368,493,917	4,339,578,474	-28,915,443	4.59	200.97

HMO Net Worth

On average, how many months of expenses do HMOs maintain in net worth in these states?

California	1.06 months
Colorado	1.37 months
Florida	0.84 months
Illinois	2.06 months
Michigan	1.04 months
Minnesota	1.8 months
Ohio	1.37 months
Texas	0.84 months
Wisconsin	1.15 months

Sources of Comparative Information on Health Plan and Provider Quality

Office of Public Advocate, 2003 Quality of Care Report Card

www.opa.ca.gov/report_card/

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

with providers not under contract. It must also maintain a restricted cash deposit of $300,000. That doesn't benefit consumers or providers directly, but would be available for the expenses of rehabilitating an HMO in distress or liquidating one that is insolvent.

As shown in *Exhibit 23*, HMOs had an average of 4.59 weeks of net worth at the end of 2002. 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 just over one month. That is down from 5.27 weeks in 2000. Viewed another way, HMOs had net worth averaging $201 per member.

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. CIGNA, PacifiCare and Kaiser Permanente all had net worth that by these measures was lower than for other health plans. Kaiser's net worth declined by $419.3 million, partly because of the investment loss and information system write-off described earlier, and partly because of pension obligations. Both Blue Cross and Blue Shield added significant amounts to their net worth.

3.13 Utilization and Effectiveness of Care Measures

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 better-known 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 has, along with other groups, developed programs for accreditation of managed care organizations. Several 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 on the opposite page. A sidebar on this page lists several public resources on the Internet for comparative information about health plans and provider groups in California.

The California Cooperative Healthcare Reporting Initiative (CCHRI), a collaborative of prominent employers, providers, and health plan companies, 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 the data compares health plans "apples to apples." The data comparisons are posted at the California HealthScope Web site

Exhibit 24

Inpatient Hospital Utilization for Commercial Health Plans, 2002

HMO	2002 Acute Days Per 1,000 Members	Average Length of Stay	Discharges Per 1,000 Members	Mental Health Days Per 1000 Members—Mental Health	Chemical Dependency Days Per 1,000 Members—Chemical Dependency	2001 Acute Days Per 1,000 Members
Aetna Health	139.79	3.64	38.41	12.13	5.51	163.43
Blue Cross of California	142.42	3.71	38.36	18.98	4.22	134.96
Blue Shield of California	176.35	3.50	50.32	13.04	2.30	NR
CIGNA HealthCare	137.12	3.44	39.83	9.96	2.81	NR
Community Health Group	NR	NR	NR	NR	NR	NR
Health Net	137.82	3.53	39.00	16.49	4.47	121.45
Kaiser Foundation - Southern California	158.06	3.22	49.08	15.34	4.64	150.57
Kaiser Foundation - Northern California	154.63	3.41	45.32	15.26	1.85	154.40
PacifiCare	156.47	3.52	44.47	15.07	5.61	138.94
Sharp Health Plan	NR	NR	NR	NR	NR	NR
Universal Care	NR	NR	NR	NR	NR	NR
Western Health Advantage	NR	NR	NR	NR	NR	NR
US Median	208.61	3.67	57.74	15.73	4.76	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.

(www.healthscope.org) of the Pacific Business Group on Health.

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 data for this section were drawn from NCQA's Quality Compass® data set, based on operations for 2002.

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 reports only its HMO enrollment.

Exhibit 24 on page 46 compares these HMOs on their rates of inpatient hospital utilization for commercial enrollees in 2002. Some did not complete all sections of the reports for a variety of reasons, so some cells in the tables are blank. The table shows inpatient utilization in three ways: inpatient days per 1,000 enrollees, discharges per 1,000 enrollees, and average length of stay. Other hospital stays, such as non-acute care, are reported separately. Two columns show rates of inpatient utilization, measured again in days per 1,000, for admissions for mental illness or chemical dependency diagnoses. These are calculated by multiplying the number of discharges times the average length of stay for each admission category. The column at the far right of the table provides a comparative rate of inpatient hospital care for 2001, from the NCQA Quality Compass® data set for that year.

California HMOs continue to report relatively low rates of inpatient hospital utilization, with all of those reporting here falling well below the national median. Some of the major plans reported a higher rate in 2002 than in 2000 and 2001. For example, Blue Cross reported 123 inpatient days per 1,000 members in 2000, but 135 days in 2001 and 142 days in 2002. PacifiCare saw its utilization rate increase from 114 inpatient days per 1,000 members in 2000 to 139 days in 2001 and 156.47 in 2002.

The Quality Compass® data set includes four measures of ambulatory care utilization. They are outpatient visits, emergency room visits, ambulatory surgery, and observation room visits. The numbers of visits and procedures were converted into rates per 1,000 members. As shown in *Exhibit 25*, commercial enrollees in PacifiCare, Health Net and Aetna Health used an average of about 2,700 outpatient (office) visits per 1,000 members, higher than in 2001. The two Kaiser Permanente plans reported rates of 3,500 to 3,700 visits, about where they were in 2000 and 2001.

As in previous years, the southern California Kaiser enrollees had higher rates of emergency room usage than their counterparts in northern California. Emergency room visit rates have increased generally 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

Exhibit 25

Ambulatory Utilization Measures for Commercial Health Plans, 2002

HMO	Outpatient Visits Per 1,000 Members	Emergency Room Visits Per 1,000 Members	Ambulatory Surgery Procedures Per 1,000 Members	Observation Room Stays Per 1,000 Members	ER Visits Per 1,000 Members, 2001
Aetna Health	2,671.52	101.71	45.26	1.40	111.32
Blue Cross of California	NR	137.18	NR	NR	125.19
Blue Shield of California	2,596.28	121.58	54.48	1.80	NR
CIGNA HealthCare	3,016.98	123.19	39.55	NR	132.99
Community Health Group	NR	NR	NR	NR	NR
Health Net	2,704.07	122.52	64.02	2.39	109.85
Kaiser Foundation Southern California	3,663.43	246.07	23.19	7.76	272.23
Kaiser Foundation - Northern California	3,526.26	160.46	28.69	4.94	164.25
PacifiCare	2,762.48	141.35	61.75	3.37	126.24
Sharp Health Plan	NR	NR	NR	NR	NR
Universal Care	NR	NR	NR	NR	NR
Western Health Advantage	NR	NR	NR	NR	NR
US Median	3,519.29	180.53	103.79	7.57	176.88

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.

NCQA Accreditation Status for California HMOs

Aetna Health
Commercial/HMO/POS Combined and Medicare HMO COMMENDABLE

Blue Cross of California
Commercial/HMO/POS Combined EXCELLENT
State Sponsored Programs Medicaid HMO SCHEDULED

Blue Shield of California
Commercial/HMO/POS Combined EXCELLENT
Medicare/HMO COMMENDABLE

CIGNA HealthCare
Commercial/HMO/POS Combined COMMENDABLE
Community Health Group Medicaid/HMO COMMENDABLE

Health Net
Commercial/HMO/POS Combined EXCELLENT
Medicare/HMO/POS Combined COMMENDABLE

Inland Empire Health Plan
Medicaid/HMO COMMENDABLE

Kaiser Foundation Health Plan
Southern California Commercial/HMO and Medicare/HMO EXCELLENT

Kaiser Foundation Health Plan
Northern California Commercial/HMO and Medicare/HMO EXCELLENT

Molina Healthcare
Medicaid/HMO COMMENDABLE

PacifiCare
Commercial/HMO/POS Combined EXCELLENT
Medicare/HMO COMMENDABLE

Universal Care
Commercial/HMO COMMENDABLE

Western Health Advantage
Commercial/HMO COMMENDABLE

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 October 2003

- ✔ California HMOs continue to report relatively low rates of inpatient hospital utilization, with all of those reporting here falling well below the national median.
- ✔ Some of the major plans reported a higher rate in 2002 than in 2000 and 2001. For example, Blue Cross reported 123 inpatient days per 1,000 members in 2000, but 135 days in 2001 and 142 days in 2002.
- ✔ Commercial enrollees in PacifiCare, Health Net and Aetna Health used an average of about 2,700 outpatient (office) visits per 1,000 members, higher than in 2001.

increased use of emergency rooms reflects a shortage of primary care capacity. Patients call to request appointments, but when none are available soon, some will go to the emergency room.

HEDIS began with measuring the effectiveness of care, looking 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.

Exhibit 26 compares HMOs on six effectiveness-of-care measures and one utilization measure. Controlling high blood pressure is included in these tables for the first time this year. (The measures are described in the notes to the table.) The results vary quite a bit, with some HMOs scoring very high on some measures and low on others. The range seems to be widest on the well-child visits—even the two Kaiser plans reported quite different results on that measure. In northern California, 71% of Kaiser enrollees met the standard of six well child visits but only 45.4% of southern California Kaiser enrollees had six visits in 2002.

3.14 Enrollee Satisfaction

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 most widely used instrument to measure enrollee satisfaction with their health plans and health care is the Consumer Assessment of Health Performance Survey (CAHPS®). Another source of information on patient satisfaction with California hospital care is the PEP-C survey, or the Patients' Evaluation of Performance in California, available at www.calhospitals.org.

Exhibit 27 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 the health plan. Consumers were asked to rate their satisfaction using a scale of 1 to 10, with 10 being the most satisfied.

Exhibit 26

Effectiveness of Care Measures for Commercial Health Plans, 2002

	Product Reporting Type	Childhood Immunization	Mammography	Cervical Cancer Screening	Eye Exams for Diabetics	6 Well-Child Visits in First 15 Months	Beta Blockers	Control High Blood Pressure
Aetna Health	HMO/POS Combined	71.73	74.85	81.10	NR	30.77	88.73	65.43
Blue Cross of California	HMO/POS Combined	73.65	74.57	78.50	54.68	NR	90.48	66.67
Blue Shield of California	HMO/POS Combined	71.02	72.65	79.60	44.93	23.55	91.10	63.46
CIGNA HealthCare	HMO/POS Combined	70.31	71.65	78.00	59.37	19.45	95.63	62.03
Community Health Group	HMO	66.07	61.29	74.26	40.59	NR	NA	NR
Health Net	HMO/POS Combined	71.43	76.43	79.20	56.34	56.67	97.01	61.48
Kaiser Foundation - Southern California	HMO	88.32	72.02	80.54	68.13	45.40	95.38	53.28
Kaiser Foundation - Northern California	HMO	73.50	75.17	80.37	72.79	70.95	97.25	52.31
PacifiCare	HMO/POS Combined	72.86	76.05	81.85	61.39	33.29	97.27	68.05
Sharp Health Plan	HMO	NR	NR	NR	NR	NR	NR	NR
Universal Care	HMO	66.05	72.53	78.32	34.78	NR	93.75	67.35
Western Health Advantage	HMO	65.47	73.48	74.21	39.17	NR	NA	NR
US Median		52.07	75.53	81.42	51.19	66.98	95.62	59.55

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 test during the reporting year or the prior two years. ***Eye Exams for Diabetics.*** Identifies members age 18-75 with diabetes who received a retinal exam during the report year.

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.

The results are quite mixed. When comparing these results to those for 2001 (which were reported in the 2002 edition of this report), some HMOs had better results and a few went down on some scores. For example, 7 of 12 health plans scored below 60% on the general rating of health plan measure in 2001. In 2002, only 2 of 13 health plans scored below 60%. In responses to the two general questions, consumers generally preferred their health care to their health plan. For example, 73% of Blue Shield enrollees gave highest marks to their overall health care but only 66% gave highest ratings to their health plan. Still, a comparison of results by plan for 2001 and 2002 suggests that gap has narrowed. In the cases of the two Kaiser plans and PacifiCare, less than one percentage point separates the results for the two questions.

- ✔ Seven of 12 health plans scored below 60% on the general rating of health plan measure in 2001. In 2002, only 2 of 13 health plans scored below 60%.
- ✔ Consumers generally preferred their health care to their health plan. For example, 73% of Blue Shield enrollees gave highest marks to their overall health care but only 66% gave highest ratings to their health plan.
- ✔ A comparison of results by plan for 2001 and 2002 suggests that gap has narrowed.

Exhibit 27

Enrollee Satisfaction Measures Reported on CAHPS Survey for Commercial Health Plans, 2002

	Customer Service	Getting Needed Care	Getting Care Quickly	Rating of All Health Care	Rating of Health Plan
Aetna Health	NA	70.71	NA	67.40	64.94
Blue Cross of California	68.66	70.93	70.41	70.56	66.42
Blue Shield of California	69.97	70.89	74.63	73.29	66.02
CIGNA HealthCare	70.02	63.73	66.51	65.58	54.60
Community Health Group	NA	68.17	NA	74.63	56.90
Health Net of	65.97	70.91	73.37	73.79	62.05
Kaiser Foundation - Southern California	76.92	74.06	69.51	67.95	68.34
Kaiser Foundation - Northern California	73.48	74.66	74.68	67.33	66.66
PacifiCare	NA	77.73	74.01	76.16	75.71
Sharp Health Plan	75.12	73.74	70.23	65.19	61.56
Universal Care	74.05	73.02	70.98	69.05	61.83
Western Health Advantage	69.13	71.46	76.32	70.54	63.06
US Median	69.96	77.28	78.18	75.81	61.69

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. 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.

✔ OSHPD also produces a valuable hospital discharge database each quarter that enables researchers to compare hospitals on their volume of key procedures and the charges for those procedures.

✔ A second pie chart in those sections shows the estimated market share of the HMOs in the region for 2002.

4.0 REGIONAL SUB-MARKETS AND PROVIDER SYSTEMS

These are challenging times for hospitals and physicians alike. As we noted earlier in this report (see Section 2.3), some provider organizations have used their expanded market power to negotiate improved payments from HMOs. However, they will have to raise a significant amount of capital in coming years to comply with state requirements for stronger construction and to stay competitive in an environment where implementing new medical technology and information systems is crucial.

The state's current budget distress further complicates the situation. While health care may have dodged a bullet and taken fewer cuts than feared in 2003, California's bleak fiscal environment clouds the financial prospects of all health care organizations in the state. Safety net providers, already under financial stress, face the threat of reduced public revenues and increased numbers of uninsured patients. Hospitals are concerned that bond rating houses will view their financial prospects negatively. Indeed, some have already seen their rating downgraded.

This section of the report examines health market issues in six regions of the state: the San Francisco Bay Area, Sacramento, the Central Valley, Los Angeles and Orange Counties, the 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. 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, 2001. That data set typically becomes available in the fall of the following year.

A few other notes on the OSHPD data: First, Kaiser does not report financial results separately for its 28 hospitals as other hospital systems do. Instead, those numbers are rolled up into two regional summaries for hospitals in northern and southern California. Second, for all hospital systems, using the OSHPD data might not provide the same result as the hospital systems report in their audited financial statements. Financial statements using Generally Accepted Accounting Principles (GAAP) for the systems might include the finances of affiliated physician practices, home health, long-term care facilities, and so on.

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. OSHPD also produces a valuable hospital discharge database each quarter that enables researchers to compare hospitals on their volume of key procedures and the charges for those procedures. (Those data were not used for this report.)

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 that were expected to be paid by Medicare, the state/federal Medi-Cal program, third-party insurers (including managed care plans), and other sources. 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. In each of the tables, hospitals are grouped based on their system or network affiliation at the end of 2001. 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. 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. A second pie chart in those sections shows the estimated market share of the HMOs in the region for 2002.

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 California physician organization database. 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, medical foundation, IPA (independent practice association), and other. Note that the distinctions between these different organization models

may change in the future. 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 2002 and are as estimated and reported by the responding physician organizations. Medical groups are not required to report to the state, except during a brief period in 2001 when they werre required to report on their finances to the Department of Managed Health Care.

For reasons of clarity and space limitations, the tables do not include some of the small 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.

4.1 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 at the east, to San Rafael at the north, to San Jose at the south, with the cities of San Francisco and Oakland in the middle. Some health care organizations cover the region widely while others benefit by dominating distinct sub-markets. *Exhibit 28* is a map of the region showing most of the hospitals and their system affiliations.

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

Overview of Hospitals. The Sutter hospital group has become the largest in the region through a series of acquisitions. There are now 10 Sutter hospitals across the Bay Area, including St. Luke's in San Francisco, which was added in 2001. 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 Oakland. 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, the Alta Bates IPA in Oakland, and the Sutter Gould Medical Foundation.

There are eight Kaiser Foundation hospitals in the area with a total of 1,822 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 shift in strategy away from hospital ownership. It was concerned about the amount of capital needed to retrofit its hospitals to meet the seismic safety requirements. After a few years during which it made only modest investments in its Bay Area hospitals, it 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. In 2000, after 10 years, it ended a contract for heart surgeries with St. Mary's Hospital in San Francisco, part of Catholic Healthcare West.

Catholic Healthcare West administered seven hospitals in the Bay Area in 2001. Ownership of the hospitals in the CHW network is retained by their respective religious orders. However, the CHW network in the Bay Area got smaller in 2002. The religious order that owned four CHW hospitals in the Bay Area, the Daughters of Charity of St. Vincent de Paul of the West, decided to withdraw from Catholic Healthcare West and resume management of those four hospitals and three others in southern California. This left three hospitals in the CHW network in the Bay Area: Sequoia Hospital in Redwood City, St. Francis Memorial in San Francisco, and St. Mary's in San Francisco.

The four hospitals that now comprise the Daughters of Charity system in northern California are: Seton Medical Center in Daly City, Seton Medical-Coastside in Moss Beach, O'Connor Hospital in San Jose ,and St. Louise Hospital in Gilroy. As is shown in *Exhibit 29,* those four hospitals accounted for most of the net income of CHW hospitals in the area in 2001. In a historical article on the Seton

✔ The Sutter system is tied to some of the leading physician groups in the Bay Area, including the Palo Alto Medical Foundation, the Alta Bates IPA in Oakland, and the Sutter Gould Medical Foundation.

✔ After a few years in which Kaider made only modest investments in its Bay Area hospitals, it returned to its strategy of being a self-contained system relying heavily on its own hospitals.

Medical Center Web site, the change is described this way: "Under the new health system, Seton Medical Center re-committed itself to fulfilling the Daughters' mission of serving the sick, the poor, and the underserved."

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 the two systems together have less than 10% of the inpatient hospital days. HCA has sold or closed hospitals and reduced its presence in the Bay Area and overall in California. It still operates three hospitals in the San Jose area. Tenet Health has four relatively small 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. That system also operates a psychiatric hospital in Concord. Their 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* compares Bay Area hospitals on their revenues and net income. In 2001, these hospitals reported a total of $352.1 million in net income. That is about 3.4% of total revenues of $10.2 billion. (Note that the denominator in this analysis is total revenues, a higher number than net patient revenues. Note also the gap between billed

Exhibit 28

Bay Area Hospital Map Legend

	System	City
★	**Catholic Healthcare West**	
1	O'Connor Hospital	San Jose
2	Sequoia Hospital	Redwood City
3	Seton Medical Center	Daly City
4	Seton Medical Center - Coastside	Moss Beach
5	St. Francis Memorial Hospital	San Francisco
6	St. Louise Health Center	Gilroy
7	St. Mary's Medical Center	San Francisco
▲	**HCA-The Healthcare Company (Columbia)**	
8	Columbia Good Samaritan Hospital	San Jose
9	Columbia South Valley Hospital	Gilroy
10	San Jose Medical Center	San Jose
11	Columbia San Leandro Hospital	San Leandro
●	**Kaiser Foundation Northern California**	
12	Kaiser Foundation - Geary (S.F.)	
13	Kaiser Foundation - Hayward	
14	Kaiser Foundation - Oakland Campus	
15	Kaiser Foundation - Redwood City	
16	Kaiser Foundation - San Rafael	
17	Kaiser Foundation - Santa Clara	
18	Kaiser Foundation - Santa Teresa Comm Hosp	
19	Kaiser Foundation - S. San Francisco	
20	Kaiser Foundation - Walnut Creek	
■	**Sutter Health**	
21	Alta Bates Medical Center	Berkeley
22	California Pacific Medical Center	San Francisco
23	Eden Medical Center	Castro Valley
24	El Camino Hospital	Mountain View
25	Laurel Grove Hospital	Castro Valley
26	Marin General Hospital	San Rafael
27	Mills-Peninsula Medical Center	Burlingame
28	Novato Community Hospital	Novato
29	Sutter Delta Medical Center	Antioch

	System	City
●	**Tenet Health**	
31	Community Hospital of Los Gatos	Los Gatos
32	Doctors Medical Center - Pinole	Pinole
33	Doctors Medical Center - San Pablo	San Pablo
34	San Ramon Regional Medical Center	San Ramon
○	**University of California**	
36	Medical Center at The University of California San Francisco	San Francisco
37	UC San Francisco/Mt Zion (closed)	San Francisco
□	**John Muir/Mt. Diablo**	
38	Mt Diablo Medical Center	Concord
49	John Muir Medical Center	Walnut Creek
■	**Other Hospitals**	
39	Valley Memorial Hospital	Livermore
40	St. Rose Hospital	Hayward
41	Alameda County Medical Center	Oakland
42	Alameda Hospital	Alameda
43	Alexian Brothers Hospital	San Jose
44	Children's Hospital Northern California	Oakland
45	Chinese Hospital	San Francisco
46	Contra Costa Regional Medical Center	Martinez
47	Davies Medical Center	San Francisco
48	Guardian Rehab Hospital San Ramon	San Ramon
50	Lucile S Packard Children's Hospital at Stanford	Palo Alto
51	San Francisco General Hospital	San Francisco
52	San Mateo General Hospital	San Mateo
53	Santa Clara Valley Medical Center	San Jose
54	St. Luke's Hospital	San Francisco
50	Stanford University Hospital	Stanford
55	Summit Medical Center	Oakland
56	Washington Hospital - Fremont	Fremont

TOTAL

charges of $22.4 billion and $9.3 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 $359.4 million in operating net income plus an additional $282.9 million in net income from other sources, including investments, philanthropy, government funds and so on. Net income was reduced by $290.2 million in transfers from certain public, district and University of California hospitals under the Disproportionate Share Hospital (DSH) program.

The Sutter hospitals reported average net income of 3.3% of revenues, but individual hospitals had quite varied results. For example, California Pacific Medical Center in San Francisco and Mills Peninsula Medical Center in Burlingame both reported healthy net income. However, Alta Bates Medical Center in Berkeley and Summit Medical Center in Oakland both reported losses of more than $25 million.

Exhibit 28

Bay Area Hospitals and Systems

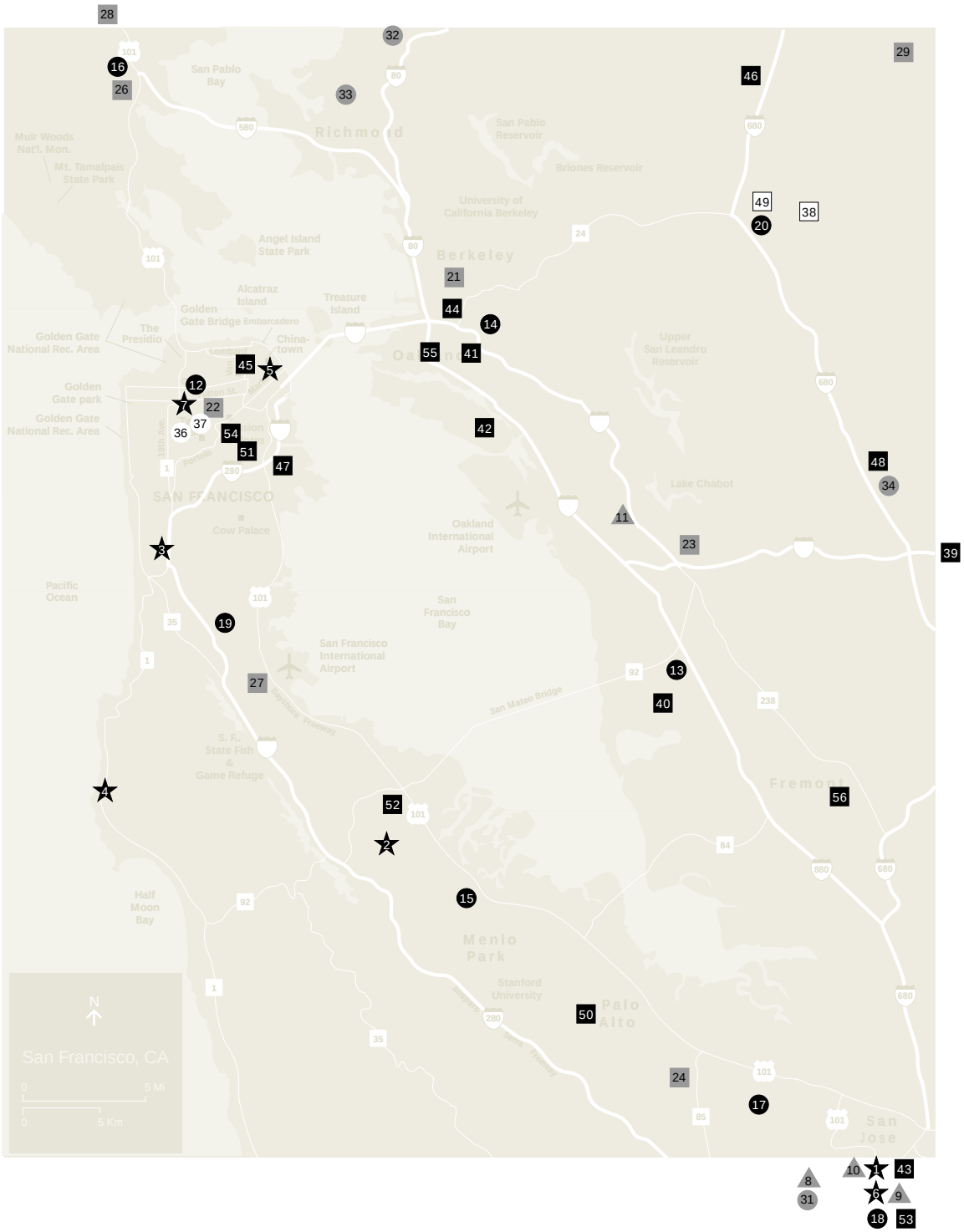


Exhibit 29

Revenues and Net Income for Bay Area Hospitals, 2001

System/Hospitals	City	Total Charges	Net Patient Revenue	Operating Expenses	Net from Operations	Net Income	% of Total Revenue
Catholic Healthcare West		**2,202,524,460**	**632,873,260**	**648,736,432**	**6,606,889**	**30,970,643**	**4.5%**
O'Connor Hospital*	San Jose	427,767,830	126,815,570	116,869,572	16,539,527	18,308,211	13.4%
Sequoia Hospital	Redwood City	377,891,804	116,904,972	118,515,455	1,552,907	2,425,929	2.0%
Seton Medical Center*	Daly City	551,863,291	151,257,305	150,423,016	2,671,775	4,743,158	3.0%
Seton Medical Center - Coastside*	Moss Beach	14,475,449	9,782,891	10,382,323	(520,255)	(517,855)	-5.2%
St. Francis Memorial Hospital	San Francisco	312,014,795	88,065,966	92,321,346	(429,689)	17,511,271	15.3%
St. Louise Regional Hospital*	Gilroy	128,075,508	36,715,159	37,344,163	(311,403)	(188,943)	-0.5%
St. Mary's Medical Center	San Francisco	390,435,783	103,331,397	122,880,557	(12,895,973)	(11,311,128)	-10.1%
HCA: The Healthcare Company		**1,275,654,160**	**452,116,925**	**465,996,071**	**(9,766,205)**	**(8,544,983)**	**-1.9%**
Good Samaritan Hospital	San Jose	576,858,904	214,561,929	214,468,578	2,184,881	3,011,117	1.4%
Regional Medical Center of San Jose	San Jose	334,825,198	108,321,122	117,101,949	(7,888,266)	(7,640,656)	-7.0%
San Jose Medical Center	San Jose	363,970,058	129,233,874	134,425,544	(4,062,820)	(3,915,444)	-3.0%
Kaiser Foundation Northern Region	**Oakland**	**2,218,250,570**	**2,193,725,284**	**1,943,126,590**	**254,990,378**	**252,722,576**	**11.5%**
Sutter Health		**5,988,729,186**	**1,867,028,021**	**1,910,562,707**	**31,128,534**	**54,260,359**	**2.7%**
Alta Bates Medical Center Ashby	Berkeley	1,270,675,028	299,476,579	333,350,006	(25,230,412)	(25,630,011)	-8.2%
Eden Medical Center	Castro Valley	319,402,876	106,843,155	103,177,528	5,857,639	5,745,096	5.2%
Summit Medical Center	Oakland	731,918,373	208,276,097	259,962,716	(36,334,896)	(29,564,207)	-12.7%
California Pacific Medical Center	San Francisco	1,637,311,048	524,407,280	467,374,266	68,667,002	80,605,709	14.7%
El Camino Hospital District	Mountain View	466,431,211	172,176,152	184,210,852	1,153,543	9,348,000	4.8%
Marin General Hospital	San Rafael	401,332,623	151,308,040	157,632,789	(4,218,682)	(5,531,274)	-3.5%
Mills-Peninsula Medical Center	Burlingame	670,533,283	233,844,607	218,851,289	20,621,726	22,867,552	9.3%
Novato Community Hospital	Novato	74,716,915	27,024,601	32,281,461	(5,098,203)	(2,998,787)	-10.1%
St. Luke's Hospital	San Francisco	206,350,348	71,316,722	90,059,987	(3,198,265)	894,554	1.0%
Sutter Delta Medical Center	Antioch	210,057,481	72,354,788	63,661,813	8,909,082	9,616,175	12.9%
Tenet Health		**1,436,157,872**	**277,411,507**	**259,828,011**	**19,935,375**	**19,407,439**	**6.9%**
Community Hospital of Los Gatos	Los Gatos	410,776,130	82,900,648	82,249,295	822,008	(155,308)	-0.2%
Doctors Medical Center - Pinole	Pinole	63,816,058	12,933,123	14,376,871	(351,227)	(371,854)	-2.5%
Doctors Medical Center - San Pablo	San Pablo	617,870,705	104,648,682	97,130,379	8,271,696	8,558,857	8.1%
San Ramon Regional Medical Center	San Ramon	343,694,979	76,929,054	66,071,466	11,192,898	11,375,744	14.7%
University of California San Francisco Medical Center		**1,838,743,681**	**724,231,942**	**756,850,797**	**(17,076,828)**	**(16,854,390)**	**-2.3%**
Stanford University Hospital	**Stanford**	**1,810,289,647**	**708,807,584**	**809,986,188**	**(35,310,000)**	**(21,296,000)**	**-2.7%**
Muir Mt. Diablo		**1,550,238,732**	**403,830,961**	**410,868,358**	**28,945,798**	**27,519,872**	**6.2%**
Mt. Diablo Medical Center	Concord	650,441,628	158,654,934	148,256,199	12,640,887	12,821,579	7.7%
John Muir Medical Center	Walnut Creek	899,797,104	245,176,027	262,612,159	16,304,911	14,698,293	5.3%
Other Hospitals		**4,084,659,521**	**2,082,516,785**	**2,299,857,743**	**(114,790,663)**	**2,778,888**	**0.1%**
Valley Memorial Hospital	Livermore	379,886,547	108,646,329	107,553,170	3,008,655	4,080,384	3.6%
St. Rose Hospital	Hayward	104,528,800	54,960,464	58,096,820	(2,132,449)	(1,917,208)	-3.4%
Alameda County Medical Center**	Oakland	409,070,702	279,691,569	271,741,499	23,588,977	(7,592,827)	-2.0%
Alameda Hospital	Alameda	151,581,899	37,419,473	39,855,943	(2,281,170)	(748,984)	-1.9%
Children's Hospital Medical Center	Oakland	293,210,411	177,854,191	229,597,082	(15,025,056)	(4,070,420)	-1.8%
Chinese Hospital	San Francisco	63,910,333	38,004,601	36,847,723	1,770,317	2,488,296	6.3%
Contra Costa Regional Medical Center**	Martinez	263,456,915	123,130,615	202,300,288	(67,475,886)	1,204,039	0.5%
Lucile S Packard Children's Hospital	Palo Alto	499,633,943	219,975,971	240,890,788	(10,737,704)	1,960,149	0.8%
San Francisco General Hospital	San Francisco	471,316,098	316,456,009	353,869,318	(30,494,617)	3,478,530	1.0%
San Mateo General Hospital**	San Mateo	131,131,572	59,106,832	130,846,863	(62,885,547)	(15,362,206)	-12.2%
Santa Clara Valley Medical Center**	San Jose	887,986,312	501,490,629	469,457,511	38,916,939	3,290,613	0.5%
Washington Hospital - Fremont	Fremont	428,945,989	165,780,102	158,800,738	8,956,878	15,968,522	9.1%
TOTAL		**22,405,247,829**	**9,342,542,269**	**9,505,812,897**	**164,663,278**	**352,056,852**	**3.4%**

*The Daughters of Charity System resumed operations of these hospitals in 2002
**Net Patient Revenues, Net from Operations and Net Income for certain county, hospital district and University of California hospitals reduced by transfer of disproportionate share hospital funds and other special Medicaid funds.
Source: Author's analysis of annual hospital report data for years ending in 2001 from Office of Statewide Health Planning and Development
% of Total Revenue is calculated using total hospital revenues as the denominator, not net patient revenues.

The Kaiser Foundation hospitals in northern California had very strong results in 2001. As shown in the table, the Northern Region hospitals (including the Bay Area and two hospitals in Sacramento) had net income of $252.7 million, or 11.5% 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. For the Kaiser hospitals, net income is from operations and they report no revenue from investments or government grants.

The Catholic Healthcare West Hospitals reported net income of 4.5% of net patient revenues. O'Connor Hospital in San Jose and St. Francis in San Francisco had the best results in that system.

The two Muir Mt. Diablo hospitals in Contra Costa County both had very good results, combining for $27.5 million in net income, or 6.2% of net patient revenues. According to interviewees, that system has effectively used its geographic dominance to negotiate much improved payment rates from health plans that need hospitals in that corner of the region.

The three HCA hospitals in the area reported a small loss of $8.5 million, or 1.9% of net patient revenues. The Tenet hospitals, on the other hand, reported $19.4 million in net income, or 6.9% of net patient revenue.

Two public hospitals, Alameda County Medical Center and Santa Clara Valley Medical Center, are significant safety net providers. Contra Costa Regional Medical Center, also county-owned, was able to turn a large operating loss in 2001 into positive net income with the help of county and state funds.

Both of the academic health center hospitals, Stanford and University of California San Francisco, reported losses in 2001. They had negative margins of about 2.5%, with operating losses partly offset by non-operating revenues.

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. Emergency departments at certain hospitals in the Bay Area are often on diversion, meaning that their emergency rooms are full and ambulances are turned away and sent on to other hospital emergency departments.

Inpatient occupancy for Bay Area Hospitals, as shown in *Exhibit 30,* averaged 63.0% in 2001. That is less than the 68% occupancy rate reported in 2000, although comparisons from year to year should be made with caution. Hospitals are not always consistent in reporting their available days, the denominator for calculating occupancy. In addition, data for certain hospitals are not found for both years. Average occupancy rates of 70% or more are often considered high for acute care hospitals. Higher occupancy can be seasonal, as in a year when a flu epidemic results 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 a hospital.

Looking at the largest systems, Kaiser Foundation reported average inpatient occupancy of 58%. CHW hospitals and the Sutter system reported occupancy rates of 63.2% and 65.9%, respectively. Kaiser Foundation hospitals showed modest growth in inpatient care in the past two years. Inpatient hospital days at area Kaiser hospitals grew from 362,486 in 1998-99 to 385,522 in 2001. In addition, the number of patients in Permanente clinics in the Bay Area grew from 1.6 million in 2000 to 1.9 million in 2002.

The highest occupancy rates in the area were reported by smaller systems: the HCA hospitals, especially Good Samaritan and San Jose Medical Center, and the Muir Mt. Diablo hospitals. Tenet Health's Bay Area hospitals had inpatient occupancy rates of less than 50%, which is typical for Tenet facilities in several states. Tenet hospitals in states like California, Florida, and Texas have relatively low occupancy 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.

Stanford University and UCSF had inpatient occupancy of 75.4% and 78.2%, respectively. Stanford's inpatient days increased since 2000, as did its occupancy rate.

Payer Mix. This analysis of hospital payer mix examines which payer is expected to pay for patients admitted to these hospitals. Commercial payers (shown here 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 that is shown in the column marked County Indigent. Finally, the column headed "Other Payers" includes hospital stays by people without insurance, some of whom will pay all or part of their hospital bill.

On average, Medicare was the largest payer for Bay Area hospitals, accounting for 37.4% of inpatient

- ✔ The Kaiser Foundation hospitals in northern California had net income of $252.7 million, or 11.5% of net patient revenues.
- ✔ The three HCA hospitals in the area reported a small loss of $8.5 million, or 1.9% of net patient revenues. The Tenet hospitals, on the other hand, reported $19.4 million in net income, or 6.9% of net patient revenue.
- ✔ Both of the academic health center hospitals, Stanford and University of California San Francisco, reported losses in 2001.
- ✔ Inpatient occupancy for Bay Area Hospitals averaged 63.0% in 2001.
- ✔ Kaiser Foundation reported average inpatient occupancy of 58%. CHW hospitals and the Sutter system reported occupancy rates of 63.2% and 65.9%, respectively.
- ✔ 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 30

Inpatient Occupancy Rates and Payer Mix for Bay Area Hospitals, 2001

Hospital	Staffed Beds	Inpatient Days	Occupancy	% Medicare Days	% Medi-Cal Days	% Other Third Parties	% County Indigent	% Other Payers
Catholic Healthcare West	**1,507**	**347,648**	**63.2%**	**47.6%**	**22.1%**	**26.0%**	**0.0%**	**4.3%**
O'Connor Hospital*	197	50,541	70.3%	57.3%	6.4%	35.7%	0.0%	0.7%
Sequoia Hospital	298	44,449	40.9%	52.0%	5.3%	38.1%	0.0%	4.6%
Seton Medical Center*	230	81,378	96.9%	49.8%	24.5%	23.6%	0.0%	2.2%
Seton Medical Center - Coastside*	121	39,792	90.1%	6.4%	84.8%	0.1%	0.0%	8.7%
St. Francis Memorial Hospital	209	50,654	66.4%	47.2%	14.2%	29.6%	0.0%	9.1%
St. Louise Regional Hospital*	89	17,701	54.5%	57.6%	13.2%	27.4%	0.0%	1.9%
St. Mary's Medical Center	363	63,133	47.6%	57.3%	12.9%	26.1%	0.0%	3.7%
HCA: The Healthcare Company	**530**	**167,886**	**86.8%**	**41.7%**	**13.9%**	**41.3%**	**0.0%**	**3.1%**
Good Samaritan Hospital	225	79,967	97.4%	39.3%	6.1%	53.2%	0.0%	1.4%
Regional Medical Center of San Jose	188	45,399	66.2%	49.0%	26.4%	21.6%	0.0%	3.1%
San Jose Medical Center	117	42,520	99.6%	38.3%	15.3%	40.1%	0.0%	6.3%
Kaiser Foundation Northern Region	**2,051**	**458,735**	**61.3%**	**33.6%**	**0.3%**	**65.5%**	**0.0%**	**0.6%**
Kaiser Foundation- Geary	323	59,027	50.1%	32.5%	0.3%	66.8%	0.0%	0.4%
Kaiser Foundation- Hayward	208	56,035	73.8%	33.3%	0.5%	65.9%	0.0%	0.4%
Kaiser Foundation- Oakland Campus	341	66,576	53.5%	37.0%	0.3%	62.0%	0.0%	0.7%
Kaiser Foundation- Redwood City	192	33,317	47.5%	33.6%	0.1%	65.3%	0.0%	1.1%
Kaiser Foundation- San Rafael	120	23,932	54.6%	46.7%	0.7%	51.5%	0.0%	1.0%
Kaiser Foundation- Santa Clara	286	68,297	65.4%	31.2%	0.2%	68.3%	0.0%	0.4%
Kaiser Foundation- Santa Teresa Community	228	52,434	63.0%	28.1%	0.3%	70.8%	0.0%	0.7%
Kaiser Foundation- South San Francisco	124	25,904	57.2%	43.8%	0.2%	55.2%	0.0%	0.7%
Kaiser Foundation- Walnut Creek	229	73,213	87.6%	30.1%	0.1%	69.2%	0.0%	0.6%
Sutter Health	**2,926**	**796,633**	**65.9%**	**41.4%**	**17.4%**	**36.9%**	**0.3%**	**4.0%**
Alta Bates Medical Center Ashby	509	148,671	80.0%	21.2%	31.8%	45.4%	0.1%	1.5%
California Pacific Medical Center	714	181,982	69.8%	46.2%	8.0%	39.4%	0.2%	6.1%
Eden Medical Center	245	52,764	59.0%	49.4%	8.4%	25.6%	0.0%	16.7%
Summit Medical Center	292	103,196	96.8%	53.7%	23.1%	22.4%	0.0%	0.8%
El Camino Hospital	313	71,497	62.8%	37.8%	16.3%	44.3%	0.0%	1.7%
Marin General Hospital	148	45,417	84.1%	40.1%	11.7%	39.36%	3.6%	5.3%
Mills-Peninsula Medical Center	363	99,937	75.4%	50.9%	1.2%	46.5%	0.0%	1.4%
Novato Community Hospital	65	9,269	82.7%	53.9%	4.0%	38.9%	0.9%	2.4%
St. Luke's Hospital	166	60,652	100.1%	40.1%	43.4%	12.0%	0.0%	4.5%
Sutter Delta Medical Center	111	23,248	57.4%	30.7%	17.0%	46.7%	0.0%	5.6%
Tenet Health	**581**	**98,572**	**46.5%**	**52.5%**	**15.1%**	**30.2%**	**0.0%**	**2.3%**
Community Hospital of Los Gatos	143	30,851	59.1%	53.5%	3.5%	41.5%	0.0%	1.4%
Doctors Medical Center - Pinole	82	6,318	21.1%	58.9%	25.8%	11.3%	0.0%	4.0%
Doctors Medical Center - San Pablo	233	40,907	48.1%	54.1%	28.7%	15.0%	0.0%	2.1%
San Ramon Regional Medical Center	123	20,496	45.7%	45.5%	2.0%	49.2%	0.0%	3.3%
University of California San Francisco	**510**	**145,554**	**78.2%**	**61.0%**	**20.3%**	**14.2%**	**0.9%**	**3.5%**
Stanford University Hospital	**420**	**110,500**	**72.1%**	**35.0%**	**4.4%**	**53.1%**	**1.8%**	**5.7%**
Muir Mt. Diablo	**425**	**128,603**	**82.9%**	**52.7%**	**6.4%**	**38.7%**	**0.2%**	**2.0%**
Mt. Diablo Medical Center	149	48,508	89.2%	59.8%	9.5%	28.2%	0.1%	2.4%
John Muir Medical Center	276	80,095	79.5%	48.4%	4.5%	45.1%	0.2%	1.8%
Other Hospitals	**2,975**	**777,879**	**67.9%**	**21.7%**	**42.2%**	**20.7%**	**4.8%**	**10.6%**
Valley Memorial Hospital	115	40,577	96.7%	55.2%	4.5%	38.9%	0.0%	1.5%
St. Rose Hospital	175	30,922	48.4%	52.1%	32.3%	12.2%	1.3%	2.0%
Alameda County Medical Center	438	120,736	75.5%	8.9%	68.6%	3.6%	4.9%	13.9%
Alameda Hospital	140	19,141	37.5%	61.2%	14.5%	22.0%	0.0%	2.2%
Children's Hospital of Northern California	205	53,764	71.9%	0.0%	55.2%	40.8%	0.0%	3.9%
Chinese Hospital	59	10,922	50.7%	81.1%	9.6%	8.1%	0.0%	1.2%
Contra Costa Regional Medical Center	124	44,837	99.1%	27.6%	46.5%	7.6%	17.9%	0.5%
Lucile S. Packard Children's Hospital	240	65,519	74.8%	0.4%	41.2%	55.2%	0.0%	3.2%
San Francisco General Hospital	475	161,834	93.3%	15.5%	31.2%	19.2%	5.2%	28.9%
San Mateo General Hospital	213	50,461	64.9%	20.6%	64.6%	1.7%	10.3%	2.9%
Santa Clara Valley Medical Center	510	116,747	62.7%	17.5%	50.5%	15.6%	8.0%	8.4%
Washington Hospital - Fremont	281	62,419	60.9%	48.6%	16.2%	32.7%	0.0%	2.5%
TOTAL	**11,925**	**3,032,010**	**63.0%**	**37.4%**	**20.6%**	**35.4%**	**1.4%**	**5.1%**

*The Daughters of Charity system resumed operation of these hospitals in 2002.
Source: Author's analysis of annual hospital report data from office of Statewide Health Planning and Development

days. Managed care and other third party payers were second with 35.4% of inpatient days.

Medicare was an especially important payer for some of the systems, accounting for 50% or more of inpatient days at the University of California San Francisco, the Tenet hospitals, and the Muir Mt. Diablo hospitals, and for 47.6% of inpatient days at the Catholic Healthcare West hospitals. On the other hand, it only covered 35% of the inpatient days at Stanford University and 33.6% of inpatient days at Kaiser hospitals in the region. The Sutter hospitals reported that Medicare covered 41.4% of their inpatient days.

Commercial payers including managed care were especially significant for the Kaiser hospitals (65.5% of inpatient days) and Stanford University Medical Center (53.1% of inpatient days.) Kaiser has about 1.5 million commercial members in the area and 190,000 seniors in Medicare plans. Managed care plans were less significant payers for the Catholic Healthcare West hospitals (26.0%) Tenet Health (30.2%), and the University of California at San Francisco (14.2%). At the Bay Area hospitals owned by HCA: The Healthcare Company, commercial insurers covered 41.3% of inpatient days.

Public hospitals care for a high percentage of Medi-Cal patients. In 2001, Alameda County reported 68.6% of its patient days covered by Medi-Cal, Santa Clara Valley reported 50.5%, and Contra Costa Regional Medical Center 46.5%. In addition, the Children's Hospital of Northern California reported more than half of its inpatient days covered by Medi-Cal. Systems like Kaiser, Muir Mt. Diablo, and HCA reported a much smaller percentage of Medi-Cal patients. Kaiser hospitals account for 1,600 of the 626,000 Medi-Cal days for area hospitals in 2001. Viewed another way, more than half of the 626,000 inpatient Medi-Cal days in this region's hospitals in 2001 were provided by hospitals outside of the six largest systems. Of the six systems, Sutter Health had the largest number of Medi-Cal days, many of them at the Alta Bates Medical Center.

Exhibit 31 shows the market share of the Bay Area hospital systems. The Sutter hospitals had the largest share of patients in the area in 2001, with 27.4% of inpatient days. The Kaiser Foundation hospitals followed with about 16% of inpatient days. Including the Daughters of Charity hospitals, Catholic Healthcare West was the third largest hospital system in the area. However, the four Daughters of Charity hospitals accounted for more than half of CHW's 348,000 inpatient days in 2001. Next year's report will separate the data for the four Daughters of Charity hospitals.

Physician Organizations. There are some prominent medical groups in the Bay Area, but most of the doctors contract for managed care through IPAs. For example, the California Pacific Medical Group and Brown & Toland Medical Group together report more than 222,000 capitated patients, 494 primary care physicians, and 1,321 specialists. That group combines community physicians and doctors practicing at the University of California at San Francisco. One of the most successful IPAs is Hill Physicians, based in San Ramon. It is profitable, invests in information systems, and is regularly praised in health plan report cards and surveys. Among medical groups, it is a prominent supporter of the Pay for Performance initiative. Still, the whole model of the IPA is under some pressure as employers migrate to PPO plans and the number of capitated enrollees in HMOs falls. (See the discussion in Section 2.4.)

Exhibit 32 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 3,000 Permanente Medical Group physicians in the area and that number is growing.

- ✔ Medicare was an especially important payer for some of the systems, accounting for 50% or more of inpatient days at the University of California San Francisco, the Tenet hospitals, and the Muir Mt. Diablo hospitals.
- ✔ Commercial payers including managed care were especially significant for the Kaiser hospitals (65.5% of inpatient days) and Stanford University Medical Center (53.1% of inpatient days.) Kaiser has about 1.5 million commercial members in the area and 190,000 seniors in Medicare plans.
- ✔ Public hospitals care for a high percentage of Medi-Cal patients. In 2001, Alameda County reported 68.6% of its patient days covered by Medi-Cal, Santa Clara Valley reported 50.5%, and Contra Costa Regional Medical Center 46.5%.
- ✔ The Sutter hospitals had the largest share of patients in the area in 2001, with 27.4% of inpatient days. The Kaiser Foundation hospitals followed with about 16% of inpatient days.
- ✔ The four Daughters of Charity hospitals accounted for more than half of CHW's 348,000 inpatient days in 2001.

Exhibit 31

Market Share of Bay Area Hospital Systems, 2001

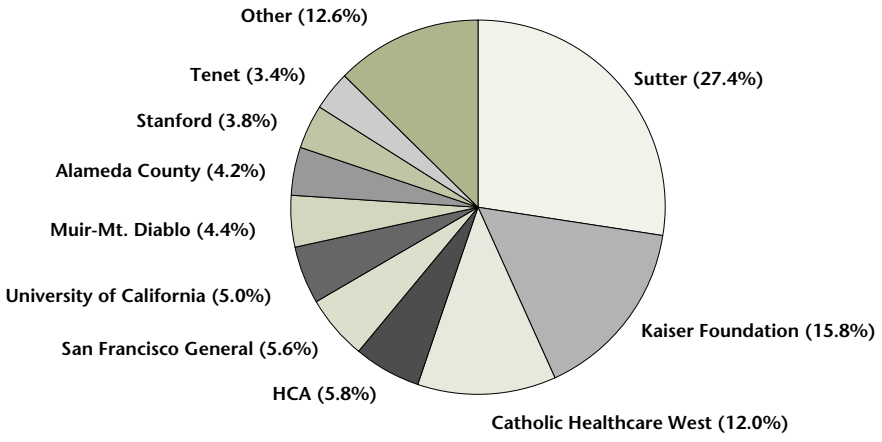


Exhibit 32

Bay Area Physician Organizations
counties: Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara, Sonoma

Name of Physician Organization	Estimated enrollment	# of PCPs	# of Specs	Management Entity	Notes
Group Practice					
The Permanente Medical Group, Inc	1,880,450	1,035	2,062	The Permanente Medical Group, Inc	
San Jose Medical Clinic, Inc	56,000	156	390	San Jose Medical Management, Inc	Includes old Good Samaritan Medical Group (absorbed into San Jose Medical Group). Includes IPA type panel.
Bay Valley Medical Group, Inc	27,700	115	286	Bay Valley Management Group	Includes IPA type panel
Palo Alto Medical Clinic/ Palo Alto Medical Foundation	71,800	105	133	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.
Camino Medical Group, Inc/	87,800	83	159	Palo Alto Medical Foundation (Sutter Health)	Palo Alto Medical Foundation MSO of Hospital System
IPAs					
California Pacific Medical Group, Inc/ Brown & Toland Medical Group, Inc	222,200	494	1,321	Brown & Toland Physician Services Organization	
Hill Physicians Medical Group, Inc	196,100	472	878	PriMed Management Consulting, Inc (Hill Physicians)	Catholic Healthcare West is an investor (27%) in PriMed.
Individual Practice Association Medical Group of Santa Clara County, Inc	113,700	259	546	Pacific Partners Management Services, Inc (Santa Clara IPA)	
Affinity Medical Group, Inc	50,500	105	650	Pacific Partners Management Services, Inc (Santa Clara IPA)	Umbrella corporation for Alameda IPA, Contra Costa IPA, Eden IPA & San Leandro IPA, for merly panels of Alta Bates Medical Group.
East County Medical Group, Inc	42,100	54	81	Sutter Connect	Self
Community Health Center Network, Inc	21,500	140	450	Community Health Center Network, Inc	IPA of group practices/clinics. Uses Alta Bates, Pacific Health Care specialists' panels, and Children's First specialists.
Alta Bates Medical Group, Inc	85,800	212	412	Sutter Connect	
Mills-Peninsula Medical Group, Inc	64,700	119	270	Mills-Peninsula Medical Group, Inc	
Community Health Network of San Francisco	32,200	100	200	San Francisco City & County Government	IPA of Group Practices/Clinics
Children First Medical Group, Inc	30,500	155	200	Mills-Peninsula Medical Group, Inc	
Physicians Medical Group of San Jose, Inc	60,000	97	105	San Francisco City & County Government	Physicians Medical Group purchased of San Jose, Inc. Regional Medical Management in 2001 and changed to Excel MSO LLC.
Marin IPA Medical Corp	34,000	80	160	Marin PHO	
Chinese Community Health Care Association	21,600	68	75	Chinese Community Health Plan	
Medical Foundation					
Stanford Health Services	24,600	75	2,000	Stanford Health Services	Began separate operations from Brown & Toland Jan 1, 2000. Includes medical group.
John Muir/Mt. Diablo Health Network	72,600	115	300	John Muir/Mt. Diablo Health Network	Includes medical group and IPA.
Sutter Medical Group of The Redwoods/ Sutter Medical Foundation North Bay	48,000	78	201	Sutter Connect	Includes medical group and IPA.
Palo Alto Medical Clinic/ Medical Foundation	71,800	105	133	Palo Alto Medical Foundation (Sutter Health)	Sutter Health is the sole corporate Palo Alto member of the foundation. Includes medical group.
State/County Faculty/Staff					
Santa Clara Valley Health & Hospital System	41,500	70	110	Santa Clara Valley Medical Center	
Contra Costa Regional Medical Center Medical Group	29,800	71	28	Contra Costa County Dept of Health Services	

Adopted from Cattaneo & Stroud's medical group inventory, April 2003

The Palo Alto Medical Foundation and its affiliate, the Camino Medical Group, have about 160,000 patients and have added patients and physicians in the past few years. The two medical groups are affiliated with the Sutter Hospitals and together they are planning a small new hospital in the area and have been negotiating to develop 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 more than 72,000 capitated patients.

Health plans. In 2002, about 3.8 million people in the Bay Area, with an estimated population of 5.9 million, were enrolled in an HMO. HMO penetration in the East Bay counties was 69.4%; on the San Francisco side, 59.7%. With an estimated 47% of HMO enrollment in the region, Kaiser Permanente is by far the largest HMO in the area. It is especially strong in the East Bay area, where it has about 900,000 enrollees.

Exhibit 33 shows the market share of the largest health plans in the area in 2002. This analysis is a component of what was reported in *Exhibits 12* and *13.* The next largest HMOs—Blue Cross, Health Net, and Blue Shield—together have just under one third of the enrollment in the area. About 3 million people in the area are enrolled in commercial HMOs and the rest are in Medicare, Medi-Cal, and Healthy Families.

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. In that year, 41.2% of seniors in Alameda County and 26.4% of seniors in San Francisco were in a Medicare+Choice plan. By 2003, only three HMOs were still offering senior plans: Health Net, Kaiser Permanente, and Chinese Community Health Plan.

At the end of 2002, about 36% of seniors in Alameda County were in an HMO while 28.6% of seniors in San Francisco were in a senior HMO plan. Because Kaiser and some other HMOs offer more than one Medicare plan, it would be correct to say that there are more than three Medicare+Choice plans offered in those counties.

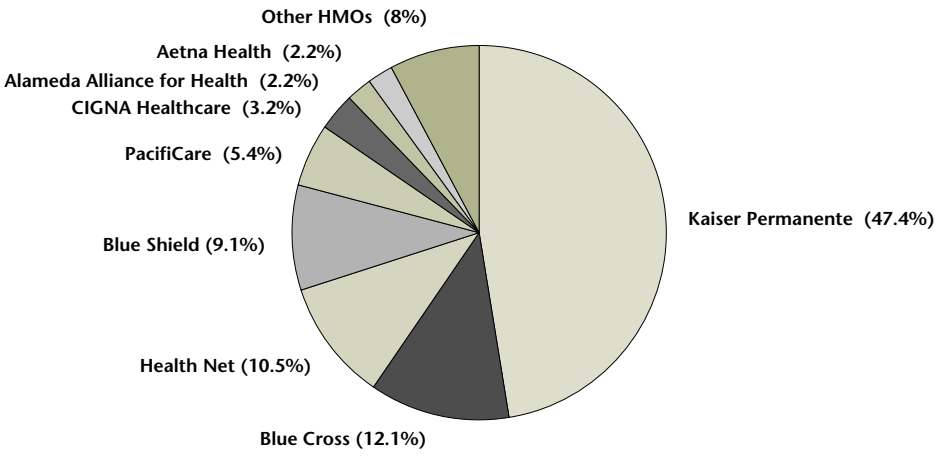
While Medicare HMO enrollment has declined, enrollment in Medi-Cal managed care has been growing. All six counties in the Bay Area use some version of Medi-Cal managed care, and four of them have a two-plan arrangement. (See Section 3.4 for a description of the two-plan arrangement and the other versions of Medi-Cal managed care.) Counties have formed HMOs (county plans) in San Francisco, Alameda, Santa Clara, and Contra Costa. Blue Cross is the second 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 Operated Health System. The county HMOs also contract with the Managed Risk Medical Insurance Board for the Healthy Families program.

Even with the growth of Medi-Cal and Healthy Families, a significant segment of the population has no health insurance. According to one estimate, about nine percent of the Bay Area's population under age 65 has no health insurance. That is 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 takeup rate of employees who are able to pool their own funds with a contribution from the employer and the participating foundations.

- ✔ By 2003, only three HMOs were still offering senior plans: Health Net, Kaiser Permanente, and Chinese Community Health Plan.
- ✔ At the end of 2002, about 36% of seniors in Alameda County were in an HMO while 28.6% of seniors in San Francisco were in a senior HMO plan.
- ✔ Enrollment in Medi-Cal managed care has been growing. All six counties in the Bay Area use some version of Medi-Cal managed care, and four of them have a two-plan arrangement.

Exhibit 33

Estimated Market Share for Bay Area HMOs, 2002



✔ The University of California—Davis Medical Center, with one hospital in Sacramento, is the largest.

✔ Sutter Health was formed in 1996 by the merger of Sutter hospitals in Sacramento with the California Healthcare System hospitals in the Bay Area.

✔ Sacramento area hospitals went through a period in 2002 when their emergency departments were frequently full and had to divert ambulances to other hospitals.

✔ Sacramento-area hospitals generally had strong net income in 2001.

✔ Their net income of $261.5 million was 10.5% of total revenues of $2.5 billion, and an improvement over the margin that was reported for hospitals in this area in 2000.

4.2 Sacramento

The eight counties in and around Sacramento have a combined population estimated at 2.2 million in 2002, up from 2 million in 1999. Sacramento shares several characteristics with state capitals in Austin and Madison, among others. Besides being the seat of state government, it has a major state university and medical school and has experienced significant population and economic growth. This growth—as in other state capitals—has been driven both by state government agencies, lobbying associations and companies that contract with states, and by the development of high tech industries. Also like Austin and Madison, Sacramento is a center for integrated health care systems and very active managed care markets.

Overview of Hospitals. Four not-for-profit hospital systems have emerged in the Sacramento area. The University of California—Davis Medical Center, with one hospital in Sacramento, is the largest of the four, with net patient revenues in 2001 of $693.8 million. Catholic Healthcare West (CHW) has six hospitals in the area and is a close second in size. 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, but has largely dismantled that regional structure in favor of a statewide organization based in San Francisco.

The Sutter Health system in the area has six hospitals, including a psychiatric facility. Sutter's flagship hospital in the area is Sutter Medical Center—Sacramento, with 650 acute care beds and $346.2 million in net patient revenues in 2001. Sutter Health was formed in 1996 by the merger of Sutter hospitals in Sacramento with the California Healthcare System hospitals in the Bay Area. Kaiser Permanente has two hospitals in Sacramento and a third in nearby Roseville.

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 completed or plans to complete several expansion projects in the Sacramento area, including a large new health center in Elk Grove. It plans a major expansion of its Roseville campus, including a new unit for women and children. It also plans to build a new hospital in Folsom. Methodist Hospital, part of Sutter Health, is the other major hospital serving Sacramento's southern suburbs.

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 for hospitals and 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, that frees up space for new admissions from the emergency department, which in turn frees up space for new emergency patients. As a rule, emergency departments on their own are not seen as hospital profit centers. Many patients presenting themselves have no insurance and the insurance payments for emergency department fees usually do not cover the hospital's costs. However, many of those patients are admitted to hospitals, and those insurance payments usually do make money for the hospitals.

Financial Results. Sacramento-area hospitals generally had strong net income in 2001. As shown in *Exhibit 34,* the 20 hospitals had net income of $261.5 million in 2001, including operating income of $211.8 million. Their net income was 10.5% of total revenues of $2.5 billion. As was discussed in Section 2.5, health plans are concerned by the ability of health plans to use their market strength to insist on higher payment rates.

The University of California Davis Medical Center reported $109 million in net income from operations and other revenues. 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. The Sutter Health hospitals had net income of $81.4 million, while the Catholic Healthcare West hospitals in this area had net income of $44.3 million. 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.

Occupancy. On average, Sacramento area hospitals had inpatient occupancy of 67% in 2001. *Exhibit 35* compares the hospital systems on their inpatient occupancy rates and payer mix. Occupancy was highest at the University of California Davis Medical

Center, at more than 78%. The two Kaiser hospitals had occupancy rates of 68.1%, while the Sutter Health hospitals in the area had average inpatient occupancy rates of 71.5% Kaiser has increased its presence in the Sacramento area based on two measures. First, inpatient hospital days at its two area hospitals grew from 121,552 in 1998-99 to 154,819 in 2001. Second, the number of patients in Permanente clinics grew from 389,300 in 2000 to 429,000 in 2002.

Payer Mix. As *Exhibit 35* shows, Medicare covered an average of 38% of inpatient hospital days in Sacramento-area hospitals while Medi-Cal covered about 22%. Commercial plans including managed care covered 35% of inpatient days for these hospitals, about the same as in the Bay Area.

The University of California Davis Medical Center served the most Medi-Cal patients of any one hospital, with about 52,000 inpatient days in 2001. That is just under 25% of a total of 220,000 Medi-Cal days. However, both the CHW and Sutter Health systems had a similar number of Medi-Cal days across their Sacramento-area hospitals. CHW hospitals provided about 60,000 Medi-Cal days and Sutter Medical Center Sacramento had 48,500 Medi-Cal inpatient days in 2001.

Physician Organizations. *Exhibit 36* lists the largest physician organizations in Sacramento County in 2002. The largest group practice was the Permanente Medical Group, with 126 primary care physicians and 383 specialists in the area. Many of the other large medical groups are tied to the hospital systems. For example, the Sutter Hospitals pro-

- ✔ Hospital and clinical capacity has emerged as a major issue in the Sacramento area.
- ✔ Kaiser has completed or plans to complete several expansion projects in the Sacramento area, including a large new health center in Elk Grove. It plans a major expansion of its Roseville campus.

Exhibit 34

Revenues and Net Income for Sacramento Area Hospitals, 2001

System/Hospitals	City	Total Charges	Net Patient Revenue	Operating Expenses	Net from Operations	Net Income	% of Total Revenue
Catholic Healthcare West		2,068,977,311	653,457,786	628,141,665	43,581,924	44,334,291	6.5%
Mercy General Hospital	Sacramento	783,501,143	218,207,133	207,296,573	18,409,604	19,372,000	8.5%
Methodist Hospital of Sacramento	Sacramento	222,263,261	68,080,139	72,989,811	(3,999,858)	(3,810,000)	-5.4%
Mercy San Juan Hospital	Carmichael	592,285,083	172,684,268	165,388,462	11,530,933	10,077,000	5.7%
Sierra Nevada Memorial Hospital	Grass Valley	147,219,093	67,102,805	61,298,221	6,348,818	6,853,291	10.0%
Woodland Memorial Hospital	Woodland	194,417,651	83,239,600	86,965,878	1,044,977	1,766,000	2.0%
Mercy Hospital - Folsom	Folsom	129,291,080	44,143,841	34,202,720	10,247,450	10,076,000	22.7%
Kaiser Foundation Hospitals							
Kaiser Foundation Hospital Sacramento	Sacramento						
Kaiser Foundation Hospital South Sacramento	South Sacramento						
Sutter Health		**2,251,303,261**	**619,251,406**	**575,905,542**	**60,654,475**	**81,398,355**	**12.3%**
Sutter Medical Center - Sacramento	Sacramento	1,424,874,298	346,222,152	350,208,567	8,865,118	24,365,447	6.4%
Sutter Roseville Medical Center	Roseville	522,186,602	162,168,791	125,866,110	38,186,136	40,809,389	24.5%
Sutter Davis Hospital	Davis	107,694,601	35,438,820	33,517,656	3,252,138	4,958,270	12.1%
Sutter-Yuba	Yuba City	2,229,836	2,229,836	2,229,836	-	-	0.0%
Sutter Center for Psychiatry	Sacramento	28,964,926	12,483,251	13,151,203	45,596	132,446	1.0%
Sutter Auburn Faith Hospital	Auburn	165,352,998	60,708,556	50,932,170	10,305,487	11,132,803	17.9%
University of California Davis Medical Center*	**Sacramento**	**2,231,991,770**	**664,648,067**	**640,372,184**	**97,172,629**	**109,048,816**	**14.0%**
Others		**571,775,968**	**283,916,666**	**314,340,012**	**10,395,045**	**26,721,412**	**7.4%**
Fremont Hospital - Yuba City	Yuba City	88,140,144	49,875,275	47,531,345	2,728,436	9,901,823	17.2%
Rideout Memorial Hospital	Marysville	145,342,299	67,444,846	68,125,933	(69,592)	4,417,468	6.1%
Marshall Hospital	Placerville	168,382,228	67,403,546	64,281,465	3,970,029	4,715,629	6.8%
Barton Memorial Hospital	South Lake Tahoe	111,580,021	64,016,231	59,945,591	4,751,751	5,345,181	6.5%
Tahoe Forest Hospital	Truckee	58,331,276	35,176,768	37,936,125	(2,116,348)	1,210,542	2.9%
Shriners Hospital Northern California	Sacramento	0	0	36,519,553	1,130,769	1,130,769	3.0%
Sierra Valley District Hospital	Loyalton	4,004,229	2,829,436	3,425,762	(573,890)	(310,553)	-10.0%
TOTAL		**7,124,048,310**	**2,221,273,925**	**2,158,759,403**	**211,804,073**	**261,502,874**	**10.5%**

*Net Patient Revenues, Net from Operations and Net Income for certain county, hospital district and University of California hospitals reduced by transfer of disproportionate share hospital funds and other special Medicaid funds.
Source: Author's analysis of annual hospital report data for years ending in 2001 from Office of Statewide Health Planning and Development
% of Total Revenue is calculated using total hospital revenues as the denominator, not net patient revenues.

✔ 69% of the residents in the Sacramento area are enrolled in an HMO. Six statewide HMOs plus Western Health Advantage, based in Sacramento, compete for commercial business in the area.

vide administrative services through an entity called Sutter Connect to three related medical groups: Sutter Independent Physicians, Sutter Medical Group, and Sutter Medical Foundation. Catholic Healthcare West is tied to MedClinic of Sacramento and is a part owner of the management company that administers Hill Physicians, which is the largest IPA in the area. Hill Physicians had more than 440 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 372 in 2002.

Health Plans. As shown in Exhibit 12, 69% of the residents in the Sacramento area are enrolled in an HMO. Six statewide HMOs plus Western Health Advantage, based in Sacramento, compete for commercial business in the area. Kaiser Permanente has more than 600,000 Sacramento-area enrollees, accounting for almost half of the HMO membership (48.2%) in the region. Health Net is the second largest HMO in the area (12.9%), with Blue Cross and Blue Shield close behind.

Five HMOs compete for Medi-Cal enrollees in a geographic managed care arrangement in Sacramento: Blue Cross, HealthNet, Kaiser Foundation, Molina, and Western Health Advantage. Blue Cross is the largest Medi-Cal contractor in Sacramento County with about 75,000 of the 160,000 total enrollees. Health Net is the second largest Medi-Cal plan in the region with about 30,000 enrollees.

In 2003, four Medicare HMOs offered senior plans in Sacramento, enrolling about 40% of the 165,000 seniors in the county. (See Exhibit 8.) 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 2004 will be $598, compared to $676 in Alameda County and $626 in San Francisco.

Exhibit 35

Inpatient Occupancy Rates and Payer Mix for Sacramento Hospitals, 2001

System/Hospital	Staffed Beds	Inpatient Days	Occupancy	% Medicare Days	% Medi-Cal Days	% Other Third Parties	% County Indigent	% Other Payers
Catholic Healthcare West	**1293**	**283496**	**60.1%**	**44.9%**	**21.1%**	**32.3%**	**1.3%**	**0.4%**
Mercy General Hospital	386	85,173	60.5%	43.3%	15.4%	40.2%	0.8%	0.2%
Methodist Hospital of Sacramento	333	76,296	62.8%	34.4%	37.4%	27.2%	0.5%	0.5%
Mercy San Juan Hospital	247	66,577	73.8%	47.5%	19.5%	30.5%	2.3%	0.1%
Sierra Nevada Memorial Hospital	121	28,530	64.6%	72.2%	6.0%	18.7%	2.1%	1.1%
Woodland Memorial Hospital	111	13,964	34.5%	50.2%	17.5%	29.0%	1.3%	2.1%
Mercy Hospital - Folsom	95	12,956	37.4%	38.3%	7.9%	52.7%	0.9%	0.2%
Kaiser Foundation	**623**	**154,819**	**68.1%**	**31.8%**	**0.6%**	**66.9%**	**0.0%**	**0.7%**
Kaiser Foundation- Sacramento	461	113,863	67.7%	31.8%	0.4%	67.1%	0.0%	0.7%
Kaiser Foundation- South Sacramento	162	40,956	69.3%	31.9%	1.0%	66.4%	0.0%	0.6%
Sutter Health	**1,060**	**276,555**	**71.5%**	**40.0%**	**22.0%**	**33.9%**	**1.5%**	**2.6%**
Sutter Medical Center - Sacramento	650	175,186	73.8%	36.3%	27.7%	33.8%	1.4%	0.8%
Sutter Roseville Medical Center	172	49,153	78.3%	49.0%	8.9%	30.5%	1.1%	10.5%
Sutter Davis Hospital	48	7,937	45.3%	38.4%	19.3%	34.7%	6.2%	1.3%
Sutter-Yuba	16	4,200	71.9%	0.0%	66.4%	33.6%	0.0%	0.0%
Sutter Center for Psychiatry	69	17,635	70.0%	30.7%	12.8%	56.1%	0.0%	0.4%
Sutter Auburn Faith Hospital	105	22,444	58.6%	64.5%	6.5%	24.0%	2.9%	2.2%
University of California Davis Medical Center	**491**	**140,403**	**78.3%**	**27.2%**	**36.9%**	**28.0%**	**5.9%**	**1.9%**
Others	**575**	**155,204**	**69.1%**	**38.6%**	**30.2%**	**16.1%**	**2.8%**	**12.3%**
Fremont Hospital - Yuba City	132	26,630	55.3%	48.2%	19.5%	26.1%	2.2%	4.1%
Rideout Memorial Hospital	113	34,220	83.0%	62.9%	13.8%	16.4%	5.7%	1.2%
Marshall Hospital	103	22,816	60.7%	65.0%	6.6%	21.0%	6.2%	1.3%
Barton Memorial Hospital	123	28,842	64.2%	24.3%	47.1%	16.3%	1.3%	10.9%
Tahoe Forest Hospital	64	17,614	75.4%	18.3%	59.2%	16.8%	0.3%	5.5%
Shriners Hospital - Northern California	40	13,157	90.1%	0.0%	0.0%	0.0%	0.0%	100.0%
Sierra Valley District Hospital	40	11,925	81.7%	3.7%	95.6%	0.0%	0.0%	0.6%
TOTAL	**4,042**	**1,010,477**	**67.0%**	**38.1%**	**21.8%**	**35.0%**	**2.0%**	**3.1%**

Source: Author's analysis of annual hospital report data from Office of Statewide Health Planning and Development

4.3 Central Valley

California's Central Valley extends from Stockton and San Joaquin County in the north through Bakersfield in Kern County to the south. An extensive range of food products are grown or processed here and exported across the country and all over the world. This industry requires a huge workforce, even with extensive mechanization. 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 is an important issue.

A high percentage of the agricultural work force 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. Like northern California, almost all hospitals in the Central Valley are non-profit. 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 by far the largest system in the area. It has six hospitals from Stockton to Bakersfield, one of which is a mental health facility. Its largest hospital in the area is St. Joseph's in Stockton.

Sutter Health has hospitals in Jackson, Merced, and Tracy. It also has affiliation arrangements with the Memorial Hospitals in Los Banos and Modesto. Sutter provides management services and some of its executives sit on the local hospital governing boards.

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 Community Health System, which absorbed University Medical Center, Fresno's county hospital. St. Agnes is part of the Trinity Health System, a Catholic hospital system based in Novi, Michigan. Last year's report includes a history of their competition, including the rise and fall of affiliated physician groups and the decisions by HMOs to move back and forth between the hospitals.

- ✔ Like northern California, almost all hospitals in the Central Valley are non-profit.
- ✔ Two of the largest hospitals in the Central Valley, Community Medical Center and St. Agnes, are historic competitors in Fresno.

Exhibit 36

Sacramento Area Physician Organizations
counties: Sacramento

Name of Physician Organization	Estimated enrollment	# of PCPs	# of Specs	Management Entity	Notes
Group Practice					
The Permanente Medical Group, Inc	389,300	126	383	The Permanente Medical Group, Inc	
Molina Healthcare, Inc	8,200	49	250	Molina Healthcare, Inc	
IPA					
Sutter Independent Physicians, a Medical Group	34,600	91	420	Sutter Connect	
River City Medical Group, Inc	33,000	96	400	River City Medical Group, Inc	
Hill Physicians Medical Group, Inc	104,900	131	308	PriMed Management Consulting, Inc (Hill Physicians)	Catholic Healthcare West is an investor (27%) in PriMed
Golden State Physicians Medical Group, Inc	13,800	145	212	Pacific Partners Management Services, Inc. (Santa Clara IPA)	
California Specialty Independent Medical Associates, Inc	3,200	59	211	Pacific Health Alliance	
M***edical Foundation***					
Sutter Medical Group/ Sutter Medical Foundation	77,000	62	213	Sutter Connect	Includes medical group.
Catholic Healthcare West Medical Foundation/ MedClinic of Sacramento	72,700	37	78	Catholic Healthcare West Medical Foundation	Includes medical group.
State/County Faculty/Staff					
UC Davis Medical Group	69,700	118	254	UC Davis Medical Center	

Exhibit 37

Revenues and Profitability for Central Valley Hospitals, 2001

System/Hospitals	City	Total Charges	Net Patient Revenue	Operating Expenses	Net from Operations	Net Income	% of Total Revenue
Adventist		**507,948,904**	**182,359,304**	**180,714,567**	**4,874,236**	**3,562,871**	**1.9%**
San Joaquin Community Hospital	Bakersfield	231,340,616	79,292,787	81,056,867	527,624	1,733	0.0%
Selma Community Hospital	Selma	44,853,650	16,055,053	17,807,356	(1,553,606)	(1,363,310)	-8.3%
Hanford Community Hospital	Hanford	155,228,858	55,374,169	52,093,791	3,896,273	2,913,197	5.1%
Central Valley General Hospital	Hanford	76,525,780	31,637,295	29,756,553	2,003,945	2,011,251	6.3%
Catholic Healthcare West		**1,479,656,445**	**450,482,387**	**499,106,290**	**(37,669,021)**	**(32,530,003)**	**-6.9%**
Bakersfield Memorial Hospital	Bakersfield	282,044,636	92,755,010	112,118,369	(18,597,754)	(16,173,945)	-16.7%
Mercy Westside Hospital	Taft	12,447,959	6,852,904	8,472,881	(1,610,037)	(1,553,690)	-22.5%
Mercy Hospital - Bakersfield	Bakersfield	231,204,481	88,878,108	116,586,957	(26,446,255)	(25,549,701)	-27.6%
St. Joseph's Behavioral Health Center	Stockton	17,054,297	5,872,012	5,556,505	335,377	336,765	5.7%
St. Joseph's Medical Center of Stockton	Stockton	650,225,226	171,844,310	175,294,851	4,438,731	6,213,341	3.4%
St. Dominic's Hospital	Manteca	102,425,220	25,781,581	25,426,513	495,748	564,258	2.2%
Mercy Medical Center Community Campus	Merced	39,484,378	9,922,791	10,939,003	(887,180)	(851,097)	-8.4%
Mercy Medical Center Dominican Campus	Merced	144,770,248	48,575,671	44,711,211	4,602,349	4,484,066	9.0%
Community Health System		**926,965,051**	**422,041,907**	**389,438,914**	**44,671,342**	**52,514,052**	**11.8%**
Clovis Community Hospital	Clovis	127,008,308	58,490,202	54,913,258	3,917,667	4,665,457	7.8%
Community Medical Center - Fresno	Fresno	799,956,743	363,551,705	334,525,656	40,753,675	47,848,595	12.4%
Sutter Health		**1,484,618,119**	**367,802,331**	**326,640,160**	**44,403,849**	**47,850,178**	**12.6%**
Memorial Hospital Modesto	Modesto	1,150,737,053	248,453,794	226,147,688	24,429,927	29,789,164	11.6%
Memorial Hospital Los Banos	Los Banos	61,152,870	17,856,091	17,203,201	723,164	716,198	4.0%
Sutter Amador Hospital	Jackson	83,607,565	39,710,748	35,370,724	4,743,587	4,997,166	12.4%
Sutter Merced	Merced	44,797,464	11,408,719	12,783,381	(1,082,608)	(3,423,899)	-28.8%
Sutter Tracy Community Hospital	Tracy	144,323,167	50,372,979	35,135,166	15,589,779	15,771,549	30.4%
Tenet Health		**2,413,226,785**	**345,286,620**	**217,011,232**	**128,619,820**	**128,476,823**	**37.1%**
Doctors Hospital of Manteca	Manteca	282,605,441	38,393,933	29,036,316	9,394,910	9,126,868	23.7%
Doctors Medical Center	Modesto	2,130,621,344	306,892,687	187,974,916	119,224,910	119,349,955	38.8%
Other Hospitals		**2,794,245,733**	**1,193,720,830**	**1,209,040,522**	**(41,228,226)**	**26,084,434**	**1.9%**
Tehachapi Hospital	Tehachapi	11,750,822	5,857,345	6,731,169	(844,225)	(551,322)	-8.7%
Dameron	Stockton	359,803,325	88,712,047	87,723,451	2,300,809	6,823,244	7.1%
Emanuel Medical Center	Turlock	150,107,138	59,679,065	64,840,065	(4,139,000)	4,677,000	6.7%
Lodi Memorial Hospital	Stockton	198,560,568	65,485,669	62,086,800	3,918,541	4,867,453	7.2%
Kern Medical Center*	Bakersfield	213,173,853	77,347,146	142,037,387	(61,910,695)	(41,680,893)	-24.9%
Kern Valley Healthcare District	Lake Isabella	38,027,761	17,798,396	17,614,564	365,926	674,248	3.7%
Madera Community Hospital	Madera	89,679,710	39,318,883	40,540,297	(656,028)	132,953	0.3%
Sierra View District Hospital	Porterville	153,644,306	53,116,962	53,626,829	(170,650)	3,225,315	5.6%
Tulare District Hospital	Tulare	72,783,086	33,100,912	35,236,827	(1,686,247)	755,848	2.1%
Delano Regional Medical Center	Delano	93,669,884	37,062,325	36,176,401	1,282,240	2,591,309	6.7%
Ridgecrest Regional Hospital	Ridgecrest	49,189,055	25,514,705	24,407,541	1,259,813	1,828,824	6.9%
Fresno Surgery Center	Fresno	54,078,813	23,428,930	22,734,110	747,319	568,549	2.4%
Memorial Hospital At Exeter	Exeter	25,850,717	7,861,033	9,806,966	(1,914,417)	(1,889,214)	-23.8%
St. Agnes Medical Center	Fresno	598,513,611	240,189,567	226,747,527	17,880,479	29,508,987	11.4%
Kaiser Foundation - Fresno	Fresno						
Valley Children's Hsp & Guidance Clinic	Madera	298,614,639	189,769,387	192,568,212	2,487,284	7,101,656	3.4%
Kaweah Delta District Hospital	Visalia	386,798,445	229,478,458	186,162,376	(149,375)	7,450,477	3.1%
TOTAL		**9,606,661,037**	**2,961,693,379**	**2,821,951,685**	**143,672,000**	**225,958,355**	**7.1%**

*Net Patient Revenues, Net from Operations and Net Income for certain county, hospital district and University of California hospitals reduced by transfer of disproportionate share hospital funds and other special Medicaid funds.
Source: Author's analysis of annual hospital report data for years ending in 2001 from Office of Statewide Health Planning and Development
% of Total Revenue is calculated using total hospital revenues as the denominator, not net patient revenues.

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.

As in other parts of the state, competing hospitals have been busily building up 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 has just completed construction of its new heart center. Community Health System is a minority owner of Fresno Heart Hospital, which is scheduled to open this year. MedCath, a national operator of cardiac hospitals and laboratories, owns the Bakersfield Heart Hospital.

There are several district hospitals and county hospitals in the area, including Memorial Hospital at Exeter in Tulare County and Kern Medical Center (county) in Bakersfield and Kern Valley Healthcare District (Lake Isabella). District hospitals have elected boards and independent taxing authority. They vary widely in their approaches to community mission (serving persons without insurance) and management.

Financial Results. *Exhibit 37* on page 64 compares area hospitals on their revenues and profitability. Across the entire region, hospitals reported net income of $226 million, or 7.1% of total revenues of $3.2 billion. Hospitals had net income on patient operations of $208.1 million.

The Catholic Healthcare West hospitals in the Central Valley lost $32.5 million in 2001, or 6.9% of total revenues. Two Bakersfield hospitals, Memorial and Mercy, both reported losses. The five Sutter hospitals fared better, reporting net income of $47.9 million, or 12.6% of total revenues.

Doctors Medical Center, the Tenet hospital in Modesto and the largest hospital in the area, reported the highest individual hospital net income of $119.2 million. Community Health System had net income of $52.5 million, or 11.8% of total revenues. Also in Fresno, St. Agnes Medical Center had a margin of 11.4% of total revenues, with net income of $29.5 million.

Most of the independent hospitals reported positive net income. Kern Medical Center had a loss of $41.7 million, but benefited from county indigent care funds, other county support and investment income.

Occupancy. Average inpatient occupancy for hospitals in the Central Valley was similar to the Bay Area but lower than in Sacramento. As shown in *Exhibit 38,* inpatient occupancy averaged 64.7% in 2001. The range was wide, even within some systems, such as Catholic Healthcare West. The average for the system in that part of the state was 63.5%. Its main Bakersfield hospital had only 50% occupancy while its Stockton hospital had an occupancy rate of 78.8%. Occupancy rates at the Community Health System hospitals were lower, averaging 56.1%. The Tenet hospital in Modesto had an inpatient occupancy rate of 68.6%, which is relatively high for a Tenet hospital.

Payer Mix. On average, Medicare covered just under 40% of inpatient days in Central Valley hospitals. Medi-Cal covered 27.5% and other commercial payers covered 26.9%, on average. Out of 366,000 Medi-Cal inpatient days, Community Medical Center provided 55,000 and was the largest single provider for Medi-Cal patients. Second was the Valley Children's Hospital in Madera.

The Adventist and Sutter hospitals had relatively high proportions of Medicare days, 49.6% and 50.7% respectively. Catholic Healthcare West hospitals had the highest proportion of commercial and managed care payers, covering 35.9% of all inpatient days.

Physician Organizations. *Exhibit 39* presents an overview of the major physician groups in the Central Valley. Both Permanente groups—Northern and Southern—are represented in the area. The Northern Permanente Medical Group is the largest group in the region, with centers in Fresno, Modesto and other locations. In the Bakersfield area, the Southern California Permanente Medical Group has 170 primary care and specialty physicians.

Bakersfield Family Medical Group, with 95 primary care doctors, is managed by Heritage Provider Network, one of the few remaining organizations that holds a Knox-Keene license with waivers. The largest IPA in the area is Sante Community Physicians, which is affiliated with St. Agnes in Fresno.

Health Plans. Based on the analysis in *Exhibit 13,* Blue Cross remains the largest health plan in the area, with about 527,000 enrollees in that part of the Central Valley that extends from Fresno to Bakersfield. Kaiser Permanente has about 210,000 in the area and has been growing in recent years. It opened new health centers in Clovis and Selma, both in the northern end of the valley, in 2003. Both Blue Shield and Health Net have more than 120,000 enrollees in the area. PacifiCare used to have a much larger presence in the area, including a large Secure Horizon plan for seniors. Aetna Health withdrew its HMO plan from the area in 2002.

✔ Competing hospitals have been busily building up 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.

✔ Across the entire region, hospitals reported net income of $226 million, or 7.1% of total revenues of $3.2 billion.

✔ On average, Medicare covered just under 40% of inpatient days in Central Valley hospitals. Medi-Cal covered 27.5% and other commercial payers covered 26.9%, on average.

✔ Kaiser Permanente has about 210,000 in the area and has been growing in recent years.

✔ Both Blue Shield and Health Net have more than 120,000 enrollees in the area.

Exhibit 38

Inpatient Occupancy Rates and Payer Mix for Central Valley Hospitals, 2001

Hospital	Staffed Beds	Inpatient Days	Occupancy	% Medicare Days	% Medi-Cal Days	% Other Third Parties	% County Indigent	% Other Payers
Adventist	**266**	**79,468**	**65.2%**	**49.6%**	**20.9%**	**24.7%**	**0.9%**	**3.9%**
San Joaquin Community Hospital	168	45,270	73.8%	49.8%	20.1%	27.4%	0.0%	2.6%
Selma Community Hospital	25	8,584	41.3%	58.1%	19.3%	17.0%	0.0%	5.6%
Hanford Community Hospital	45	16,071	73.4%	57.8%	10.9%	22.5%	2.7%	6.1%
Central Valley General Hospital	28	9,543	53.4%	26.9%	43.1%	22.2%	3.4%	4.5%
Catholic Healthcare West	**1,416**	**298,081**	**63.5%**	**43.3%**	**19.3%**	**35.9%**	**0.2%**	**1.3%**
Bakersfield Memorial Hospital	385	70,298	50.0%	32.5%	4.8%	61.2%	0.0%	1.5%
Mercy Westside Hospital	84	22,727	74.1%	11.2%	82.7%	4.8%	0.0%	1.3%
Mercy Hospital - Bakersfield	261	57,429	60.3%	48.1%	3.6%	47.0%	0.0%	1.4%
St. Joseph's Behavioral Health Center	35	10,604	83.0%	68.9%	0.0%	28.4%	0.0%	2.7%
St. Joseph's Medical Center of Stockton	294	84,593	78.8%	58.1%	14.9%	26.1%	0.2%	0.8%
St. Dominic's Hospital	77	22,545	80.2%	15.3%	68.4%	14.1%	0.0%	2.1%
Mercy Medical Center Community Campus	174	4,832	30.5%	45.1%	29.9%	16.6%	6.7%	1.7%
Mercy Medical Center Dominican Campus	106	25,053	64.8%	56.3%	15.3%	27.5%	0.2%	0.8%
Community Health System	**845**	**173,056**	**56.1%**	**33.7%**	**32.1%**	**26.4%**	**4.8%**	**3.0%**
Clovis Community Hospital	100	20,387	55.9%	36.7%	9.9%	52.1%	0.3%	1.1%
Community Medical Center - Fresno	745	152,669	56.1%	33.4%	35.0%	23.0%	5.4%	3.3%
Sutter Health	**483**	**127,672**	**66.8%**	**50.7%**	**13.6%**	**32.9%**	**0.4%**	**2.4%**
Sutter Amador Hospital	66	16,956	70.4%	61.7%	18.8%	16.2%	1.3%	2.0%
Sutter Merced	57	5,110	40.6%	47.8%	29.5%	14.8%	4.7%	3.3%
Sutter Tracy Community Hospital	75	12,130	44.3%	40.8%	9.5%	47.8%	0.0%	1.9%
Memorial Hospital Modesto	237	86,416	78.9%	50.0%	11.3%	36.3%	0.0%	2.4%
Memorial Hospital Los Banos	48	7,060	40.3%	51.9%	25.7%	19.1%	0.0%	3.3%
Tenet Health	**465**	**110,958**	**65.4%**	**40.6%**	**25.5%**	**28.4%**	**3.8%**	**1.8%**
Doctors Hospital of Manteca	73	12,820	48.1%	49.1%	8.7%	40.0%	0.4%	1.8%
Doctors Medical Center	392	98,138	68.6%	39.5%	27.7%	26.8%	4.2%	1.8%
Other Hospitals	**2,631**	**697,703**	**67.3%**	**35.6%**	**33.5%**	**22.1%**	**3.4%**	**5.4%**
Tehachapi Hospital	28	6,442	63.0%	3.2%	92.8%	3.8%	0.0%	0.1%
Memorial Hospital Modesto	48	7,060	40.3%	51.9%	25.7%	19.1%	0.0%	3.3%
Emanuel Medical Center	340	87,953	70.7%	25.9%	36.9%	7.3%	0.0%	29.9%
Dameron Hospital	188	47,768	69.6%	49.0%	13.6%	36.3%	0.1%	1.1%
Lodi Memorial Hospital	173	39,303	62.2%	47.2%	31.4%	18.8%	0.0%	2.5%
Kern Medical Center	180	53,200	68.4%	13.2%	54.3%	18.1%	14.3%	0.0%
Kern Valley Healthcare District	101	30,300	82.2%	12.9%	76.2%	9.7%	0.3%	0.9%
Madera Community Hospital	100	21,727	59.5%	40.8%	28.1%	23.6%	5.1%	2.4%
Sierra View District Hospital	147	31,169	58.1%	44.1%	35.2%	13.6%	2.0%	2.3%
Tulare District Hospital	100	15,709	43.0%	50.8%	25.6%	15.3%	2.2%	6.1%
Delano Regional Medical Center	89	31,180	54.8%	27.9%	52.9%	15.9%	1.1%	2.2%
Ridgecrest Regional Hospital	80	8,170	27.9%	43.8%	14.4%	40.1%	0.0%	1.7%
Fresno Surgery Center	20	4,398	60.2%	23.4%	0.0%	74.2%	0.0%	2.4%
Memorial Hospital At Exeter	80	19,797	67.8%	9.1%	87.6%	2.5%	0.0%	0.9%
St. Agnes Medical Center	327	89,986	75.4%	60.8%	9.0%	29.2%	0.0%	1.0%
Kaiser Foundation Fresno	95	34,281	98.9%	41.9%	0.1%	57.5%	0.0%	0.5%
Valley Children's Hospital	242	61,065	69.1%	0.4%	69.5%	29.9%	0.1%	0.1%
Kaweah Delta District Hospital	341	115,255	70.2%	49.9%	15.2%	19.1%	11.4%	4.3%
Total	**6,106**	**1,486,938**	**64.7%**	**39.4%**	**27.5%**	**26.9%**	**2.5%**	**3.7%**

Source: Author's analysis of annual hospital report data from office of Statewide Health Planning and Development

In 2003, only two HMOs in Fresno County had Medicare+Choice plans: Kaiser and PacifiCare, which had fewer than 4,500 seniors at the end of 2002. Even though federal payment rates have increased, HMOs have not been willing to return to the area.

Most of the counties in the area have two-plan Medi-Cal managed care arrangements; Blue Cross or Health Net is the commercial plan in these counties. In Tulare County, Blue Cross and Health Net compete with each other, with one designated the county plan. Enrollment in both the commercial and county Medi-Cal plans grew by about 10% during 2002.

Exhibit 39

Central Valley Physician Organizations
counties: Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, Tulare, Tuolumne

Name of Physician Organization	Estimated enrollment	# of PCPs	# of Specs	Management Entity	Notes
Group Practice					
The Permanente Medical Group, Inc	331,430	197	377	The Permanente Medical Group, Inc	
Southern California Permanente Medical Group	88,500	51	118	Southern California Permanente Medical Group	
Clinica Sierra Vista	21,500	17	2	Clinica Sierra Vista	Self
Lodi Primary Care Medical Associates, Inc	1,000	24	239	Lodi Primary Care Medical Associates, Inc	
Bakersfield Family Medical Group, Inc	69,400	95	90	Heritage Provider Network, Inc	Includes IPA type panel.
IPA					
Sante Community Physicians IPA Medical Corp	131,000	241	566	Sante Health System, Inc	
Omni IPA Medical Group, Inc/ Medcore Medical Group	16,000	116	229	Medcore Management, Inc	
Independent Physicians Associates Medical Group, Inc/ Allcare IPA	30,200	142	170		Independent Physicians Associates Medical Group, Inc
Delta Individual Practice Association	84,400	125	138	Delta IPA Medical Group, Inc	
Golden Empire Managed Care, a Medical Group, Inc/ Gemcare Medical Group	56,000	96	213	Managed Care Systems, LP	
Key Medical Group, Inc	15,350	67	175	Foundation for Medical Care of Tulare & Kings Counties, Inc	
Merced-Mariposa IPA Medical Group, Inc	3,100	106	94	Foundation for Medical Care For Merced County	
ChildNet Medical Associates, Inc	3,800	42	106	Children's Hospital Central California	
Central Valley Medical Group, Inc	17,000	60	73	North American Medical Management, Inc	
Delano Regional Medical Group, Inc	4,100	22	64	Managed Care Systems, LP	
Medical Foundation					
Sutter Gould Medical Foundation/ The Gould Medical Group, Inc	96,300	120	210	Sutter Connect	Sutter Health sole corporate member of Gould Medical Foundation. Includes med ical group and IPA.
State/County Faculty/Staff					
San Joaquin Faculty Medical Group	8,050	35	72	San Joaquin County Health Care Services	
Central California Faculty Medical Group, Inc	5,800	29	69	Central California Faculty Medical Group, Inc	

✔ 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. The problem is that maintaining this system demands an ongoing commitment of a huge amount of resources.

✔ Development of hospital systems is still an ongoing process in Los Angeles and Orange counties, with affiliations often changing.

✔ In an area so spread out, geographic access to hospitals and physicians is important. This could drive some consolidation of providers, particularly physician groups.

✔ A second bailout in 2000 brought federal money to the county but did not resolve fundamental issues on the future direction of the system.

4.4 Los Angeles—Orange County

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 continues to grow and is now estimated at about 12.5 million. Many have no insurance.

There is a large private and public health care infrastructure—more than 140 acute care hospitals (many of them organized into multi-site 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 their 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 a full waiting room 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. The problem is that maintaining this system demands an ongoing commitment of a huge amount of resources. 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. Orange County has a well-developed system of community health centers to provide ambulatory care. A year ago 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 designated tobacco funds for community health purposes.

The seemingly imminent collapse of the Los Angeles County health system presents a major challenge to leaders in the area. 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. Despite repeated bailout attempts, the agency continues to face huge budget deficits.

A bailout in the 1990s called for the expansion of local clinic services and a reduction in hospital services. While it did expand clinical services, the department remained heavily committed to its hospitals. Politicians objected to proposals to reduce inpatient hospital capacity in their districts. A second bailout in 2000 brought federal money to the county but did not resolve fundamental issues on the future direction of the system. In 2003, the county adopted a plan to close two facilities, High Desert Hospital in Lancaster, and the county's rehabilitation hospital in Downey. Advocates for the poor and others challenged those cuts and the county is embroiled in lawsuits.

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.

Tenet Health acquired the two Daniel Freeman hospitals from the Carondolet system, but was blocked in its attempt to buy a third Carondolet hospital. Tenet has since announced its intent to close inpatient services at one of the hospitals. But it agreed as a condition of the sale that it would continue the Ethical and Religious Directives of the Catholic Church, which forbid abortion, euthanasia, and sterilization procedures. The directives also require that hospital employees have the right to join a union. Acceptance of the directives has been an issue to health activists especially if it severely limits access to certain services in a given community.

Earlier this year Tenet Health announced that it would sell Santa Ana Hospital Medical Center, a small facility in Orange County, as part of a national strategy to shed some hospitals and focus on those remaining.

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. These ever-shifting alliances suggest a health care Monopoly game with players trading hospital properties and trying to develop a system with geographic strength as well as reputation.

Overview of Hospitals. *Exhibit 40* is a map of the Los Angeles area showing many of the acute care hospitals and their system affiliations. For-profit hospitals are much more common in this part of the state than in northern California.

In an area so spread out, 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.

Tenet Health has 29 hospitals in Los Angeles and Orange Counties with more than 5,000 acute care beds, making it one of the largest systems in the area. 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.

There are many hospital systems in the Los Angeles area, some relatively small. The two exhibits that follow list 15 hospital systems in the area and about 45 hospitals that are not part of those systems. Of course, some of the independent hospitals, like Cedars-Sinai, are bigger than some of the systems in the area. Still, out of nearly 30,000 inpatient hospital beds in the area, all but 8,000 are in one of those 15 systems.

Based on inpatient hospital days, Tenet Health is the largest hospital system in the region. Catholic Healthcare West (still including the three Daughters of Charity hospitals in 2001) is the largest nonprofit system, followed by the six Los Angeles County hospitals (one of which is a rehabilitation facility) and the eight Kaiser hospitals.

Financial Results. Beginning on page 72, *Exhibit 41* compares Los Angeles/Orange County hospitals and systems on their revenues and net income. On average, hospitals in the area reported net income of 4.5% on total revenues (patient care and other revenue sources) of $17.8 billion. About 40 hospitals reported losses for 2001 operations. Hospitals in the two counties had total net income of $797.2 million. As in other parts of the state, 2001 was a better year for hospitals than 2000.

The reporting also shows some rather striking and possibly misleading results. For example, the Los Angeles County hospitals, part of a health system in crisis, show net income of $17.3 million. The hospitals receive significant other revenues, including county indigent care funds, disproportionate share hospital funds (to hospitals serving a high proportion of Medicaid recipients) and so on. However, they transferred out $812.7 million as part of the DSH program.

Tenet Health had the next highest net income, with $271.6 million after taxes, or 12.4% of $2.2 billion of total revenues. The most profitable Tenet hospitals in the area are Centinela in Inglewood, Garfield in Monterey Park, Encino Tarzana and the University of Southern California University Hospital in Los Angeles. In 2002 and 2003, the two Daniel Freeman hospitals became part of the Tenet system in the area. Tenet bought the hospitals from the Carondolet systems. In 2001, the two hospitals lost about $40 million.

The Kaiser hospitals for southern California, including San Diego, had net income of $229.2 million, or 9.4% of $2.4 billion in total revenues. That is a significant improvement over 2000 when the Kaiser hospitals had total losses of $104.8 million.

Of the other nonprofit systems, the St. Joseph hospitals in Orange County had the best results, with net income of $35.4 million, an improvement over 2000. In the past three years, it has revised its strategies by cutting ties with physician groups and using its geographic presence to leverage better payments from a more select group of health plans.

Adventist had the second best results. In 2001, the two Adventist hospitals in the area had net income of $38 million, or 10.7% of total revenues of $353.2 million. That was less than the 13.1% net income they reported in 2000. The Catholic Healthcare West hospitals had net income of $21.5 million, but about half of that was from the three hospitals that formed the Daughters of Charity system in that part of the state. That is about the same net income as in 2000. California Hospital Medical Center in Los Angeles had the best results for the CHW hospitals in the area.

Occupancy. Hospital capacity is a major issue in this part of the state. Major new construction or reconstruction projects are now underway or planned. 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 latest and greatest equipment. Interviewees spoke of the desire to have the heart center (or orthopedic center or other specialty clinic) that will not only appeal to patients but will keep star doctors happy and generate business for that hospital.

Other projects are tied to the need to bring hospitals up to the state's new standards for seismic safety. The medical center at UCLA, heavily earthquake-damaged, is now under reconstruction. The University of California Irvine Medical Center has started to raise money for a new hospital, intended to help the hospital and medical school advance to higher levels among its peers. Kaiser plans to replace six of its hospitals in the area over the next 10 years, largely to comply with the state's standards for seismic safety in hospital construction. Children's Hospital in Los Angeles will construct a

✔ On average, hospitals in the area reported net income of 4.5% on total revenues (patient care and other revenue sources) of $17.8 billion.

✔ The Catholic Healthcare West hospitals had net income of $21.5 million, but about half of that was from the three hospitals that formed the Daughters of Charity system in that part of the state.

✔ Hospital capacity is a major issue in this part of the state. Major new construction or reconstruction projects are now underway or planned.

new patient care tower designed to meet the new standards. Several other hospital projects are already underway to address seismic safety standards.

Exhibit 42, beginning on page 74, compares Los Angeles and Orange County hospitals and systems on their inpatient occupancy rates and payer mix in 2001. Hospitals in the area had, on average, 62.9%

Exhibit 40

Los Angeles Hospital Map Legend

System/Hospitals	City
★ **Adventist**	
1 Glendale Adventist	Glendale
2 White Memorial Medical Center	Los Angeles
☆ **Carondolet**	
3 Daniel Freeman Memorial	Inglewood
★ **Catholic Healthcare West**	
4 California Hospital	Los Angeles
5 Glendale Memorial	Glendale
6 Northridge Hospital	Northridge
7 San Gabriel Valley	San Gabriel
8 St. Francis Medical Center	Lynwood
9 St. Mary Medical Center	Long Beach
10 St. Vincent Medical Center	Los Angeles
▼ **Citrus Valley Medical Center**	
11 Citrus Valley Medical Center-Qv Campus	West Covina
▽ **Columbia-HCA**	
12 Columbia West Hills	West Hills
▼ **County of Los Angeles**	
13 LA County/Harbor-UCLA	Torrance
14 LA County/Martin Luther King Jr./Drew Med Ctr	Los Angeles
15 LA County/Olive View	Sylmar
16 LA County/USC Medical Center	Los Angeles
● **Kaiser Foundation Southern Region**	
17 Kaiser Foundation - Anaheim	
18 Kaiser Foundation - Bellflower	
19 Kaiser Foundation - Harbor City	
20 Kaiser Foundation - Panorama City	
21 Kaiser Foundation - Sunset	
22 Kaiser Foundation - West LA	
23 Kaiser Foundation - Woodland Hills	
24 Kaiser Foundation - Baldwin Park	
◆ **Little Company of Mary**	
26 Little Company of Mary	Torrance
27 San Pedro Peninsula Hospital	San Pedro
◇ **Memorial Health Services**	
28 Anaheim Memorial	Anaheim
29 Long Beach Memorial	Long Beach
29A Saddleback Memorial	Laguna Hills
◆ **Sisters of Providence**	
30 Providence Saint Joseph	Burbank
31 Providence Holy Cross	Mission Hills

System/Hospitals	City
▲ **Southern California Healthcare Systems**	
32 Huntington Memorial Hospital	Pasadena
33 Methodist Hospital Southern Cal	Arcadia
▲ **St. Joseph**	
34 Mission Hospital Regional	Mission Viejo
35 St. Joseph Hospital - Orange	Orange
36 St. Jude Medical Center	Fullerton
● **Tenet Health**	
37 Brotman Medical Center	Culver City
38 Centinela Hospital	Inglewood
39 Century City Hospital	Los Angeles
40 Encino Tarzana Regional	Tarzana
41 Fountain Valley - Euclid	Fountain Valley
42 Garden Grove Hospital	Garden Grove
43 Garfield Medical Center	Monterey Park
44 Irvine Medical Center	Irvine
45 Lakewood Regional - South	Lakewood
46 Los Alamitos Medical Center	Los Alamitos
47 Queen of Angels-Hollywood Presbyterian Med Ctr	Los Angeles
48 USC University Hospital	Los Angeles
49 Western - Santa Ana	Santa Ana
50 Whittier Hospital Medical Center	Whittier
△ **University of California**	
51 Santa Monica - UCLA	Santa Monica
52 UCLA Medical Center	Los Angeles
53 University of California Irvine	Orange
■ **Other Hospitals**	
54 St. John's	Santa Monica
55 Antelope Valley	Lancaster
56 Beverly Hospital	Montebello
57 Cedars-Sinai Medical Center	Los Angeles
58 Children's Hospital of Los Angeles	Los Angeles
59 Children's Hospital of Orange County	Orange
60 Downey Community Hospital	Downey
61 Good Samaritan Hospital	Los Angeles
62 Henry Mayo Newhall Memorial	Valencia
63 Hoag Memorial Presbyterian	Newport Beach
64 Long Beach Community	Long Beach
65 Pomona Valley Hospital	Pomona
66 Presbyterian Intercommunity	Whittier
67 Torrance Memorial	Torrance
68 USC Norris Cancer Hospital	Los Angeles
69 Valley Presbyterian Hospital	Van Nuys

inpatient occupancy. That is higher than in 2000 when average occupancy for the region was about 60%. Again, note that the cautions about possible changes in reporting by hospitals apply to this comparison.

At the largest systems, occupancy rates ranged from 93.7% at the Los Angeles County hospitals to 63.3% at the Kaiser hospitals in Los Angeles to 62.4% at the Tenet hospitals.

Tenet increased its occupancy rate by about five percentage points over 2000. In its markets in California, Texas, and Florida, Tenet has historically had relatively low occupancy rates but high net income. That result might come from billing practices that have been challenged in the last year, but it also reflects Tenet's ability to identify the patients and the payers that are able to make a contribution to margin. It is not a given that high occupancy

Exhibit 40

Los Angeles Area Hospitals and Systems

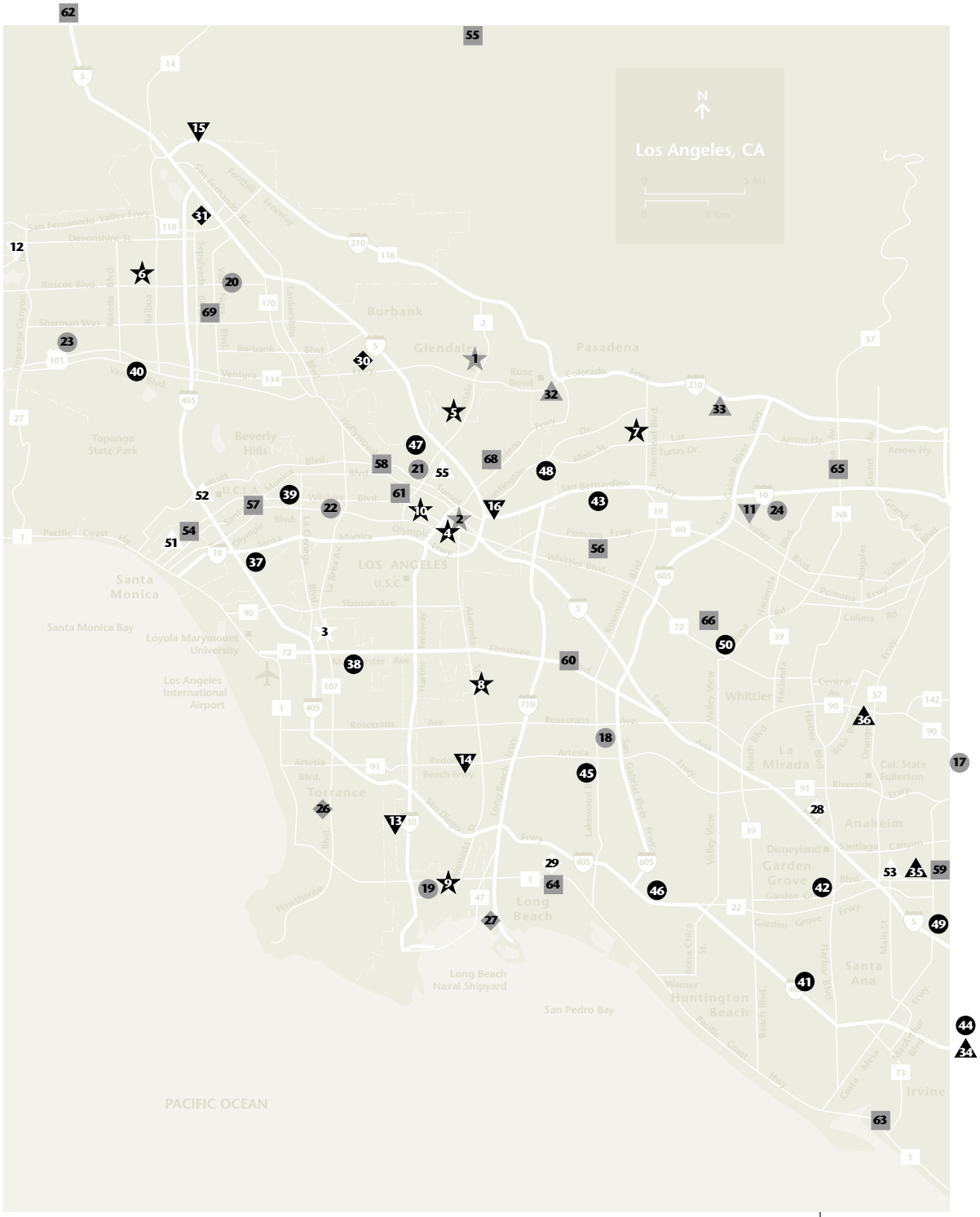


Exhibit 41

Revenues and Net Income for Los Angeles Area Hospitals, 2001

System/Hospitals	City	Total Charges	Net Patient Revenue	Operating Expenses	Net from Operations	Net Income	% of Total Revenue
Adventist		**750,115,293**	**319,478,119**	**312,760,291**	**17,123,764**	**37,950,094**	**10.7%**
Glendale Adventist Medical Center	Glendale	437,660,468	157,536,432	167,933,916	(5,004,713)	(747,176)	-0.4%
White Memorial Medical Center	Los Angeles	312,454,825	161,941,687	144,826,375	22,128,477	38,697,270	20.9%
Carondolet		**554,072,650**	**167,288,726**	**197,278,787**	**(24,574,920)**	**(42,968,257)**	**-24.6%**
Daniel Freeman Marina Hospital	Marina Del Rey	119,498,744	30,169,138	38,106,652	(6,084,121)	(7,711,588)	-23.6%
Daniel Freeman Memorial Hospital	Inglewood	374,082,298	111,402,039	130,086,149	(15,394,421)	(32,330,156)	-27.9%
Catholic Healthcare West		**3,796,787,922**	**1,246,064,082**	**1,252,773,662**	**16,604,219**	**21,511,037**	**1.7%**
California Hospital Medical Center	Los Angeles	312,312,997	114,641,834	109,218,176	12,370,336	12,546,949	10.3%
Glendale Memorial Hospital & Health Center	Glendale	457,576,755	127,278,470	123,513,085	5,343,313	5,970,455	4.6%
Northridge Hospital Medical Center	Northridge	491,323,539	173,724,835	168,919,767	8,761,565	8,199,000	4.6%
Northridge Hospital Medical Center – Sherman	Van Nuys	149,196,118	52,435,382	50,793,376	2,222,997	2,297,639	4.3%
Robert F. Kennedy Medical Center*	Hawthorne	114,153,800	43,223,594	53,925,485	(9,982,693)	(12,404,404)	-29.7%
San Gabriel Valley Medical Center	San Gabriel	280,066,760	81,084,906	82,194,177	(336,751)	(1,049,877)	-1.3%
St. Francis Medical Center*	Lynwood	513,610,781	171,011,280	159,050,923	12,618,051	15,617,158	8.9%
St. Mary Medical Center	Long Beach	404,159,202	121,122,523	135,430,544	(12,480,147)	(10,894,724)	-8.7%
St. Vincent Medical Center*	Los Angeles	402,316,757	131,831,136	126,643,369	6,868,576	8,744,219	6.2%
Citrus Valley		**672,071,213**	**229,710,122**	**243,084,760**	**(8,781,028)**	**(7,515,378)**	**-3.2%**
Citrus Valley Medical Center-QV Campus	West Covina	567,279,335	187,257,392	200,541,598	(9,490,218)	(8,270,000)	-4.3%
HCA: The Healthcare Company		**791,868,835**	**224,715,578**	**225,036,722**	**1,839,616**	**2,444,113**	**1.1%**
West Hills Hospital & Medical Center	West Hills	310,719,200	87,576,087	87,345,965	1,355,078	1,510,426	1.7%
Huntington Beach Hospital	Huntington Beach	128,988,201	35,789,801	36,150,743	(206,755)	(540,953)	-1.5%
West Anaheim Medical Center	Anaheim	218,019,771	57,008,317	50,484,722	6,920,480	6,174,437	10.8%
County of Los Angeles**		**4,275,522,721**	**1,221,898,436**	**1,850,483,009**	**(585,486,669)**	**17,334,698**	**0.6%**
LAC/Harbor/UCLA Medical Center**	Torrance	964,053,514	239,298,159	330,618,218	(81,242,785)	3,047,071	0.6%
LAC/Martin Luther King Jr./Drew Med Center**	Los Angeles	685,639,869	210,023,424	333,830,653	(116,163,915)	16,664,409	3.4%
LAC/Olive View-UCLA Medical Center**	Sylmar	470,035,347	120,246,551	224,704,900	(99,937,137)	(29,569,440)	-9.2%
LAC/Rancho Los Amigos National Rehab Center**	Downey	327,353,492	118,008,321	173,274,623	(51,110,218)	(7,425,779)	-3.3%
LAC/USC Medical Center**	Los Angeles	1,729,032,112	503,258,297	731,142,229	(212,340,310)	34,278,463	3.1%
LAC/High Desert Hospital**	Lancaster	99,408,387	31,063,684	56,912,386	(24,692,304)	339,974	0.5%
Kaiser Foundation Southern California		**2,493,770,848**	**2,447,740,467**	**2,220,951,984**	**229,156,704**	**229,156,704**	**9.4%**
Little Company of Mary		**771,316,887**	**245,373,413**	**240,237,542**	**10,165,863**	**10,614,369**	**4.2%**
Little Company of Mary Hospital	Torrance	495,998,453	159,105,650	154,576,757	7,622,734	7,251,358	4.5%
San Pedro Peninsula Hospital	San Pedro	275,318,434	86,267,763	85,660,785	2,543,129	3,363,011	3.8%
Memorial Health Services		**1,405,206,883**	**625,678,062**	**674,138,601**	**16,407,927**	**13,700,662**	**2.0%**
Anaheim Memorial Medical Center	Anaheim	360,274,266	116,990,034	122,440,434	(4,052,773)	(3,585,500)	-3.0%
Long Beach Memorial Medical Center	Long Beach	589,462,764	291,110,040	325,424,715	14,794,554	13,550,518	3.9%
Saddleback Memorial Medical Center	Laguna Hills	311,265,659	147,587,829	154,056,889	7,536,972	4,273,277	2.6%
Orange Coast Memorial Medical Center	Fountain Valley	144,204,194	69,990,159	72,216,563	(1,870,826)	(537,633)	-0.7%
Pacific Health Corp		**326,305,053**	**102,361,917**	**112,147,968**	**(9,008,950)**	**4,439,164**	**3.9%**
Bellflower Medical Center	Bellflower	105,633,827	32,346,566	32,101,524	490,260	275,555	0.8%
Anaheim General Hospital	Anaheim	99,502,502	29,500,061	32,821,190	(3,259,692)	(2,713,528)	-8.6%
Alta Health		**456,590,670**	**146,158,784**	**145,150,298**	**2,061,484**	**1,966,667**	**1.3%**
Los Angeles Community Hospital	Los Angeles	103,061,782	38,414,738	35,648,578	3,379,989	3,418,915	8.7%
Lancaster Community Hospital	Lancaster	202,428,196	53,488,637	51,475,064	2,151,779	2,293,370	4.2%
Sisters of Providence		**967,231,490**	**290,251,134**	**297,995,911**	**(2,774,419)**	**83,977**	**0.0%**
Providence Saint Joseph Medical Center	Burbank	572,068,836	183,957,246	190,186,922	(2,554,721)	(797,934)	-0.4%
Providence Holy Cross Medical Center	Mission Hills	395,162,654	106,293,888	107,808,989	(219,698)	881,911	0.8%
Southern California Healthcare Systems		1,077,809,942	347,597,261	359,056,469	357,540	4,873,732	1.3%
Huntington Memorial Hospital	Pasadena	668,611,174	223,692,053	234,268,717	(207,629)	4,365,801	1.8%
Methodist Hospital of Southern California	Arcadia	365,756,533	110,305,129	109,754,451	1,961,671	1,885,263	1.7%
St. Joseph		**1,747,389,964**	**605,798,629**	**624,576,307**	**31,430,821**	**35,447,664**	**5.2%**
Mission Hospital Regional Medical Center	Mission Viejo	469,192,648	160,595,408	159,126,526	7,601,253	8,679,262	4.9%
St. Joseph Hospital - Orange	Orange	757,004,421	273,432,307	298,073,675	14,847,789	16,623,446	5.1%
St. Jude Medical Center	Fullerton	521,192,895	171,770,914	167,376,106	8,981,779	10,144,956	5.7%
Tenet Health		**10,887,203,869**	**2,162,050,878**	**1,873,086,079**	**296,784,280**	**271,580,641**	**12.4%**
Brotman Medical Center	Culver City	459,112,043	84,072,346	84,540,812	(324,506)	(268,352)	-0.3%
Centinela Hospital Medical Center	Inglewood	875,162,370	176,413,154	153,220,578	23,407,803	22,896,768	12.9%
Century City Hospital	Los Angeles	390,583,473	67,292,535	67,068,929	372,879	96,904	0.1%

Revenues and Net Income for Los Angeles Area Hospitals, 2001, continued

System/Hospitals	City	Total Charges	Net Patient Revenue	Operating Expenses	Net from Operations	Net Income	% of Total Revenue
Chapman Medical Center	Orange	189,085,126	39,508,209	35,953,182	3,704,965	3,617,269	9.0%
Coastal Communities Hospital	Santa Ana	155,765,686	37,889,528	38,188,022	(29,292)	(298,722)	-0.8%
Fountain Valley Regional	Fountain Valley	781,410,772	177,721,663	152,504,490	25,687,596	23,587,596	13.2%
Encino Tarzana Regional -Tarzana	Tarzana	746,733,174	150,117,864	106,086,271	45,025,320	23,557,143	15.5%
Encino Tarzana Regional - Encino	Encino	298,300,211	52,131,107	46,402,865	5,906,342	5,235,658	9.9%
Community & Mission Hospital	Huntington Park	129,686,177	35,778,732	31,960,515	3,851,531	3,769,573	10.4%
Garden Grove Hospital	Garden Grove	252,122,546	61,893,488	51,371,565	10,718,023	11,127,228	17.6%
Garfield Medical Center	Monterey Park	714,227,365	127,986,496	87,641,509	40,839,972	40,172,386	30.9%
Greater El Monte Community Hospital	South El Monte	176,619,638	31,129,943	32,056,003	(1,770,822)	(1,713,002)	-5.5%
Irvine Medical Center	Irvine	334,960,663	70,399,729	72,450,390	(1,919,684)	(2,694,517)	-3.8%
Lakewood Regional Medical Center - South	Lakewood	402,987,424	73,146,568	61,629,533	12,299,357	10,978,762	14.5%
Los Alamitos Medical Center	Los Alamitos	420,556,064	77,145,727	64,049,714	13,278,727	13,650,136	17.5%
Queen of Angels-Hollywood Presbyterian	Los Angeles	601,717,831	144,131,426	124,305,361	20,659,444	20,834,667	14.3%
St. Luke Medical Center	Pasadena	315,528,512	36,813,296	47,002,515	(10,008,077)	(10,273,398)	-27.7%
USC University Hospital	Los Angeles	956,439,781	216,000,317	165,800,809	51,128,566	52,649,888	24.0%
Western Medical Center-Anaheim	Anaheim	277,177,120	55,475,397	56,108,000	(495,286)	(504,759)	-0.9%
Western Medical Center-Santa Ana	Santa Ana	625,459,406	137,412,724	120,212,640	17,591,424	18,086,204	13.1%
Whittier Hospital Medical Center	Whittier	442,959,914	76,464,799	65,266,289	11,332,361	12,079,164	15.5%
Midway Hospital Medical Center	Los Angeles	406,681,537	55,968,404	53,263,033	2,918,903	1,802,071	3.1%
Monterey Park Hospital	Monterey Park	218,311,202	41,868,689	33,299,952	8,722,355	8,722,543	20.8%
Placentia-Linda Community Hospital	Placentia	151,243,197	34,735,528	28,457,715	6,324,842	6,233,159	17.8%
Suburban Medical Center	Paramount	227,574,075	45,911,305	40,878,446	5,286,200	5,485,059	11.7%
San Dimas Community Hospital	San Dimas	266,868,629	36,979,757	34,490,905	2,673,367	2,910,083	7.7%
University of California		**2,366,801,573**	**957,245,090**	**1,022,031,314**	**(5,378,013)**	**(1,011,189)**	**-0.1%**
UCLA Medical Center	Los Angeles	1,248,820,482	586,443,513	616,697,268	17,388,241	17,388,241	2.7%
Santa Monica - UCLA Medical Center	Santa Monica	229,475,015	85,185,897	114,791,579	(23,981,071)	(21,656,728)	-23.3%
University of California Irvine Medical Center**	Orange	850,684,312	255,035,412	262,153,829	(976,813)	(742,128)	-0.2%
Other Hospitals		**12,697,161,116**	**4,111,485,216**	**4,329,647,060**	**25,466,381**	**197,637,983**	**4.3%**
Cedars-Sinai Medical Center	Los Angeles	2,676,994,914	808,771,666	874,633,403	25,694,702	32,121,660	3.5%
Pomona Valley Hospital Medical Center	Pomona	863,271,597	219,531,684	224,546,682	639,356	4,953,683	2.1%
St. John's Hospital And Health Center	Santa Monica	648,601,367	172,897,567	162,818,556	11,467,411	32,215,239	16.2%
Torrance Memorial Medical Center	Torrance	690,063,681	195,978,889	190,276,709	5,702,180	15,106,955	7.4%
Hoag Memorial Hospital Presbyterian	Newport Beach	651,209,562	316,171,382	328,011,498	6,572,950	59,864,619	15.3%
Good Samaritan Hospital	Los Angeles	594,229,778	167,929,067	189,815,688	(19,946,709)	(1,955,853)	-1.0%
Children's Hospital of Los Angeles	Los Angeles	514,928,777	214,486,851	304,366,658	(8,779,193)	27,212,828	8.2%
Antelope Valley Hospital Medical Center	Lancaster	475,228,629	149,109,807	152,757,759	82,965	5,315,577	3.3%
Presbyterian Intercommunity Hospital	Whittier	380,982,170	148,116,376	148,206,146	4,116,291	(2,533,106)	-1.7%
Children's Hospital of Orange County	Orange	320,734,653	133,490,759	150,447,984	3,497,230	5,323,491	3.4%
Valley Presbyterian Hospital	Van Nuys	273,902,922	98,044,515	96,144,616	2,879,044	16,784,905	13.8%
Pacific Hospital of Long Beach	Long Beach	321,737,780	103,564,478	93,930,897	10,540,232	7,265,686	6.8%
Beverly Hospital	Montebello	191,243,861	73,790,529	74,057,936	(19,879)	453,905	0.6%
Henry Mayo Newhall Memorial Hospital	Valencia	218,867,715	78,805,568	96,375,794	(15,921,880)	(49,824,577)	-61.2%
Verdugo Hills Hospital	Glendale	157,684,678	51,378,968	53,417,030	(1,841,063)	(1,294,207)	-2.5%
Coast Plaza Doctors Hospital	Norwalk	196,610,699	55,736,027	47,130,663	9,261,637	9,708,821	16.7%
Specialty Hospital of Southern California	La Mirada	138,532,899	51,843,311	49,411,563	2,499,109	1,745,521	3.4%
USC Kenneth Norris Jr. Cancer Hospital	Los Angeles	168,130,847	67,739,701	64,608,001	3,316,385	3,914,292	5.7%
Sherman Oaks Hospital & Health Center	Sherman Oaks	127,466,615	48,619,601	49,424,707	(467,520)	(248,436)	-0.5%
Granada Hills Community Hospital	Granada Hills	107,279,379	35,867,879	41,023,314	(5,000,366)	(1,896,854)	-4.8%
Downey Regional Medical Center	Downey	329,084,424	83,211,751	99,746,102	(16,125,069)	(3,368,929)	-3.5%
Earl & Lorraine Miller Children's Hospital	Long Beach	152,534,327	65,172,310	65,242,008	2,049,303	2,049,303	3.0%
Memorial Hospital of Gardena	Gardena	112,419,996	44,855,690	45,962,511	(1,007,186)	(266,630)	-0.6%
South Coast Medical Center	South Laguna	144,048,186	41,928,940	45,881,735	(3,280,712)	(2,255,263)	-5.1%
Fountain Valley Regional Hospital	Fountain Valley	781,410,772	177,721,663	152,504,490	25,687,596	23,587,596	13.2%
Garden Grove Hospital & Medical Center	Garden Grove	252,122,546	61,893,488	51,371,565	10,718,023	11,127,228	17.6%
TOTAL		**46,037,226,929**	**15,450,895,914**	**15,980,436,764**	**11,394,600**	**797,246,681**	**4.5%**

*The Daughters of Charity System resumed operations of these hospitals in 2002
**Net Patient Revenues, Net from Operations and Net Income for certain county, hospital district and University of California hospitals reduced by transfer of disproportionate share hospital funds and other special Medicaid funds.
Source: Author's analysis of annual hospital report data for years ending in 2001 from Office of Statewide Health Planning and Development
% of Total Revenue is calculated using total hospital revenues as the denominator, not net patient revenues.

Exhibit 42

Inpatient Occupancy Rates and Payer Mix for Los Angeles Area Hospitals, 2001

Hospital	Staffed Beds	Inpatient Days	Occupancy	% Medicare Days	% Medi-Cal Days	% Other Third Parties	% County Indigent	% Other Payers
Adventist	**604**	**186,408**	**84.6%**	**49.4%**	**37.0%**	**11.2%**	**0.0%**	**2.3%**
Glendale Adventist Medical Center	368	100,677	75.0%	57.4%	24.5%	16.6%	0.0%	1.6%
White Memorial Medical Center	236	85,731	99.5%	40.1%	51.7%	5.0%	0.0%	3.3%
Carondolet	**602**	**110,601**	**50.3%**	**47.8%**	**24.4%**	**21.7%**	**0.0%**	**6.1%**
Daniel Freeman Marina Hospital	153	29,606	53.0%	51.7%	13.6%	28.2%	0.0%	6.5%
Daniel Freeman Memorial Hospital	339	66,392	53.7%	47.4%	25.4%	21.0%	0.0%	6.1%
Catholic Healthcare West	**3,226**	**754,665**	**64.1%**	**45.5%**	**31.2%**	**0.4%**	**20.1%**	**2.9%**
California Hospital Medical Center	275	58,328	58.1%	34.1%	56.1%	7.0%	0.0%	2.8%
Glendale Memorial Hospital & Health Center	334	80,557	66.1%	49.7%	19.7%	26.7%	0.0%	4.4%
Northridge Hospital Medical Center	415	84,332	55.7%	42.2%	19.2%	37.9%	0.0%	0.7%
Northridge Hospital Medical Center-Sherman	209	41,000	53.7%	44.8%	45.5%	7.9%	0.0%	3.0%
Robert F. Kennedy Medical Center*	250	36,186	39.7%	40.6%	41.8%	11.2%	0.0%	6.3%
San Gabriel Valley Medical Center	274	66,306	66.3%	57.9%	10.5%	29.4%	0.0%	2.2%
St. Francis Medical Center*	384	97,476	69.5%	34.9%	49.6%	9.8%	1.7%	4.0%
St. Mary Medical Center	259	86,059	91.0%	59.0%	28.4%	8.4%	1.3%	2.9%
St. Vincent Medical Center*	181	59,794	90.5%	57.2%	15.2%	25.6%	0.0%	2.0%
Citrus Valley	**645**	**144,627**	**61.4%**	**39.7%**	**33.1%**	**24.5%**	**0.0%**	**2.6%**
Citrus Valley Medical Center-QV Campus	539	125,328	63.7%	39.0%	36.1%	22.1%	0.0%	2.7%
HCA: The Healthcare Company	**633**	**153,758**	**66.5%**	**45.4%**	**7.7%**	**40.4%**	**1.4%**	**5.1%**
West Hills Hospital & Medical Center	236	40,265	46.7%	55.7%	1.8%	41.9%	0.0%	0.6%
Huntington Beach Hospital	67	23,726	97.0%	57.8%	21.6%	14.9%	3.1%	2.6%
West Anaheim Medical Center	111	39,739	98.1%	54.0%	4.6%	37.2%	2.9%	1.3%
County of Los Angeles	**1,819**	**622,041**	**93.7%**	**7.4%**	**51.4%**	**4.7%**	**34.7%**	**1.9%**
LAC/Harbor/UCLA Medical Center	320	116,709	99.9%	10.2%	49.7%	4.6%	34.8%	0.8%
LAC/Martin Luther King Jar/.Drew Medical Center	249	79,546	87.5%	11.8%	47.1%	2.3%	36.9%	1.9%
LAC/Olive View-UCLA Medical Center	237	71,688	82.9%	4.3%	50.1%	1.0%	43.9%	0.6%
LAC/Rancho Los Amigos National Rehab Center	207	72,666	96.2%	10.7%	60.9%	4.0%	16.5%	8.0%
LAC/USC Medical Center	732	254,736	95.3%	5.0%	48.7%	6.9%	38.4%	1.0%
Kaiser Foundation	**1,882**	**434,791**	**63.3%**	**35.4%**	**1.9%**	**44.9%**	**0.0%**	**17.8%**
Kaiser Foundation - Anaheim	150	41,386	75.6%	32.8%	1.1%	48.2%	0.0%	17.9%
Kaiser Foundation - Bellflower	271	64,977	65.7%	29.4%	1.2%	42.7%	0.0%	26.7%
Kaiser Foundation - Harbor City	193	42,313	60.1%	35.6%	3.0%	47.2%	0.0%	14.2%
Kaiser Foundation - Panorama City	192	38,582	55.1%	47.6%	1.6%	42.8%	0.0%	8.0%
Kaiser Foundation - Sunset	547	124,250	62.2%	33.4%	2.1%	45.8%	0.0%	18.6%
Kaiser Foundation - West Los Angeles	212	42,875	55.4%	44.4%	3.5%	43.1%	0.0%	9.0%
Kaiser Foundation - Woodland Hills	154	44,931	79.9%	49.9%	0.9%	37.0%	0.0%	12.2%
Kaiser Foundation - Baldwin Park	163	35,477	59.6%	13.9%	1.3%	53.3%	0.0%	31.5%
Little Company of Mary	**892**	**226,304**	**69.5%**	**38.0%**	**22.1%**	**33.3%**	**0.0%**	**6.6%**
Little Company of Mary Hospital	383	111,554	79.8%	44.0%	15.3%	30.9%	0.0%	9.7%
San Pedro Peninsula Hospital	509	114,750	61.8%	32.1%	28.7%	35.6%	0.0%	3.6%
Memorial Health Services	1,254	274,836	60.0%	43.1%	6.1%	48.7%	1.3%	2.6%
Anaheim Memorial Medical Center	262	56,027	58.6%	36.6%	7.9%	48.6%	4.5%	2.3%
Long Beach Memorial Medical Center	541	133,495	67.6%	39.3%	8.3%	50.4%	0.3%	1.7%
Saddleback Memorial Medical Center	221	55,769	69.1%	48.0%	1.5%	53.5%	0.7%	5.4%
Orange Coast Memorial Medical Center	230	29,545	35.2%	63.5%	1.5%	32.2%	0.9%	2.0%
Pacific Health Corporation	**503**	**82,507**	**44.9%**	**42.2%**	**46.0%**	**7.7%**	**0.5%**	**3.5%**
Alta Health Corporation	**605**	**113,550**	**51.4%**	**52.4%**	**33.4%**	**10.3%**	**0.0%**	**3.9%**
Lancaster Community Hospital	78	28,608	100.5%	69.9%	4.5%	22.0%	0.0%	3.6%
Sisters of Providence	**617**	**182,505**	**81.0%**	**55.5%**	**18.2%**	**21.8%**	**1.1%**	**3.3%**
Providence Saint Joseph Medical Center	362	109,150	82.6%	60.0%	15.3%	22.8%	0.0%	2.0%
Providence Holy Cross Medical Center	255	73,355	78.8%	49.0%	22.5%	20.4%	2.7%	5.3%
Southern California Healthcare Systems	**650**	**194,096**	**86.9%**	**53.6%**	**13.0%**	**31.3%**	**0.0%**	**2.1%**
Huntington Memorial Hospital	331	120,894	100.1%	51.7%	13.4%	32.8%	0.1%	2.1%
Methodist Hospital of Southern California	201	62,369	85.0%	56.8%	9.2%	32.1%	0.0%	1.9%
St. Joseph	**928**	**248,901**	**73.5%**	**46.4%**	**8.4%**	**42.4%**	**1.4%**	**1.4%**
Mission Hospital Regional Medical Center	254	67,707	73.0%	48.4%	6.4%	40.9%	1.9%	2.4%
St. Joseph Hospital - Orange	365	98,055	73.6%	40.8%	12.0%	45.3%	0.9%	1.1%
St. Jude Medical Center	309	83,139	73.7%	51.4%	5.7%	40.3%	1.5%	1.1%

Inpatient Occupancy Rates and Payer Mix for Los Angeles Area Hospitals, 2001, continued

Hospital	Staffed Beds	Inpatient Days	Occupancy	% Medicare Days	% Medi-Cal Days	% Other Third Parties	% County Indigent	% Other Payers
Tenet Health	**5,081**	**1,157,763**	**62.4%**	**48.0%**	**29.1%**	**19.8%**	**0.7%**	**2.5%**
Brotman Medical Center	244	67,142	75.4%	61.1%	21.9%	13.5%	0.0%	3.5%
Centinela Hospital Medical Center	367	83,535	62.4%	53.1%	29.2%	15.2%	0.0%	2.5%
Century City Hospital	124	34,617	76.5%	68.8%	12.8%	16.8%	0.0%	1.6%
Chapman Medical Center	110	27,075	67.4%	25.3%	31.6%	36.4%	1.1%	5.6%
Coastal Communities Hospital	178	33,922	52.2%	31.0%	29.6%	25.0%	1.7%	12.7%
Fountain Valley Regional Hospital-Euclid	365	88,817	66.7%	39.4%	25.3%	31.1%	2.7%	1.4%
Encino Tarzana Regional - Tarzana	227	59,723	72.1%	44.3%	17.2%	36.1%	0.0%	2.5%
Encino Tarzana Regional - Encino	102	31,610	84.9%	59.0%	29.2%	9.8%	0.0%	2.0%
Community & Mission Hospital-Huntington Park	157	17,095	29.8%	19.6%	69.0%	7.4%	0.0%	4.0%
Garden Grove Hospital & Medical Center	167	29,106	47.7%	42.8%	34.7%	16.0%	3.2%	3.3%
Garfield Medical Center	210	65,479	85.4%	53.2%	33.2%	13.0%	0.0%	0.5%
Greater El Monte Community Hospital	117	22,175	51.9%	41.3%	52.7%	1.5%	0.0%	4.5%
Irvine Medical Center	176	29,979	46.7%	48.6%	4.5%	44.0%	1.2%	1.7%
Lakewood Regional Medical Center - South	161	42,877	73.0%	71.4%	10.3%	17.4%	0.0%	1.0%
Los Alamitos Medical Center	167	40,193	65.9%	69.6%	5.9%	22.3%	0.8%	1.3%
Queen of Angels-Hollywood Presbyterian	434	118,125	74.6%	40.2%	55.8%	3.2%	0.0%	0.8%
St. Luke Medical Center	165	32,182	53.4%	48.4%	34.1%	14.6%	0.0%	2.8%
USC University Hospital	183	66,030	98.9%	49.5%	9.4%	39.7%	0.0%	1.4%
Western Medical Center-Anaheim	188	39,375	57.4%	46.8%	34.5%	13.3%	2.9%	2.6%
Western Medical Center-Santa Ana	274	56,020	56.0%	39.2%	27.2%	27.0%	2.9%	3.6%
Whittier Hospital Medical Center	181	42,688	64.6%	39.9%	29.8%	28.1%	0.0%	2.2%
Midway Hospital Medical Center	225	32,348	39.4%	72.8%	7.6%	18.3%	0.0%	1.2%
Monterey Park Hospital	101	23,295	63.2%	54.1%	39.2%	5.7%	0.0%	1.0%
Placentia-Linda Community Hospital	114	11,746	28.2%	47.9%	5.5%	42.1%	2.4%	2.0%
Suburban Medical Center	182	31,899	48.0%	32.3%	56.2%	7.3%	0.0%	4.2%
San Dimas Community Hospital	93	23,881	70.4%	35.6%	44.0%	18.6%	0.0%	1.8%
University of California	**1,448**	**344,027**	**65.1%**	**31.8%**	**21.1%**	**40.6%**	**2.4%**	**4.1%**
UCLA Medical Center	658	163,238	68.0%	30.9%	17.7%	47.8%	0.3%	3.4%
Santa Monica - UCLA Medical Center	337	58,529	47.6%	59.9%	5.8%	32.1%	0.0%	2.1%
University of California Irvine Medical Center	383	97,589	69.8%	16.3%	39.4%	30.6%	8.1%	5.6%
Other Hospitals	**8,047**	**2,084,958**	**71.6%**	**42.8%**	**26.6%**	**26.9%**	**0.3%**	**3.3%**
Cedars-Sinai Medical Center	870	276,899	87.2%	49.3%	11.7%	35.9%	0.3%	2.8%
Pomona Valley Hospital Medical Center	436	100,688	63.3%	42.4%	36.8%	17.9%	0.0%	3.0%
St. John's Hospital And Health Center	233	63,858	75.1%	63.0%	0.6%	34.1%	0.0%	2.3%
Torrance Memorial Medical Center	252	91,365	99.3%	46.2%	5.8%	43.0%	0.0%	5.0%
Hoag Memorial Hospital Presbyterian	345	105,404	83.7%	45.5%	2.4%	46.3%	1.0%	4.8%
Good Samaritan Hospital	374	95,339	69.8%	51.0%	13.8%	32.6%	0.0%	2.6%
Children's Hospital of Los Angeles	279	85,576	84.0%	0.3%	68.7%	30.4%	0.0%	0.6%
Antelope Valley Hospital Medical Center	318	89,153	76.8%	44.9%	27.5%	24.5%	0.0%	3.2%
Presbyterian Intercommunity Hospital	226	74,757	90.6%	52.5%	15.6%	29.6%	0.0%	2.3%
Children's Hospital of Orange County	172	40,086	63.9%	0.1%	49.5%	49.7%	0.0%	0.7%
Valley Presbyterian Hospital	322	58,960	50.2%	33.0%	47.6%	17.0%	0.0%	2.4%
Pacific Hospital of Long Beach	130	41,588	87.6%	36.4%	52.6%	10.2%	0.0%	0.7%
Beverly Hospital	223	48,704	59.8%	57.9%	27.6%	12.5%	0.0%	1.9%
Henry Mayo Newhall Memorial Hospital	217	46,194	58.3%	44.2%	7.4%	39.7%	1.2%	7.6%
Verdugo Hills Hospital	132	35,110	72.9%	59.2%	11.4%	26.9%	0.0%	2.4%
Coast Plaza Doctors Hospital	123	20,451	45.6%	50.0%	21.8%	24.7%	0.0%	3.5%
Specialty Hospital of Southern California	234	59,880	70.1%	91.4%	0.1%	8.4%	0.0%	0.0%
USC Kenneth Norris Jr. Cancer Hospital	49	16,214	90.7%	41.4%	0.0%	57.0%	0.0%	1.7%
Sherman Oaks Hospital & Health Center	153	25,218	45.0%	71.0%	5.2%	17.9%	0.0%	5.9%
Doctors Hospital of West Covina	29	8,861	83.7%	8.9%	88.7%	2.1%	0.0%	0.3%
Downey Regional Medical Center	193	47,572	67.5%	55.9%	16.2%	24.7%	0.0%	3.2%
Earl & Lorraine Miller Children's Hospital	171	43,306	69.4%	0.0%	49.5%	50.2%	0.0%	0.3%
South Coast Medical Center	88	27,072	84.3%	36.0%	8.9%	46.1%	0.0%	9.0%
Fountain Valley Regional Hospital Euclid	365	88,817	66.7%	39.4%	25.3%	31.1%	2.7%	1.4%
Garden Grove Hospital	167	29,106	47.7%	42.8%	34.7%	16.0%	3.2%	3.3%
TOTAL	29,586	7,357,724	62.9%	40.9%	25.9%	25.8%	3.4%	4.0%

* The Daughters of Charity system resumed operation of these hospitals in 2002.

- ✔ Medicare patients are especially important to the Tenet hospitals and to some of the religious systems like St. Joseph and Sisters of Providence.
- ✔ Medi-Cal is an especially important payer to the Los Angeles County hospitals (as are county indigent funds) and some of the Tenet hospitals.
- ✔ While the Bay Area has prominent IPAs, medical groups are much more important in southern California.

rates will result in strong financial results, especially if some payers offer low payment rates or when it is expensive to add staff needed for those patients. Financially successful hospitals consider the revenues brought in by the marginal expense of additional patients.

Payer Mix. Medicare covered about 41% of inpatient days for Los Angeles/Orange County hospitals in 2001. Medi-Cal paid for about 26% of inpatient days and commercial insurers and managed care plans covered 25.8% of inpatient days. 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.

Medicare patients are especially important to the Tenet hospitals and to some of the religious systems like St. Joseph and Sisters of Providence. For example, Medicare covered an average of 48% of inpatient days at Tenet hospitals. Five Tenet hospitals reported more than 70% of inpatient days paid by Medicare.

Similarly, 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 data there were about 3.1 million inpatient days covered by Medi-Cal for these hospitals in 2001. Tenet hospitals had 337,000 inpatient days covered by Medi-Cal, more than the Los Angeles County hospitals, which had 320,000.

Exhibit 43 looks at hospital market share across the Los Angeles/Orange Counties area. The figure shows that Tenet Health has almost 16% of the market. Catholic Healthcare West (including the Daughters of Charity hospitals) is second with 10.3% followed by the Kaiser hospitals with nearly 6%.

Physician Organizations. While the Bay Area has prominent IPAs, medical groups are much more important in southern California. *Exhibit 44* 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 clinics that could not succeed on their own.

The largest medical group in the area by far is the Permanente group for southern California, which has grown by about 400,000 lives and 500 doctors in the past two years. HealthCare Partners is an example of a large medical group that has grown and reports that it now has nearly a half million capitated patients.

As was noted earlier in the report, many of these medical groups are experiencing a decline in capitated HMO lives. They are trying to reconfigure themselves to get patients through PPO plans, but are encountering difficulties. 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.

Some large medical groups that appeared in earlier versions of this report have since folded, 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 the end they failed but they also helped to drive down payment rates for

Exhibit 43

Market Share for Los Angeles Area Hospitals, 2001

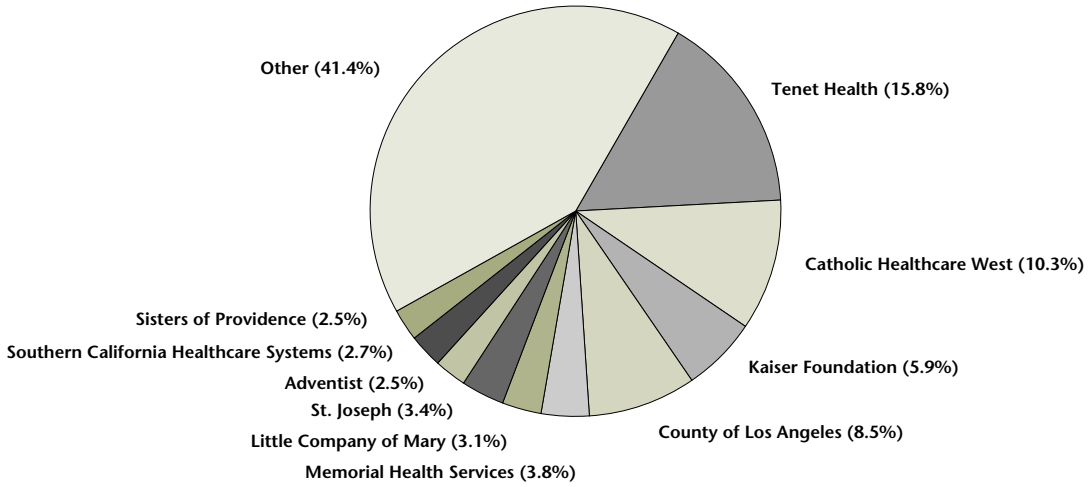


Exhibit 44

Los Angeles Area Physician Organizations (Including Orange County)

Name of Physician Organization	Estimated enrollment	# of PCPs	# of Specs	Management Entity	Notes
Group Practice					
Southern California Permanente Medical Group	1,872,300	1,053	1,537	Southern California Permanente Medical Group	
Lakeside Medical Group, Inc.	58,400	180	860	Lakeside Healthcare, Inc	Includes IPA type panel.
La Vida Medical Group, Inc.	186,100	580	3,500	La Vida Medical Group, Inc	Includes IPA type panel.
HealthCare Partners Medical Group, Inc	497,300	589	866	HealthCare Partners Management Co, Inc	
Pacific Alliance Medical Group, Inc	13,850	79	80	SynerMed	
Glendale Memorial Medical Group, Inc	31,450	118	86	Lakeside Healthcare, Inc	
Facey Medical Group, aka Medical Corp/ Facey Medical Foundation	121,000	91	104	Facey Medical Foundation	MSO of Hospital System
Bristol Park Medical Group, Inc.	118,500	119	520	Bristol Park Medical Group, Inc	Self
Starcare Medical Group, Inc/ Gateway Medical Group, Inc.	52,300	142	204	Pinnacle Health Resources	MSO of Sponsoring Group
High Desert Medical Corp., a Medical Group	46,000	64	114	Heritage Provider Network, Inc	MSO of Sponsoring Group
Harriman Jones Medical Group, a Professional Corp	45,300	44	119	Harriman Jones Medical Group, a Professional Corp	MSO of Sponsoring Group
Bright Medical Associates, Inc	65,500	77	157	Integrated Medical Management, Inc (Bright Medical Associates)	Includes IPA type panel.
Community Medical Group of the West Valley, Inc	46,300	26	110	Progressive Healthcare Systems, LLC (Community Medical Group)	Includes IPA type panel.
Hispanic Physicians/Clinica Medica General Medical Group, Inc	6,050	56	104	Physicians Care Management Co	Includes IPA type panel.
Talbert Medical Group, Inc	75,700	79	282	Talbert Medical Management	
IPA					
Exceptional Care Medical Group	30,600	375	899	CAP Management Systems (CMS-Tenet)	
Global Care Medical Group, Inc	48,400	315	720	MedPoint Management, Inc	
Physician Associates of the Greater San Gabriel Valley, a Medical Group Inc	179,100	325	610	Physician Associates of the Greater San Gabriel Valley, a Medical Group Inc	
Preferred IPA of California Medical Group, Inc/ Thrifty Healthcare	74,200	300	450	Thrifty Management Services	
Allied Physicians of California, a Professional Medical Corp	57,000	258	488	Network Medical Management, Inc (Allied Physicians of California)	
Good Samaritan Medical Practice Associates, Inc, a Medical Group	32,600	154	357	Advanced Medical Management, Inc	
Memorial Healthcare IPA, a Medical Corp	75,700	131	362	Memorial Healthcare Management Services	
Pacific Independent Physicians Association	40,700	175	290	California Management Service Enterprises (Pacific Independent Physicians Assn)	
CareMore Medical Group, Inc	66,900	143	315	CareMore Medical Management Company	
THIPA Medical Group, Inc	51,800	133	235	THIPA Management Consultants, Inc	
Noble Community Medical Associates, Inc	43,400	145	313	Cap Management Systems (CMS-Tenet)	
Physicians' Healthways Medical Corp	60,700	386	185	HealthCare Partners, Ltd.	
Lakewood Health Plan, a Medical Group	44,750	150	195	Central Health MSO, Inc	
Northridge Medical Group IPA, Inc	38,100	93	236	Meridian Health Care Management	
Accountable Health Care IPA, a Professional Medical Corp.	30,800	165	250	Accountable Healthcare MSO	
Physicians of Greater Long Beach IPA, Inc.	26,005	93	187	Managed Care Innovations	
Pro Med Health Medical Group Network of Pomona Valley, Inc	69,600	109	170	Pro Med Healthcare Administrators	
West Covina Plan IPA, Inc, a Medical Group/ Greater Covina Medical Group, Inc	17,000	86	177	Heritage Provider Network, Inc	
Regal Medical Group, Inc/	43,700	428	1,506	Heritage Provider Network, Inc	

✔ The demise of many physician groups has been sobering to the groups that remain. Some of them 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 are asking for.

other medical groups. It is widely understood that payment rates to physicians in southern California are typically lower than in the northern part of the state.

The demise of many physician groups has been sobering to the groups that remain. Some of them 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 are asking for. There have been some tentative efforts to bring smaller 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 shown more interest in acquisition recently.

Health Plans. According to the estimates made in constructing Exhibit 13, 8.4 million people in the area, or 65% of Los Angeles County residents and 66% of Orange County residents were enrolled in an HMO in 2002. The largest health plan in the area is Blue Cross, followed by Kaiser Permanente.

Exhibit 45 shows an estimate of market share of the largest health plans in Los Angeles and Orange Counties combined. Blue Shield, PacifiCare, and Health Net together account for 29% of the enrollment. Blue Shield added several hundred thousand CalPERS enrollees in 2003, which will be reflected in market share figures in next year's report.

About 6.3 million people in 2002 in the area were enrolled in a commercial HMO plan. That 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 or other kinds of features, are being offered outside of HMOs.

The number of Los Angeles/Orange County seniors in Medicare+Choice HMOs has also declined. The

Exhibit 44

Los Angeles Area Physician Organizations (Including Orange County), continued

Name of Physician Organization	Estimated enrollment	# of PCPs	# of Specs	Management Entity	Notes
San Gabriel Valley Medical Group					
Universal Care Medical Group	61,300	47	520	Universal Care (HMO)	Self
Affiliated Doctors of Orange County Medical Group, Inc.	61,200	163	228	Affiliated Management Services	MSO of Own Medical Group
Arta Health Network, a Professional Medical Corp.	41,100	242	312	Western Medical Management, LLC	MSO of Own Medical Group
Bay Area Community Medical Group, Inc.	40,600	61	220	Santa Monica Bay Physicians Health Services, Inc	MSO of Own Medical Group
Prospect Medical Group	46,300	360	313	Prospect Medical Systems, Inc	
New Horizon Medical Group IPA	4,600	48	111	MV Medical Management	
Omnicare Health Systems Medical Group	36,100	72	102	Advanced Medical Management, Inc	
Meridian Medical Group/ Capnet IPA	6,100	70	80	Meridian Holdings, Inc	
Medical Foundation					
St. Joseph Heritage Medical Foundation	195,000	366	748	St. Joseph Heritage Health Foundation	MSO of Hospital System
Monarch Healthcare, a Medical Group, Inc	150,900	373	743	Physician Weblink (Telesis/Vectis-Monarch)	MSO of Sponsoring Group
Greater Newport Physicians Medical Group, Inc	130,800	159	205	Greater Newport Physicians Medical Group, Inc	Self managed
Cedars-Sinai Medical Care Foundation	57,600	146	157	Medical Network Services	MSO of Hospital System
Presbyterian Health Physicians	32,500	112	133	HealthMed Services, Inc (Presbyterian Intercommunity Hospital)	Includes medical group.
State/County Faculty/Staff					
UCLA Medical Group	77,080	197,229	1,199	UCLA Medical Center	Includes 100-physician Internal Medicine Faculty Medical Group, Includes old Santa Monica Medical Center Medical Group and United Physicians Association of Santa Monica; both merged into UCLA July 1, 2001.
County of Los Angeles Dept of Health Services	183,700	454	2,371	County of Los Angeles Dept of Health Services	

change was not large—from about 462,000 at the end of 2001 to about 446,000 in 2002. There are still many HMOs offering senior plans in the Los Angeles area, about nine or 10 HMOs in most of the area. That is more options for seniors than in other parts of the state. Still, seniors have become 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.

At least through the first half of 2003, enrollment in Medi-Cal HMO plans has grown along with the overall Medi-Cal caseloads. However, figures from the Department of Health Services show that enrollment in some counties in the managed care arrangements is starting to decline in the second half of 2003. At the end of 2002 there were almost 1.4 million Medi-Cal recipients in managed care in Los Angeles County and about 280,000 in Orange County. In Los Angeles, a Two-Plan model county, L.A. Care continues its model of subcontracting out enrollees and risk to health plan partners. It has fewer partners left with the demise last year of MaxiCare and Tower Health. Health Net is the commercial plan for the county and it also subcontracts out a portion of its enrollees.

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.

4.5 Inland Empire

East of Los Angeles is California's Inland Empire of Riverside and San Bernardino Counties. Its population has grown by 10% in just the past two years. Two-thirds of the population (2.4 million out of 3.5 million) is enrolled in one of 15 HMOs. While the economy of the area is linked to Los Angeles and Orange County, it is in many respects its own empire. This is also true of the health care systems in these counties. Many 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. The religious hospital systems in the area include Catholic Healthcare West and St. Joseph Health System of Orange. 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 of southern California).

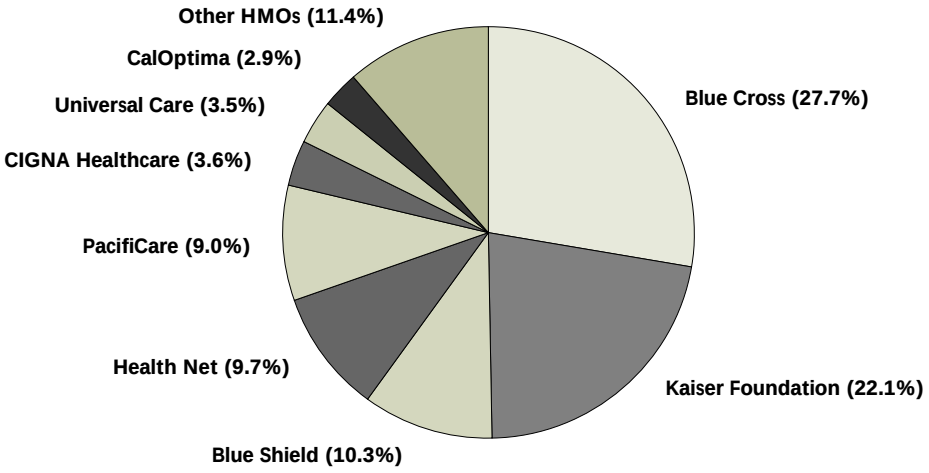
Kaiser has two hospitals in the area, in Fontana and Riverside. Both San Bernardino and Riverside Counties own their own county hospitals and there is a district hospital at San Gorgonio. Investor-owned systems are represented as well: Tenet has three hospitals here (it sold one to Universal Health Systems) and HCA owns Riverside Community Hospital.

Financial Results. On average hospitals in the area posted net income of 4.3% of total revenues of $3.0 billion. As shown in *Exhibit 46*, they had net income of $126.6 million in 2001. Three county and district hospitals transferred out $104.3 million under the DSH program. Much of the net income was for the three Tenet hospitals in the area and especially Desert Regional Medical Center in Palm

✔ On average hospitals in the area posted net income of 4.3% of total revenues of $3.0 billion.

Exhibit 45

Estimated Market Share for Los Angeles HMOs, 2002



Springs. On the other hand, Valley Health, a local three-hospital system, reported a small loss in 2001. Some of the independent hospitals, including Loma Linda University Medical Center, had strong net income in 2001.

Occupancy. As shown in *Exhibit 47*, occupancy in hospitals in the region averaged 66.2% in 2001. The largest hospital in the area, Loma Linda University Medical Center, had occupancy of 73.3%. In 2001, the three Tenet hospitals had occupancy of 88%. The two Kaiser hospitals had

Exhibit 46

Revenues and Net Income for Inland Empire Hospitals, 2001

System/Hospitals	City	Total Charges	Net Patient Revenue	Operating Expenses	Net from Operations	Net Income	% of Total Revenue
Catholic Healthcare West		**618,902,859**	**201,730,059**	**204,459,827**	**(514,260)**	**1,273,626**	**1.8%**
Community Hospital of San Bernardino	San Bernardino	259,477,452	85,044,682	84,950,865	1,151,145	2,291,246	2.6%
St. Bernardine Medical Center	San Bernardino	359,425,407	116,685,377	119,508,962	(1,665,405)	(1,017,620)	-0.9%
Kaiser Foundation Hospitals							
Kaiser Foundation	Fontana						
Kaiser Foundation	Riverside						
Tenet Health		**1,379,605,854**	**328,179,621**	**255,664,082**	**74,804,655**	**75,642,086**	**22.7%**
Desert Regional Medical Center	Palm Springs	883,689,870	211,595,954	161,023,342	52,673,900	53,131,026	24.6%
John F. Kennedy Memorial Hospital	Indio	324,922,223	64,618,537	52,027,813	12,742,705	12,839,708	19.6%
Rancho Springs Medical Center	Murrieta	170,993,761	51,965,130	42,612,927	9,388,050	9,671,352	18.5%
Valley Health		**387,950,190**	**136,768,725**	**143,705,819**	**(5,720,328)**	**(2,172,468)**	**-1.5%**
Hemet Valley Medical Center	Hemet	223,822,415	79,032,588	81,549,412	(1,683,083)	318,659	0.4%
Menifee Valley Medical Center	Sun City	81,021,990	26,728,790	28,595,630	(1,702,307)	(1,019,660)	-3.7%
Moreno Valley Community Hospital	Moreno Valley	83,105,785	31,007,347	33,560,777	(2,334,938)	(1,471,467)	-4.6%
Other Hospitals		**5,412,143,950**	**2,014,708,465**	**2,145,107,435**	**(23,085,574)**	**51,902,539**	**0.3%**
San Gorgonio Memorial Hospital	Banning	47,740,993	17,014,960	17,612,745	(471,967)	(442,586)	-2.6%
Riverside Community Hospital	Riverside	391,674,892	142,936,532	136,539,148	(9,101,740)	10,186,162	6.9%
Eisenhower Medical Center	Rancho Mirage	563,557,529	172,710,018	229,720,081	(2,551,891)	(2,144,024)	-1.2%
Chino Valley Medical Center	Chino	115,830,716	36,022,778	38,873,713	(2,497,111)	(2,374,561)	-6.5%
Barstow Community Hospital	Barstow	83,471,943	23,934,408	21,325,514	2,653,275	1,480,305	6.2%
Palo Verde Hospital	Blythe	47,740,391	18,714,407	15,605,405	3,174,787	1,993,672	10.6%
St. Mary Regional Medical Center	Apple Valley	266,104,617	86,758,024	84,463,495	3,160,629	3,036,526	3.4%
Riverside County Regional Med Center*	Moreno Valley	390,616,731	184,261,477	192,862,518	(5,473,693)	11,143,177	4.4%
San Antonio Community Hospital	Upland	508,508,096	163,105,007	166,876,138	(1,454,835)	(1,368,509)	-0.8%
Arrowhead Regional Medical Center*	Colton	450,088,473	227,652,198	275,048,881	(45,844,702)	(2,931,793)	-0.9%
Corona Regional Medical Center	Corona	249,550,775	70,213,808	68,256,527	4,021,471	3,095,547	4.2%
Redlands Community Hospital	Redlands	226,257,115	77,077,694	76,067,175	1,607,009	6,134,042	7.5%
Hi-Desert Medical Center*	Joshua Tree	57,954,129	33,508,824	35,039,445	(1,179,597)	1,573,252	4.2%
Victor Valley Community Hospital	Victorville	101,124,753	34,375,329	35,945,170	(1,426,508)	1,533,307	4.1%
Parkview Community Hospital	Riverside	165,932,308	65,418,056	69,210,265	(3,483,126)	(2,893,104)	-4.4%
Inland Valley Regional Medical Center	Wildomar	155,930,586	48,916,479	45,439,282	3,677,760	3,606,324	7.3%
Desert Valley Hospital	Victorville	132,606,017	37,205,892	38,411,188	(1,140,678)	(10,732)	0.0%
Northern Inyo Hospital	Bishop	33,577,615	21,229,192	22,481,190	(1,076,549)	78,339	0.3%
Colorado River Medical Center	Needles	52,279,670	19,055,439	17,509,559	1,658,614	874,156	4.5%
Mountains Community Hospital	Lake Arrowhead	16,237,903	7,816,551	10,550,737	(2,471,274)	443,075	4.0%
Mammoth Hospital	Mammoth Lakes	20,731,366	15,282,870	14,961,654	398,480	1,590,273	9.6%
Loma Linda University Medical Center	Loma Linda	1,334,627,332	511,498,522	532,307,605	16,532,592	17,299,691	3.1%
TOTAL		**7,798,602,853**	**2,681,386,870**	**2,748,937,163**	**45,484,493**	**126,645,783**	**4.3%**

*Net Patient Revenues, Net from Operations and Net Income for certain county, hospital district and University of California hospitals reduced by transfer of disproportionate share hospital funds and other special Medicaid funds.

Source: Author's analysis of annual hospital report data for years ending in 2001 from Office of Statewide Health Planning and Development

% of Total Revenue is calculated using total hospital revenues as the denominator, not net patient revenues.

average occupancy of 75.2%, while the two Catholic Healthcare West hospitals posted an occupancy rate of 62.7%.

Payer Mix. *Exhibit 47* shows that Medicare covered an average of 39.4% of inpatient days in 2001, while Medi-Cal covered 26.6%. Though parts of the Inland Empire are well known as retirement destinations, the portion of inpatient hospital days covered by Medicare is not any higher here than in other parts of the state. Commercial payers including managed care covered about 27% of inpatient days.

✔ Occupancy in hospitals in the region averaged 66.2% in 2001.

Exhibit 47

Inpatient Occupancy Rates and Payer Mix for Inland Empire Hospitals, 2001

Hospital	Staffed Beds	Inpatient Days	Occupancy	% Medicare Days	% Medi-Cal Days	% Other Third Parties	% County Indigent	% Other Payers
Catholic Healthcare West	**543**	**124,181**	**62.7%**	**39.0%**	**43.6%**	**13.8%**	**0.3%**	**3.2%**
Community Hospital of San Bernardino	275	64,204	64.0%	29.7%	63.5%	5.8%	0.1%	1.0%
St. Bernardine Medical Center	268	59,977	61.3%	49.0%	22.4%	22.5%	0.5%	5.6%
Kaiser Foundation	**497**	**136,397**	**75.2%**	**44.4%**	**1.9%**	**41.5%**	**0.1%**	**12.1%**
Kaiser Foundation - Fontana	305	85,327	76.6%	41.4%	2.6%	43.3%	0.1%	12.5%
Kaiser Foundation - Riverside	192	51,070	72.9%	49.4%	0.7%	38.3%	0.1%	11.5%
Tenet Health	**420**	**134,327**	**88.0%**	**49.8%**	**26.0%**	**20.7%**	**0.6%**	**2.8%**
Desert Regional Medical Center	239	86,736	99.4%	50.5%	25.1%	21.2%	0.4%	2.7%
John F. Kennedy Memorial	130	29,795	62.8%	47.5%	38.5%	10.9%	1.3%	1.8%
Rancho Springs Medical Center	51	17,796	98.9%	50.3%	9.7%	34.9%	0.4%	4.7%
Valley Health	**533**	**127,818**	**65.7%**	**62.9%**	**20.4%**	**9.8%**	**0.2%**	**6.8%**
Hemet Valley Medical Center	377	88,770	64.5%	60.8%	20.7%	9.5%	0.2%	8.8%
Menifee Valley Medical Center	84	19,770	64.5%	85.0%	3.5%	9.9%	0.1%	1.5%
Moreno Valley Community	72	19,278	73.4%	49.8%	36.6%	10.6%	0.2%	2.9%
Other Hospitals	**3,529**	**929,568**	**72.6%**	**34.0%**	**28.9%**	**29.8%**	**4.2%**	**3.1%**
Loma Linda University Medical Center	653	174,761	73.3%	25.6%	37.9%	34.2%	0.6%	1.6%
Riverside Community Hospital	327	77,741	65.1%	44.0%	14.2%	37.8%	0.6%	3.4%
Eisenhower Medical Center	236	63,705	74.0%	69.5%	6.5%	20.9%	0.1%	2.9%
Chino Valley Medical Center	75	19,531	96.8%	29.3%	23.4%	41.0%	0.0%	6.4%
Barstow Community Hospital	24	8,775	100.2%	50.5%	21.7%	23.7%	0.0%	4.1%
Palo Verde Hospital	35	6,678	52.3%	44.4%	20.9%	27.7%	0.4%	6.6%
St. Mary Regional Medical Center	186	49,830	73.4%	44.2%	20.7%	33.7%	0.0%	1.4%
Riverside County Regional	347	80,036	63.2%	9.5%	37.2%	31.3%	14.7%	7.3%
San Antonio Community Hospital	297	66,765	61.6%	48.6%	11.2%	38.4%	0.0%	1.8%
Arrowhead Regional	327	99,028	83.0%	9.8%	54.6%	11.9%	23.7%	0.0%
Corona Regional Medical Center	216	45,766	58.0%	51.6%	22.7%	23.7%	0.3%	1.7%
Redlands Community Hospital	172	45,698	72.8%	42.5%	10.1%	44.2%	0.1%	3.1%
Hi-Desert Medical Center	175	50,084	78.4%	23.4%	68.9%	4.6%	0.0%	3.1%
Victor Valley Community Hospital	62	22,355	98.8%	33.3%	26.9%	29.4%	4.4%	6.3%
Parkview Community Hospital	100	35,896	98.3%	22.9%	26.7%	41.6%	0.2%	8.5%
Inland Valley Regional	67	23,909	97.8%	45.3%	6.4%	42.1%	2.1%	4.0%
Desert Valley Hospital	57	20,588	99.0%	51.2%	9.9%	35.0%	0.0%	3.8%
San Gorgonio Memorial Hospital	46	16,035	95.5%	47.2%	13.0%	37.2%	0.5%	2.0%
Northern Inyo Hospital	32	3,304	28.3%	52.2%	16.6%	24.1%	3.8%	3.3%
Colorado River Medical Center	53	9,862	51.0%	59.3%	8.7%	27.0%	0.0%	5.0%
Mountains Community Hospital	27	7,959	80.8%	11.4%	71.3%	8.8%	0.0%	8.5%
Mammoth Hospital	15	1,262	23.1%	12.1%	16.2%	55.9%	1.8%	13.9%
TOTAL	**5,932**	**1,511,550**	**67.6%**	**40.3%**	**25.1%**	**23.2%**	**2.1%**	**9.4%**

✔ About two-thirds of the population of the Inland Empire is enrolled in an HMO and that figure has increased in 2001 and 2002.

✔ Medicare managed care is still competitive in the area with eight or nine HMOs selling senior plans.

Medicare was an especially important payer to the Valley Health system, where 62.9% of inpatient days are covered by Medicare and also to the Tenet hospitals. Medicare is less significant to Loma Linda University Medical Center.

More than two-thirds of the 386,000 Medi-Cal inpatient days were provided outside of the systems, mostly in the county hospitals and at Loma Linda University Medical Center, which provided 66,000 days of inpatient care for Medi-Cal patients. Community Hospital of San Bernardino provided almost 41,000 days of care covered by Med-Cal.

Physician Organizations. *Exhibit 48* shows that the Permanente clinics in this region now have more than 1,200 doctors serving about 608,000 patients. Another large group is PrimeCare Medical Network, which includes more than 900 doctors in the area in medical groups and IPA arrangements. PrimeCare Medical Network is one of the few southern California medical groups that still 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 units of PhyCor that remains in business, provides management services. The Beaver Medical Group now numbers about 190 physicians, plus it provides IPA management services. The Loma Linda University Health Care group has about 450 physicians, most of them specialists.

Health Plans. About two-thirds of the population of the Inland Empire is enrolled in an HMO and that figure increased in 2001 and 2002. By the estimates in this analysis, almost 2.4 million people belong to HMOs here. Kaiser Permanente is the largest HMO in the area with more than 600,000 lives. Blue Cross is close behind at about 475,000 lives, and PacifiCare is third with about 280,000 lives.

Medicare managed care is still competitive in the area with eight or nine HMOs selling senior plans. About 53,000 of Kaiser's enrollees are in its Medicare HMO plan. PacifiCare has about 48,000 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.

Riverside and San Bernardino counties collaborate for Medi-Cal managed care in a Two-Plan Model. Molina Medical Centers is the commercial plan. 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. In 2002, Molina had about 88,000 Medi-Cal enrollees in those two counties.

Exhibit 48

Inland Empire Physician Organizations
counties: Imperial, Riverside, San Bernardino

Name of Physician Organization	Estimated enrollment	# of PCPs	# of Specs	Management Entity	Notes
Group Practice					
Molina Healthcare, Inc	18,300	22	0	Molina Healthcare, Inc	
Southern California Permanente Medical Group	607,700	561	649	Southern California Permanente Medical Group	
PrimeCare Medical Network	244,800	297	642	North American Medical Management California	Includes IPA type panel.
Inland Healthcare Group, a Medical Corp	28,500	33	167	Inland Health Organization of Southern California	Includes IPA type panel.
Inland Medical Clinic, Inc/ Inland Medical Center, Inc	4,100	17	246	IMC Management, Inc	
San Bernardino Medical Group, Inc	13,900	18	173	San Bernardino Medical Group, Inc	
Beaver Medical Group, LP	90,000	88	97	Epic Management LP (Beaver Medical Group)	Includes IPA type panel.
United Family Care Medical Corp	26,500	15	169	United Family Care Medical Group	
High Desert Primary Care Medical Group, a California General Partnership	13,500	14	68	High Desert Primary Care Medical Group	
Inland Faculty Medical Group, Inc	19,300	32	140	Arrowhead Medical Management Services, Inc (Inland Faculty)	
Family Practice Medical Group of San Bernardino, Inc	9,800	50	105	Family Practice Medical Group of San Bernardino, Inc	Includes IPA type panel.
Desert Medical Group, Inc	19,500	25	88	Heritage Provider Network, Inc	Includes IPA type panel.
Riverside Medical Clinic, Inc	79,000	58	50	Riverside Medical Clinic, Inc	
Desert Valley Medical Group, Inc	41,000	48	88	Desert Valley Medical Group, Inc	Self
LaSalle Medical Associates	36,000	35	0	MV Medical Management	Independent MSO
IPA					
Vantage Medical Group, Inc	78,500	140	490	Primary Provider Management Company, Inc	
Empire Physicians Medical Group, Inc	14,700	44	93	North American Medical Management California	
Hemet Community Medical Group, Inc	63,000	123	172	KM Strategic Services, Inc (Chaudhuri/Foutz)	
Riverside Community Healthplan Medical Group, Inc/ Riverside Physician Network	65,600	65	158	Riverside Community Healthplan Medical Group, Inc	
Riverside Family Health Medical Group	2,000	17	170	MedPoint Management, Inc	
Family/Seniors Medical Group, Inc	5,700	16	300	Meridian Health Care Management	
Alpha Care Medical Group, Inc	21,300	28	150	Primary Provider Management Company	
Oasis IPA Medical Group, Inc	24,200	121	71	Heritage Provider Network, Inc	
Hi-Desert Physician Association Medical Group	1,700	12	48	KM Strategic Services, Inc (Chaudhuri/Foutz)	
Physicians Health Network Medical Corp	20,700	42	97	Epic Management LP (Beaver Medical Group)	
Pro Med Health Medical Group Network of Pomona Valley, Inc	9,000	79	50	Pro Med Healthcare Administrators	
St. Mary Choice Medical Group, a Medical Corp	23,900	44	84	St. Mary Choice Medical Group, a Medical Corp	Old Corwin IPA and merger of St. Mary Medical Group and Choice Medical Group IPAs. Effective September 1, 2001 became self-administered.
Mission Medical Group of the Inland Empire, Inc	26,450	16	109	Primary Provider Management Company	
Medical Foundation					
Loma Linda University Health Care	35,800	50	401	Adventist Health Managed Care	Includes medical group.

✔ With 28.7% of the inpatient market in the county, Sharp has the largest share, followed by the Scripps Health hospitals (19.8%) and the University of California San Diego Medical Center (8.4%).

✔ Both Sharp and Scripps Health are closely tied to medical groups.

✔ Sharp has two large affiliated medical groups and provides management services to the Sharp Community Medical Group IPA.

4.6 San Diego

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 health care market in certain respects. Its major provider systems—Sharp, Scripps Health, and the University of California San Diego—are local, without 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 hospitals are non-profit organizations but, unlike most of the nonprofit hospitals in the state, without religious affiliation. 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.

The San Diego area has significant problems: An estimated 15% of the population is without health insurance. Further, its provider safety net is seriously stressed, partly because there is no county general hospital.

But San Diego County also has important health care resources. Its hospital systems, to differing degrees, provide significant amounts of care to people without insurance. There is an active foundation that promotes community-based approaches to addressing health care issues through its grantmaking and by convening employers, providers, consumers and government agencies—to become part of the solution. It 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 can address and have a real impact on problems of health care access, cost, and quality.

Overview of Hospitals. *Exhibit 49* shows the relative market share of the major hospital systems in the San Diego area in 2001. *Exhibit 50* is a map showing acute care hospitals in the San Diego area and their system affiliations.

With 28.7% of the inpatient market in the county, Sharp has the largest share, followed by the Scripps Health hospitals (19.8%), and the University of California San Diego Medical Center (8.4%). Scripps grew during the 1990s as several community hospitals affiliated. Kaiser's single hospital in the area is also a major provider of care with 6.6% of the inpatient days.

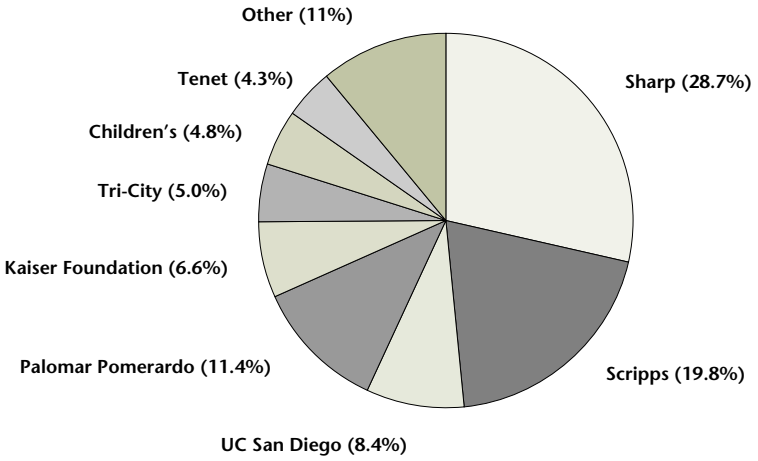
Both Sharp and Scripps Health are closely tied to medical groups. (Those ties have not always been so close or cordial, particularly in the case of Scripps.) For example, Scripps Clinic has about 335 physicians in a foundation model and Scripps Health also provides management services to a 420-doctor 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. (The hospital and some of its administrators are the targets of federal investigations into certain payment practices.) HCA/Columbia owned the Mission Bay hospital in

Exhibit 49

San Diego Hospital Market Share, 2001

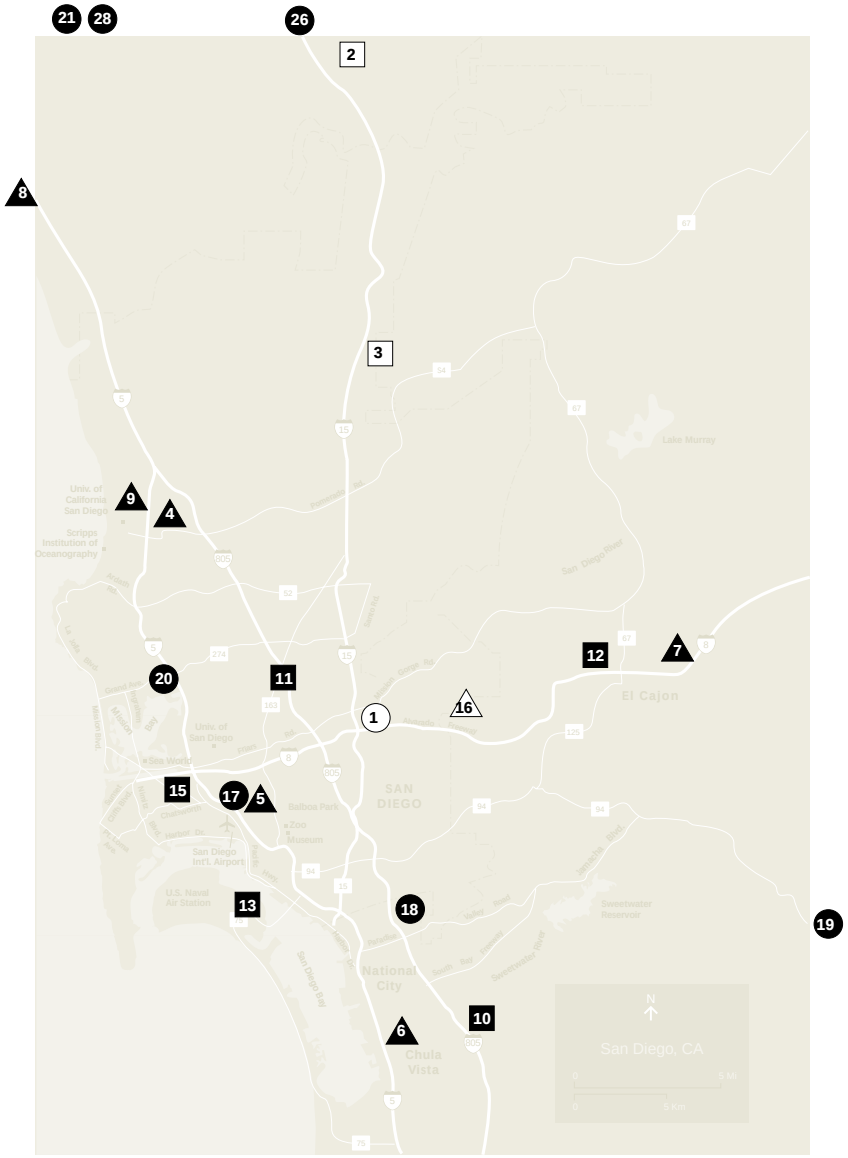


the 1990s and attempted a deal with the Sharp system that would have made it a major presence in the area. That proposed transaction stirred enormous controversy and was never completed.

Financial Results. *Exhibit 51* shows that hospitals in the area reported net income of $78.3 million in 2001, which was 2.7% of $2.9 billion in total revenue. In general, hospitals made money on their

Exhibit 50

San Diego Hospitals and Systems



San Diego Hospital Map Legend

	System/Hospitals	City
○	**Kaiser Foundation**	**San Diego**
1	Kaiser Foundation	
□	**Palomar Pomerado**	
2	Palomar Medical Center	Escondido
3	Pomerado Hospital	Poway
▲	**Scripps**	
4	Scripps Memorial Hospital - La Jolla	La Jolla
5	Scripps Mercy Hospital	San Diego
6	Scripps Memorial Hospital - Chula Vista	Chula Vista
7	Scripps Hospital - East County	El Cajon
8	Scripps Memorial Hospital - Encinitas	Encinitas
9	Green Hospital	La Jolla
■	**Sharp**	
10	Sharp Chula Vista Medical Center	Chula Vista
11	Sharp Memorial Hospital	San Diego
12	Grossmont Hospital	La Mesa
13	Sharp Coronado Hospital	Coronado
14	Sharp Mary Birch Hospital for Women	San Diego
15	Sharp Cabrillo Hospital	San Diego
△	**Tenet Health**	
16	Alvarado Hospital Medical Center	San Diego
●	**Other**	
17	University of California-San Diego	San Diego
18	Paradise Valley Hospital	National City
19	Pioneers Memorial Hospital	Brawley
20	Mission Bay Hospital	San Diego
21	Tri-City Medical Center	Oceanside
22	San Diego County Psychiatric	San Diego
23	Children's Hospital	San Diego
24	Continental Rehab Hosp	San Diego
25	El Centro Regional	El Centro
26	Fallbrook Hospital District	Fallbrook
27	Villa View Community	San Diego
28	San Luis Rey Hospital	Encinitas

operations and benefited from other revenues, including investment income and philanthropy.

The University of California San Diego medical center reported $36.7 million in net income, which includes disproportionate share hospital funds and county indigent care funds. The Sharp hospitals had net income of $34 million, which was 4.8% of $713.8 million in total revenue. That was an improvement over net income of $19 million in 2000.

The two Palomar Pomerado hospitals reported net income of 3.3% of total revenue of $230.2 million. The hospital district plans to 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.

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 52,* average 2001 occupancy rates for inpatient care in the San Diego area were 67.6%—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. Some

Exhibit 51

Revenues and Net Income for San Diego Hospitals, 2001

System/Hospitals	City	Total Charges	Net Patient Revenue	Operating Expenses	Net from Operations	Net Income	% of Total Revenue
Kaiser Foundation Hospital Palomar Pomerado		**588,664,442**	**217,350,498**	**222,315,824**	**1,481,978**	**7,698,561**	**3.3%**
Palomar Medical Center	Escondido	427,083,983	155,866,927	159,749,022	1,106,737	6,251,123	3.8%
Pomerado Hospital	Poway	161,580,459	61,483,571	62,566,802	375,241	1,447,438	2.3%
Scripps		**2,005,103,215**	**646,100,417**	**665,523,373**	**9,273,670**	**11,767,106**	**1.7%**
Scripps Memorial Hospital - La Jolla	La Jolla	618,047,432	194,618,942	201,591,105	3,904,349	4,348,390	2.1%
Scripps Mercy Hospital	San Diego	618,442,058	201,433,951	196,427,877	9,195,061	11,091,131	5.3%
Scripps Memorial Hospital - Chula Vista	Chula Vista	219,736,265	66,369,068	75,864,486	(7,098,211)	(7,098,211)	-10.3%
Scripps Memorial Hospital - Encinitas	Encinitas	196,763,315	66,931,622	66,819,963	1,100,963	1,254,288	1.8%
Scripps Green Hospital	La Jolla	352,114,145	116,746,834	124,819,942	2,171,508	2,171,508	1.7%
Sharp Health		**2,154,887,454**	**688,173,292**	**675,766,020**	**22,780,064**	**33,962,878**	**4.8%**
Sharp Chula Vista Medical Center	Chula Vista	363,963,694	103,108,300	102,278,288	2,115,826	3,152,650	3.0%
Sharp Memorial Hospital	San Diego	783,515,206	263,122,509	256,672,869	12,812,717	16,620,558	6.1%
Grossmont Hospital	La Mesa	700,921,505	221,163,192	210,719,323	12,923,267	18,636,357	8.1%
Sharp Coronado Hospital	Coronado	87,948,010	34,543,598	35,669,894	(1,071,617)	(474,557)	-1.3%
Sharp Mary Birch Hospital for Women	San Diego	175,970,851	50,812,001	53,421,454	(2,422,641)	(2,394,642)	-4.7%
Sharp Cabrillo Hospital	San Diego	40,101,837	14,465,154	15,527,596	(1,061,719)	(1,061,719)	-7.3%
Sharp Vista Pacifica	San Diego	2,466,351	958,538	1,476,596	(515,769)	(515,769)	-53.7%
Tenet Health		**618,727,681**	**137,638,193**	**488,998,918**	**7,909,430**	**(594,906)**	**-0.4%**
Alvarado Medical Center*	San Diego	618,727,681	137,638,193	488,998,918	7,909,430	(594,906)	-0.4%
University of California -San Diego Medical Center*		**874,492,664**	**397,274,831**	**399,095,625**	**26,977,846**	**36,672,007**	**7.4%**
Other		**1,328,214,161**	**553,427,291**	**617,693,351**	**(35,185,225)**	**(11,243,769)**	**-1.8%**
Paradise Valley Hospital	National City	218,344,904	89,346,142	98,371,629	(6,833,566)	(4,491,749)	-4.8%
Pioneers Memorial Hospital	Brawley	87,221,664	36,637,089	39,666,769	(2,439,058)	303,537	0.8%
Tri-City Medical Center	Oceanside	405,144,908	145,985,693	155,496,424	(6,500,438)	3,110,001	2.0%
Children's Hospital - San Diego	San Diego	401,815,925	193,514,267	232,406,108	(16,658,262)	(4,786,616)	-2.1%
El Centro Regional Medical Center*	El Centro	120,511,118	46,318,138	47,949,364	(864,346)	(1,045,786)	-2.0%
Fallbrook Hospital District	Fallbrook	66,785,325	27,165,760	25,438,148	1,862,074	1,904,447	7.0%
Villa View Community Hospital	San Diego	28,390,317	14,460,202	18,364,909	(3,751,629)	(6,237,603)	-42.7%
TOTAL		**7,570,089,617**	**2,639,964,522**	**3,069,393,111**	**33,237,763**	**78,261,877**	**2.7%**

*Net Patient Revenues, Net from Operations and Net Income for certain county, hospital district and University of California hospitals reduced by transfer of disproportionate share hospital funds and other special Medicaid funds.
Source: Author's analysis of annual hospital report data for years ending in 2001 from Office of Statewide Health Planning and Development
% of Total Revenue is calculated using total hospital revenues as the denominator, not net patient revenues.

hospitals have recently been closed, boosting occupancy in the remaining hospitals.

The University of California San Diego Medical Center's occupancy rate of 70.5% was among the highest in the area, but less than the 98.4% reported for the Palomar Pomerado hospitals. At the Sharp hospitals, occupancy averaged 71.8% in 2001 while it was only 65.5% at the Scripps hospitals.

Payer Mix. On average, Medicare covered 40.2% of inpatient days in 2001 while Medi-Cal covered 25%. Medicare is especially important to the Scripps hospitals, where Medicare covers 45% of inpatient days. Most of the Medi-Cal days in the San Diego area are provided by the University of California San Diego Medical Center, with the Children's Hospital and some of the district hospitals also playing an important role. UC San Diego Health Plan has about 12,000 Medi-Cal enrollees in its HMO.

Exhibit 52

Inpatient Occupancy Rates and Payer Mix for San Diego Hospitals, 2001

Hospital	Staffed Beds	Inpatient Days	Occupancy	% Medicare Days	% Medi-Cal Days	% Other Third Parties	% County Indigent	% Other Payers
Kaiser Foundation	**337**	**99,377**	**80.8%**	**43.1%**	**0.2%**	**44.4%**	**0.0%**	**12.3%**
Palomar Pomerado	**480**	**172,415**	**98.4%**	**39.4%**	**28.5%**	**20.7%**	**0.8%**	**10.6%**
Palomar Medical Center	297	106,836	98.6%	40.0%	26.2%	22.6%	1.2%	10.0%
Pomerado Hospital	183	65,579	98.2%	38.4%	32.3%	17.6%	0.2%	11.6%
Scripps	**827**	**300,506**	**65.5%**	**45.2%**	**15.6%**	**29.0%**	**2.8%**	**7.4%**
Scripps Memorial Hospital - La Jolla	262	95,757	73.7%	41.6%	4.6%	42.4%	1.3%	10.0%
Scripps Mercy Hospital	257	93,350	99.5%	41.5%	27.5%	19.7%	5.0%	6.4%
Scripps Memorial Hospital - Chula Vista	111	40,036	98.8%	49.9%	33.5%	7.4%	3.7%	5.5%
Scripps Memorial Hospital - Encinitas	91	33,038	99.5%	56.7%	9.4%	28.1%	3.0%	2.8%
Scripps Green Hospital	106	38,325	99.1%	48.3%	0.7%	41.5%	0.0%	9.5%
Sharp	**1,580**	**434,833**	**71.8%**	**41.0%**	**26.4%**	**16.9%**	**1.5%**	**14.2%**
Sharp Chula Vista Medical Center	288	83,330	79.3%	42.0%	37.0%	12.6%	1.5%	7.0%
Sharp Memorial Hospital	431	133,296	84.7%	46.1%	13.0%	20.4%	1.6%	18.9%
Grossmont Hospital	433	103,864	65.7%	56.9%	19.1%	18.7%	2.8%	2.5%
Sharp Coronado Hospital & Healthcare Center	175	52,169	81.7%	16.4%	62.6%	6.2%	0.1%	14.7%
Sharp Mary Birch Hospital For Women	165	39,492	65.6%	1.4%	27.8%	23.1%	0.1%	47.5%
Sharp Cabrillo Hospital	76	19,607	70.7%	70.0%	16.3%	10.1%	0.0%	3.7%
Sharp Vista Pacifica	12	3,075	70.2%	0.0%	0.0%	62.3%	0.0%	37.7%
Tenet	**1,120**	**64,846**	**57.1%**	**61.0%**	**12.8%**	**23.0%**	**0.6%**	**2.6%**
Alvarado Hospital Medical Center	1,120	64,846	57.1%	61.0%	12.8%	23.0%	0.6%	2.6%
University of California San Diego Medical Center	**456**	**127,881**	**76.8%**	**26.9%**	**31.3%**	**28.3%**	**7.9%**	**5.6%**
Other	**1,144**	**314,767**	**76.4%**	**34.9%**	**38.0%**	**19.4%**	**1.4%**	**6.3%**
Paradise Valley Hospital	207	72,766	96.3%	44.9%	40.3%	5.2%	2.7%	6.9%
Pioneers Memorial Hospital	99	17,119	47.4%	36.7%	26.3%	28.4%	5.5%	3.0%
Tri-City Medical Center	209	75,155	98.5%	58.2%	10.6%	24.1%	0.0%	7.1%
Children's Hospital - San Diego	276	73,308	72.8%	0.1%	60.7%	38.1%	0.0%	1.1%
El Centro Regional Medical Center	107	24,410	62.5%	49.4%	32.6%	6.9%	5.8%	5.1%
Fallbrook Hospital District	146	34,958	65.6%	24.4%	47.3%	12.1%	0.0%	16.2%
Villa View Community Hospital	100	17,051	55.0%	38.6%	50.6%	2.2%	1.1%	7.5%
TOTAL	**5,944**	**1,514,625**	**67.6%**	**40.2%**	**25.0%**	**23.3%**	**2.1%**	**9.5%**

Physician Organizations. *Exhibit 53* provides information about 15 of the largest physician groups in San Diego. Scripps Clinic MD Group, a medical foundation, has about 330 doctors and 120,000 enrollees. A second foundation, Scripps Mercy Medical Group, is also affiliated with Scripps Health. 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 2002, the Knox Keene company reported 152,000 enrollees, mostly in commercial plans. (See Exhibit 5.)

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 2002, HMO penetration in San Diego was an estimated 58.4%, or 1.8 million members out of an estimated population of 3.1 million. (See the analysis for Exhibits 12 and 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.

As shown in *Exhibit 54,* Kaiser continues to be the largest HMO in San Diego, with an estimated 27.4% of the market. Just under 1.5 million are enrolled in commercial plans. Another 175,000 are in Medi-Cal managed care, split among seven HMOs.

Exhibit 53

San Diego Physician Organizations
counties: San Diego

Name of Physician Organization	Estimated enrollment	# of PCPs	# of Specs	Management Entity	Notes
Group Practice					
Southern California Permanente Medical Group	506,800	411	523	Southern California Permanente Medical Group	
Sharp Mission Park Medical Group, Inc	52,100	67	404	Sharp Healthcare/Sharp Mission Park Medical Corp	Includes IPA type panel.
Sharp Rees-Stealy Medical Group, Inc	146,100	92	208	Sharp Rees-Stealy Corp	
Centre for Health Care Medical Associates	30,000	23	117	Centre for Health Care Medical Associates, Inc	Includes IPA type panel.
Graybill Medical Group, Inc	1,000	34	70	Graybill Medical Group, Inc	
IPA					
Sharp Community Medical Group, Inc	165,000	225	650	MSO of Sharp Community Medical Group	
San Diego Physicians Medical Group, Inc	47,700	119	300	Southern California Physicians Managed Care Services, Inc (Scripps Heallth)	
San Diego IPA	3,250	66	300	San Diego IPA	
Mercy Physicians Medical Group, Inc	26,200	85	252	North American Medical Management California	
Children's Physicians Medical Group	4,400	30	165	Children's Health Network	
Primary Care Associates Medical Group, Inc	54,300	57	98	Primary Care Associates Medical Group, Inc	
Greater Tri-Cities IPA Medical Group, Inc	5,900	24	89	Physicians Data Trust, Inc	
Medical Foundation					
Scripps Clinic MD Group, Inc/ Scripps Medical Foundation/Scripps Clinic	120,000	99	235	Scripps Clinic Health Plan Services, Inc	Includes medical group.
La Maestra Family Clinic	4,800	7	200	La Maestra Family Clinic	
Scripps Mercy Medical Group, Inc/ Scripps Medical Foundation	15,000	56	150	Scripps Clinic Health Plan Services, Inc	Includes medical group and IPA.
State/County Faculty/Staff					
UCSD Healthcare Network	39,950	63	482	UCSD Healthcare Network	

According to data from the Centers for Medicare and Medicaid Services, about 41% (149,000) 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 less than 10,000 seniors each.

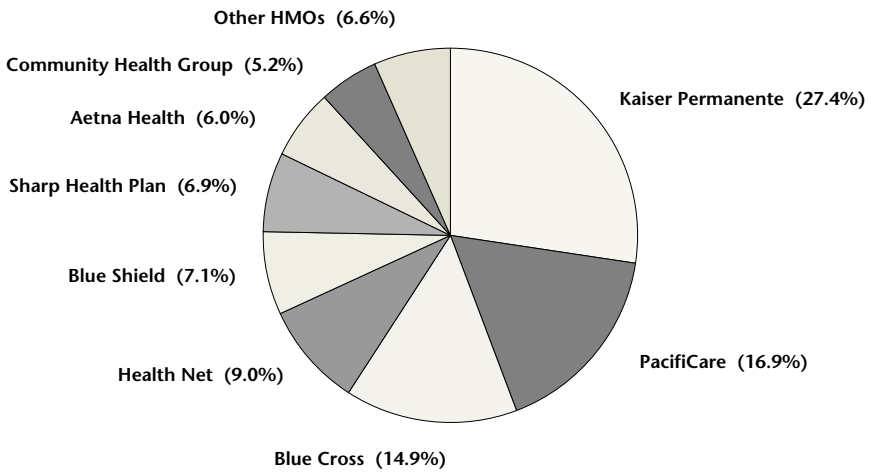
Sharp continues to operate one of the few provider-sponsored HMOs left in California. At the end of 2002 it served 70,000 commercial members and 49,000 Medi-Cal recipients, ranking it second to Community Health Group for Medi-Cal members in San Diego.

Unlike most other California hospital systems, the Sharp hospitals continue to contract with health plans on a capitated basis. In contrast, the Scripps hospitals and physician groups have ended most of their capitation contracts. 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.

Exhibit 54

Estimated HMO Market Share for San Diego, 2002



ABOUT THE AUTHOR

Allan Baumgarten is a nationally recognized consultant and analyst on health care policy and finance. Working with a variety of organizations, he helps them to analyze the market competition and health care policy issues they face and to develop business strategies to meet the challenges of changing markets and health reform. His clients include health plans, provider groups, vendors of pharmaceuticals, systems and devices, government agencies and employers.

Mr. Baumgarten is the author of *Minnesota Managed Care Review* and annual market studies for Colorado, Florida, Illinois, Michigan, Ohio, Texas, and Wisconsin. The California HealthCare Foundation has provided funding for him to prepare this report analyzing the California managed care market.

He has published recent articles in publications such as *Health System Leader, Managed Care Quarterly* and *Business and Health.* He has presented his research to numerous national and local meetings, including the Agency for Health Care Policy and Research, American Association of Health Plans, National Managed Health Care Congress, and the Association for Health Services Research.

From 1988 to 1993, Mr. Baumgarten was Associate Director of the Citizens League, a nonprofit public affairs research, education and advocacy organization in Minneapolis-St. Paul, Minnesota. Before that, he was Staff Attorney and Evaluation Coordinator for the Legislative Auditor's office in St. Paul, Minnesota. There he directed studies of state agencies and their programs, including a study of how state agencies were regulating HMOs and other health plans.

Mr. Baumgarten received his J.D. degree from the University of Minnesota Law School and an M.A. from the University's Hubert H. Humphrey Institute of Public Affairs.

For more information about the author's research:

www.allanbaumgarten.com

4800 West 27th Street

Minneapolis, Minnesota 55416

(952) 925-9121 Fax: (952) 925-9341

E-mail: Baumg010@tc.umn.edu

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