California HealthCare Foundation

California Health Care Market Report 2006

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BY
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About the Foundation

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

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About This Report

The recent history of health care in California can be described as a series of spirited confrontations separated by brief intervals of quiet. Confrontations have included hospitals and health plans challenging each other about payments and other contract terms, and employers pushing both health plans and providers to demonstrate the value that they provide in exchange for billions in premium dollars each year.

The 2005 edition of this report described how the first years of the 21st century were a period of relative calm in the California health care market. New money was coming into the system through significant premium increases and many providers (with some conspicuous exceptions) were enjoying those higher payments. Hospitals and health plan companies reported generally strong (in some cases exceptionally strong) profitability, which made it possible for hospitals to embark on major construction projects. Providers, health plans, and purchasers found common ground and collaborated on programs to measure, reward, and improve the quality of care.

In this report, we will describe some changes occurring in California that seem to signal an end to the relative tranquility of the past few years. For example, health plans sense an opportunity to push back on hospital payments and have begun to act on it. Employers are asking why they should support incentive payments for provider performance that only meets, but does not exceed, expectations.

This analysis, *California Health Care Market Report 2006*, is supported by a grant from the California HealthCare Foundation. This is the fifth annual edition of the report, first published in 2001 as *California Managed Care Review.* It aims to provide an objective analysis of health care market trends and comprehensive data on health care organizations. Policymakers and leaders in health care organizations as well as consumers can use the report as a common source of data and insight on health care markets in the state. The Foundation makes the report available widely on its Web site.

California Health Care Market Report 2006 is based on two kinds of research. First, the author analyzed data on health plans, hospital systems, and physician organizations to evaluate financial performance, health plan enrollment trends, measures of utilization and effectiveness of care, and patient satisfaction. These data are drawn mostly from public sources, including the annual and quarterly statements that HMOs file with the California Department of Managed Health Care and the annual surveys that hospitals submit to the Office of Statewide Health Planning and Development. Data on utilization and effectiveness of care and on patient satisfaction within health plans are from the Quality Compass® data set licensed from the National Committee for Quality Assurance.

Second, 30 leaders in key health care organizations and government participated in interviews with the author. These are in addition to about 160 interviews completed in preparing the four earlier editions of this report. Most of the new interviews were conducted in person between April and July 2006. The insights gained through these interviews provided helpful perspectives and a supporting context for the data. The interviewees are not quoted directly in the report. Instead, their insights are integrated into this report as unattributed comments.

Report Organization

This report is organized into four major sections.

Section 1.0, Overview of Findings, summarizes the report's analysis of key trends and issues in the market.

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

Section 3.0, Trend Review, presents an analysis of health plans in the state, examining trends in enrollment and profitability, developments with Medicare managed care, and the different models used by the state for Medi-Cal managed care. This section also offers data for large commercial HMOs on measures of utilization and effectiveness of care. Sidebars in this section compare California health plans with HMOs in the eight other states where the author prepares similar market analyses: Colorado, Florida, Illinois, Michigan, Minnesota, Ohio, Texas, and Wisconsin.

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

What is Managed Care?

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

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

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

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

Source: America's Health Insurance Plans

1.0 Overview of Findings

The money that finances health care benefits and the delivery of health care in the United States begins with employer purchasers and government agencies. It passes through the hands of various intermediaries, including health plans and management service organizations, before it gets to the providers of care and the vendors of pharmaceuticals, devices, and information technology.

When Californians seek health care, almost all of them participate in one of four broad sub-markets:

1. THE KAISER SYSTEM, where more than six million Californians get their health care in a largely self-contained system of clinics and hospitals.
2. THE CAPITATED/DELEGATED MODEL HMO WORLD, where about 12 million people get their care from doctors who practice in groups and through independent clinics linked through IPAs (independent practice associations). The physicians practicing in these settings still receive the bulk of their revenue in the form of monthly capitation payments, though they are concerned by the steady erosion of this part of their patient base.
3. THE FEE-FOR-SERVICE MARKET, where between six and seven million people are enrolled in health benefit plans that pay physicians and hospitals for each unit of service provided. This market includes those in PPO (preferred provider organization) benefit plans, which do not require them to select a primary care clinic or physician. Leaders of physician organizations interviewed for this report said that the number of patients coming to them from HMO employer groups has declined 2 or 3 percent each year for the past several years, and it is generally believed that most of them moved to PPO plans.
4. THE UNINSURED, which includes six to seven million Californians who get their care from safety net providers such as community health centers and county hospitals, as well as those community hospitals and physicians that serve patients without insurance.

1.1 Key Findings

Health care organizations in California face formidable challenges that go to the core of how health care and health benefits are organized, financed, and delivered. Here is an overview of the key findings in this report.

1 The migration away from HMOs continues, putting pressure on physician organizations.

Physician organizations built their medical management and administrative systems under the capitated/delegated model, but now face a steady erosion of their patient base as employers shift their benefits from the HMO model to PPOs and similar arrangements. Previous editions of this report have discussed the reasons for this movement, including: (1) employers seeking relief from double-digit premium increases by moving away from rich HMO benefits to PPO arrangements with additional cost sharing; (2) a perceived preference by consumers for more flexible plans with easier access to specialists; and (3) a preference by the health plans to move employer accounts to plans that are subject to less state regulation.

All of this has left physician groups scrambling to retool themselves to attract PPO patients, with limited success so far. Those that are successful in adding PPO patients are faced with the need to change a culture that encouraged physicians to be conservative in providing care and to be "modest" in reporting the amount of care provided, into a culture focused on maximizing fee-for-service payments. While the percentage of the commercially insured population in HMOs is still much higher in California than in other states, the trend away from HMOs is worrisome to physician groups. Some continue to expect (or wish for) a consumer backlash against the "skinny" benefits of PPO plans. But others recognize that while consumers may be getting reduced benefits, they don't feel that they are getting reduced care—a subtle but important distinction.

In a trend that seems counterintuitive, the more enrollees HMOs lose the more profitable they have become. The past two years have been the most profitable for HMOs in California and the comparison states. According to past underwriting cycles, HMOs should have become less profitable as the growth in their medical expenses began to outpace their premium increases. That has not happened yet, although some Wall Street analysts assume that it will happen very soon and have already written down the value of companies like UnitedHealthcare.

2 Health plans are pushing back against hospitals.

For the past few years, consolidated hospital systems had the upper hand in their negotiations with health plans, and they used that leverage to secure higher payment rates and to exit risk-sharing arrangements. Now the pendulum of economic power may be swinging back to the health plans for two reasons: the construction of new hospital capacity, and the most recent mega-mergers by health plan companies. As new hospitals open, the threat by health plans to move their patients away if they can't get favorable discounts is becoming credible once again. And the recently completed combinations of WellPoint with Anthem, and PacifiCare with UnitedHealthcare have created health plan giants that are no longer based in California, and that have very strong notions about how much hospital care should cost.

In a few recent cases, the pushback has come from large purchasers of health benefits, such as CalPERS. One factor keeping health plans from pushing on providers has been concern that employers will not stand with them in the face of provider threats to leave the network. CalPERS sent a very pointed message to hospitals when it pushed to exclude hospitals it regarded as unnecessarily expensive from the Blue Shield network. It remains to be seen if other major purchasers will also be willing to forego broad networks in favor of more select provider panels, even if offered an explicit tradeoff of broader networks or lower costs.

3 Hospitals are spending major funds on new construction.

In a related development, hospitals are in the midst of a construction boom that is likely without precedent. Three factors have been driving the new construction: (1) compliance with the seismic safety standards; (2) the desire to build new centers for lucrative specialties like cardiology, orthopedics, and general surgery, and to cater to star physicians who bring in patients and revenues; and (3) a large amount of investment that was deferred in years when hospitals were not profitable. Hospitals' much-improved profitability has made it possible to pay for new construction partly from cash flow and partly from borrowing based on healthier balance sheets.

Still, hospitals face significant financial challenges in the next few years. In addition to the pushback from health insurers, they also may see a period of reduced utilization as patients either lose coverage or see significant reductions in their benefits. Simply put, patients that are required to pay a high deductible on their hospital bill may defer procedures. Given that hospitals have borrowed money for their construction projects based on assumptions about the flow of patients and service revenues, changes in health coverage may affect them adversely.

The greatest challenge to hospitals in the next five years may be the soaring cost of building materials. Given the construction boom in China and other countries, the cost of imported steel and wallboard in the United States has increased by as much as 25 percent annually. Combined with the lengthy regulatory reviews needed before ground can be broken, hospitals have to include large inflation factors in their cost estimates. These enormous costs are making hospitals even more nervous about filling their costly new beds, particularly as their leverage against health plans is waning.

4 Kaiser is expanding and creating new challenges.

Kaiser is in the midst of a huge investment program and is constructing new hospitals and physician clinics, sometimes in areas where Kaiser had contracted with the local providers. As new Kaiser facilities come on-line in places like Ventura County in the south and Vacaville in the north, the Kaiser Permanente

HMO is dropping its contracts with local physicians and hospitals. Consumers and employers can choose to continue with their providers by signing up with competing health plans, but many of those enrollees will remain Kaiser members and move to Kaiser providers.

5 Consumer protections are an issue.

Unlike HMOs that are regulated by the Department of Managed Health Care (DMHC), PPO plans come under the regulation of the California Department of Insurance (CDI) and are subject only to limited regulation, especially with regard to product design and consumer cost sharing. Indeed, observers have commented that most new product designs are now brought to the Department of Insurance as PPO plans because it is easier to get approval. As new products that impose additional consumer cost sharing gain ground in the market, concerns have been expressed that consumers may not merely postpone unnecessary care, but may also forego needed care, jeopardizing health. The Department's statutory authority is circumscribed, although it has recently supported legislation to widen its authority in these matters.

Another concern for both DMHC- and CDI-regulated plans is the state role in ensuring appropriate access to care. Recent problems with the Kaiser kidney transplant program revived an age-old concern about whether there may be incentives to reduce care when the care provider and the insurer are the same entity. The Kaiser episode raised the question: Is it the state's responsibility to respond to complaints after the fact, or should state regulators be more pro-active in scrutinizing arrangements for the delivery of care before they are put into effect?

6 Purchasers are demanding value and health plans want transparency.

Employers have been turning to their health plans asking them to demonstrate value, namely cost savings and improved quality and access. In turn, the health plans have been asking their providers for more transparency, wanting to see the differences in provider quality, costs, and how they practice. The quest for transparency has taken a variety of forms, including Pay for Performance initiatives and the identification of high-performing provider networks. Providers have responded by challenging the health plans to be explicit on how they are being evaluated.

7 The uninsured and the underinsured continue to challenge the health care system.

According to data from the 2005 Current Population Survey, 21.3 percent of Californians under age 65 have no health insurance. Much of the care provided to people without insurance is provided by a fraying safety net of public hospitals, some community hospitals, and community health centers. Where possible, these providers try to recover some of their costs by charging higher rates to employer purchasers and individuals.

In the past few years, concerns have been expressed about the underinsured: individuals and households that have coverage that is subject to significant cost sharing in the form of co-payments and high deductibles. Some local surveys in California and elsewhere suggest that some people will not fill a prescription or will delay a procedure because of worries about not being able to afford the cost of the deductible or co-payment.

2.0 Market Review: Key Organizations

The following subsections provide an overview of the major organizations that finance, deliver, and organize health care and health benefits for most Californians. These entities include purchasers of health insurance products, health plans, hospital systems and networks, and physician organizations.

2.1 Purchasers

Private employers and government agencies face enormous challenges in sponsoring health insurance benefits for their employees and beneficiaries. Prices continue to rise, with only moderate relief in sight. So far, employers have absorbed most of the annual increases, but it is hard to imagine that they can continue to sustain the perennially rising costs. In addition, the system of employer-sponsored health insurance imposes a role on employers that they accept reluctantly. Many employers would prefer not to shoulder responsibility for decisions about who is eligible for coverage, which health plan options are offered, and what kind of benefits are included in the plans.

Employers and their consultants talk increasingly about strategies and benefit plans designed to get consumers more "engaged" in their health care. This is in response to the frequently voiced complaint: "Consumers don't understand the cost of health care. They think that a prescription costs only the $10 co-payment or that outpatient surgery can be had for a few hundred dollars." Some argue that if consumers were more financially engaged in their health care decisions, they would act more efficiently, saving money for employers. Following this logic, some employers have introduced new cost-sharing requirements and implemented small increases for enrollees, either in premiums or in co-payments at the time of care.

A variety of new plans has emerged which employers and consumers are testing. Many of these plans are built around a health savings account (HSA), which got a big boost from the Medicare Modernization Act of 2003. HSAs are linked to high-deductible benefits designs, with "high" meaning at least $1,050. After the deductible is satisfied, a comprehensive insurance policy typically applies with relatively little additional cost sharing.

A slowly but steadily growing number of employers are offering high-deductible plans as a benefit option. The most recent Employer Health Benefits Survey for California (released in 2005 by the California HealthCare Foundation and the Center for Studying Health System Change) shows that about 20 percent of employers offered high-deductible health plans. In that survey, the proportion was higher for smaller employers than large employers. About 25 percent of employers in the California survey said that they were very or somewhat likely to offer an HSA plan in 2006.

The strong interest of employers in experimenting with cost-sharing increases for employees has contributed to a shift away from HMOs, which historically have been limited in their ability to offer plans that incorporate significant cost sharing. The notion was that HMOs provided comprehensive care, and that significant cost sharing created barriers to access. As a result, much of what is considered innovative in plan design in the past few years has taken place outside of HMOs, and has targeted larger employers that self-fund their employee health benefits.

Types of Managed Care Plans

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

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

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

This shift away from HMOs was one of the state's major concerns about the acquisition of PacifiCare by UnitedHealthcare: Would the combined company introduce new benefit designs on its PPO platform or through PacifiCare's HMO license? As one of the conditions of approval, the Department of Managed Health Care insisted that United agree to present new product filings through the PacifiCare HMO. To the extent that these offerings are made available through HMOs, the migration of HMO customers to other plans may be reduced. However, the strong preference of health plans for now is to run those new plans outside of their HMOs.

In another trend, employers are pressing health plan companies to hold down their health care costs, particularly the cost of hospital care. In the past, employers felt that plan administrators accepted and passed on hospital rate increases without offering much resistance. In response to pressure from employers, health plans are now pushing back against hospital systems, seeking to hold down payment increases. The recent consolidation of national health plans has afforded them additional leverage in making those demands in many parts of the country.

Finally, employers are grappling with whether they are willing to trade off narrower networks of physicians and hospitals in exchange for savings. That was one of the original premises of managed care, one that has largely fallen away as health plans typically contract with a high percentage of local providers. Many HMOs are now testing that notion and are offering what they call high-performance networks, with a limited number of providers that meet some criteria for preferred status. Given consecutive years of increasing health benefit costs, employers may be more open to plans with more limited networks, or that provide incentives to steer enrollees toward a high-performing subset of a larger network.

Purchasing Coalitions: CalPERS and PBGH

The two largest employer purchasers of health benefits in the state are the California Public Employees' Retirement System (CalPERS) and the Pacific Business Group on Health (PBGH). To strengthen their negotiating power with managed care companies, both CalPERS and PBGH have built coalitions of employers that sponsor benefit plans. Both organizations have established reputations as innovators in health benefit administration, and also as bellwethers for trends in the health care industry.

Both CalPERS and PBGH represent employers that have very large numbers of employees, dependents, and retirees for whom they purchase health benefits. For much of the 1990s, these large numbers gave both of them significant power in negotiating with health plans, allowing them to beat the price trend of the rest of the California market. For many years, they set the standard against which other employers compared the increases in their health benefit premiums.

However, the CalPERS plan absorbed double-digit increases for three consecutive plan years from 2003 to 2005. Some employers criticized CalPERS for accepting large increases in those years, for perhaps undercutting the ability of other employers to resist similar increases.

California Public Employees' Retirement System (CalPERS)

CalPERS administers pension benefits for California state employees and oversees the investment of the assets used to pay those pensions. By the end of 2005, CalPERS assets had grown to over $200 billion, compared to about $136 billion in 2002. This report looks at CalPERS' role in administering health benefit plans for 1.026 million covered lives, including about 740,000 state agency employees and their dependents, in addition to employees and dependents of about 1,300 local government units. CalPERS spends about $4.0 billion to purchase health benefits on behalf of those government units, making it the third largest benefits purchaser in the United States, behind the federal government and General Motors.

Exhibit 1 shows enrollment in the CalPERS health plans from 1996 through June of 2005. Total enrollment in all plans peaked in 2002 at about 1.1 million. After 2002 enrollment began to decline, dropping by about 21,000 enrollees in 2003 and losing another 45,000 enrollees in 2004. Some 35 local government units dropped out of the purchasing coalition at the end of 2003 over concern about increasing premiums. As of June 2005, 73.2 percent of enrollees were in HMOs, 21 percent were in PPOs, and 5.7 percent were in association plans.

HMOs. During the past decade, as many as 85 percent of the CalPERS enrollees were in HMO plans. CalPERS was an early proponent of HMOs for its members and offered a dozen or more HMO options for many years. (In those days there were many more HMOs offering plans to employers in the state. Of the 11 HMOs listed in *Exhibit 1,* three are no longer in business.) To contain the annual increases in premiums, CalPERS decided to reduce the number of HMO options. In 2003 it switched and offered only two plans statewide, Kaiser and Blue Shield, plus Western Health Advantage, a provider-owned plan in the Sacramento area.

EXHIBIT 1. Enrollment in CalPERS Health Plan Options, 1996 to 2005: Active and Retiree Enrollment in Basic Plans

Plan	1996	2000	2001	2002	June 2003	June 2004	June 2005	Change 2005/2004	Share
HMOs	**739,981**	**796,081**	**878,063**	**849,797**	**813,431**	**781,873**	**751,767**	**– 3.90%**	**73.20%**
Aetna Health	23,609	31,124	36,003	0	0	0	0	NA	NA
Blue Shield HMO*	31,267	44,766	59,478	118,566	435,164	412,042	371,392	– 9.90%	36.20%
CIGNA	35,023	27,709	29,232	0	0	0	0	NA	NA
Health Net	201,886	215,544	223,344	162,924	0	0	0	NA	NA
Health Plan of the Redwoods	7,738	7,255	7,322	0	0	0	0	NA	NA
Kaiser Permanente	294,460	324,649	347,866	368,417	373,544	360,996	363,161	0.60%	35.40%
Maxicare	8,980	8,606	9,546	0	0	0	0	NA	NA
National	2,696	0	0	0	0	0	0	NA	NA
PacifiCare	103,014	107,164	130,936	175,574	0	0	0	NA	NA
Universal Care	0	1,327	5,822	19,135	0	0	0	NA	NA
Western Health Advantage	0	0	0	5,181	4,723	8,835	17,214	94.80%	1.70%
PPOs	**99,538**	**157,486**	**166,243**	**217,372**	**223,745**	**208,400**	**215,975**	**3.60%**	**21.00%**
PERS Care	63,359	51,942	39,180	34,874	30,032	25,395	23,287	– 8.30%	2.30%
PERS Choice	36,179	105,544	127,063	182,498	193,713	183,005	192,688	5.30%	18.80%
Association Plans	**41,922**	**34,161**	**38,166**	**41,943**	**51,038**	**53,116**	**58,589**	**10.30%**	**5.70%**
California Association of Highway Patrolmen	15,240	18,638	20,401	21,852	22,879	23,002	23,514	2.20%	2.30%
California Correction and Peace Officers Association	17,933	9,695	9,426	9,637	17,121	19,459	22,736	16.80%	2.20%
Peace Officers Retirement Association of California	4,630	5,828	8,339	10,454	11,038	10,655	12,339	15.80%	1.20%
TOTAL	881,441	987,728	1,082,472	1,109,112	1,088,214	1,043,389	1,026,331	– 1.60%	100.00%

NA: Not applicable.
*Blue Shield's internal enrollment reports consistently show a higher number of CalPERS lives than CalPERS' own reports, which may be because Blue Shield also provides some Medicare supplemental coverage to CalPERS retirees.
Source: Author's analysis of CalPERS enrollment reports. 1996 to 2002 figures are as of December.

Blue Shield picked up most of the enrollees from the other network HMOs in 2003 and now covers 36 percent of the group. It lost some enrollees in 2005 when, at CalPERS' direction, it dropped dozens of hospitals from its network. While some of those hospitals have since been restored to the Blue Shield network, some of the members took the opportunity to switch to PPO plans.

PPOs. Besides the HMOs, which are not available in all counties of the state, CalPERS offers two self-funded PPO plans, for which Blue Cross provides administrative services. CalPERS also administers association plans for about 40,000 law enforcement personnel in the state.

There were about 100,000 CalPERS enrollees in PPOs in 1996, comprising about 11 percent of the total group. By June 2005, PPO enrollment was about 216,000, or 21 percent of total enrollment. PPO enrollment grew primarily for two reasons: favorable pricing compared to HMO options and a growing number of counties where no HMOs were offered. Since then, the favorable pricing for the PPO plans has evaporated. Prices were increased sharply because reserves for the self-funded plans had fallen to dangerously low levels and needed to be replenished.

Strategic Issues. In 2004, CalPERS decided to reduce the size of the Blue Shield hospital network as a cost-cutting measure. It targeted high-cost hospitals in some parts of the state for removal from the network. Most of these were Sutter Health hospitals, although hospitals from some other systems were also marked for exclusion, including Cedar-Sinai in Beverly Hills, two Catholic Healthcare West hospitals, and two of the Daughters of Charity hospitals. On its Web site, CalPERS explained: "These hospitals represent the highest-cost providers in the network, which results in increased costs to everyone in the CalPERS Health Program." The network reduction plan was reviewed and largely approved by the Department of Managed Health Care, and took effect in January 2005. According to CalPERS, about 52,000 enrollees were affected, with some of them dropping out

California Government Agencies Involved with Managed Care

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

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

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

of the Blue Shield HMO and enrolling in one of the PPOs. A few of the eliminated hospitals have since been returned to the Blue Shield network after reaching accord on either the cost or quality measures.

CalPERS' officials say that the move to a more restrictive hospital network reduced premium increases for the 2005 plan year by about three percentage points. In addition, they say that it sent an important and pointed message to providers about the need for more accountability and more transparency in pricing. However, whether the message was received is not clear. Even a purchaser the size of CalPERS has consumers scattered around the state, meaning that the impact of their actions at the local level may be somewhat diluted. Some medical group executives speculate that the next logical step for CalPERS would be to reduce the number of physician groups in the Blue Shield network, using some combination of quality and efficiency criteria to reduce the size of that network and reward those physicians that are defined as high performing with more patients.

CalPERS has found that coalitions can be difficult to maintain, especially when members believe that they can secure better deals by going out on their own. In particular, regional price issues have become a concern. Since health care costs are lower in southern California than in the north (particularly for hospital care), local governments in southern California have argued that they are, in effect, unfairly subsidizing government units in northern California.

In March 2004, the CalPERS board approved the concept of setting regional rates for as many as five different regions in the state. For the 2005 plan year, CalPERS adopted five regional rates for contracting agencies (though not state employees), resulting in a wide range of premiums. In 2006, for example, family coverage for Blue Shield in the Bay Area and Sacramento will cost $1,106 per month. The same coverage will cost only $814 per month in Los Angeles and some nearby counties. Units of state government will continue to pay a uniform rate statewide. Public employee unions opposed the pricing change, but others view it as a necessary measure to stem the outflow of participating local governments. In that respect, local public agencies have generally stayed with their CalPERS coverage, even though individual units of government can sometimes secure better rates on their own.

Despite CalPERS's efforts to contain costs, its HMO premiums will increase by more than 10 percent in 2007. The Blue Shield family coverage rates will increase by 13.8 percent. Monthly premiums in the Los Angeles area will go up to $926 and the same coverage in the Bay Area and Sacramento will increase to $1,259. Kaiser Permanente's rates in the Bay Area and Sacramento for 2007 will increase by 10.7 percent to $1,121. The CalPERS board decided to increase premiums and not to impose higher co-payments for care. It also deferred for a year action on a proposal by Blue Cross to restructure the PPO provider network into a select network, a move that Blue Cross said would reduce costs by as much as 7.5 percent.

Pacific Business Group on Health (PBGH)

Nearly 50 large companies are members of PBGH and many, though not all, purchase their employee health benefits through PBGH. PBGH disseminates comparative information on health plans — and now provider groups — through its HealthScope Web site at www.healthscope.org. To extend the benefits of its purchasing expertise to smaller employers, PBGH successfully bid to administer the state's health insurance purchasing pool, renamed it PacAdvantage, and marketed those benefit plans to small and medium-sized employers in the state. However, in 2006 it decided to close down PacAdvantage because it found it increasingly difficult to offer a range of plan options that competed favorably with options available outside the pool.

PBGH is a founding member of several collaboratives that collect quality data on providers and health plans, and that survey enrollees on their satisfaction with health plans and medical groups in the state. In the past year, it has helped to start two new collaboratives. One of its new ventures is participating in the Ambulatory Quality Alliance, a national group that is developing a series of pilot projects (including one in California) to put together data on physician performance. The Alliance is building consensus around a group of HEDIS measures and quality measures developed by specialty societies of the American Medical Association. (HEDIS is the Health plan Employer Data Information Set, coordinated by NCQA, the National Committee for Quality Assurance.)

In addition, through the California Cooperative Healthcare Reporting Initiative, PBGH is participating as one of six pilot sites to gather data on physicians and to report these data to consumers, giving them tools for choosing providers. For the California demonstration, it is hoped that the major PPOs in the state will contribute their data to the pool, and that the federal government (through the Centers for Medicare and Medicaid Services) will make Medicare data available.

PBGH and CalPERS are collaborating on the Hospital Value Initiative, a new venture intended to develop efficiency standards and better information for purchasers on resource use in hospitals. It is planned that the efficiency standards and measures can be used by health plans and providers in crafting incentive programs, and by consumers in making health care decisions.

Other collaboratives include Leapfrog, a national coalition of 45 private and public health benefit purchasers and 24 business coalitions that joined together to improve patient safety and quality of care in hospitals. (See www.leapfroggroup.org.) Leapfrog has teamed with the National Quality Forum and has surveyed hospitals on their compliance with 30 safety improvement standards. In addition, PBGH was an early proponent of the Pay for Performance initiative developed by the Integrated Healthcare Association.

2.2 Health Plans

California employers use HMOs more than their counterparts in other states. About 13 million Californians (about 37 percent of the state's population) are enrolled in commercial HMO plans. HMO penetration in the state is also relatively high for seniors and for beneficiaries of state assistance programs.

Even so, a growing number of employers and consumers have migrated from HMO to PPO plans. Data from the 2005 California Employee Health Benefits survey show that 34 percent of employees were enrolled in PPO plans, a significant increase from 25 percent in 2001. By comparison, the PPO percentage nationally has always been significantly higher, going from 46 percent in 2001 to 61 percent in 2005. The percentage of California workers in HMO plans decreased from 54 percent in 2001 to 49 percent in 2004. That shift has occurred steadily over the past three years.

HMOs

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

- The first group, STANDARD PLANS, now includes about two dozen plans, some national and others doing business in California only. Last year it was noted that four of the largest managed care companies in the United States are based in California: Blue Cross (part of WellPoint, Inc.), Health Net, Kaiser Permanente, and PacifiCare. Since then, it has become clearer that the headquarters of

State Government Agencies, cont.

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

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 third largest benefits purchaser in the United States, behind the federal government and General Motors. The Public Employees' Medical and Hospital Care Act governs the benefit program. CalPERS is administered by a board of directors. The program was established in 1962 for employees of the state. In 1967, other public employers were allowed to join the program on a contract basis and about 1,200 other public employers now participate in the program.

State Government Agencies, cont.

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

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

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

WellPoint, Inc. is in Indianapolis. And, since UnitedHealthcare acquired PacifiCare, that company's corporate center has shifted to Minnesota. Most of these HMOs are investor-owned, but a few — notably Kaiser and Blue Shield — are organized as nonprofit organizations. Almost all of these HMOs serve commercial groups; a few do not contract with employers but only with the state for its Medi-Cal and Healthy Families programs. And some new plans have started in California and other states that are doing only Medicare Advantage contracts.

- The second category, COUNTY-SPONSORED HEALTH PLANS, includes 13 HMOs that are organized by county governments to serve enrollees in Medi-Cal managed care and in Healthy Families. Some of them are County Operated Health Systems, which operate all Medi-Cal managed care in those counties. The others are local initiative county plans that compete with plans run by commercial HMOs in their respective counties. The state has announced plans for a significant expansion of Medi-Cal managed care, which will increase the service areas of some of the County Operated Health Systems and add some new counties to the Geographic Managed Care programs in Sacramento and San Diego.

  Additional details about HMOs serving the Medi-Cal population are found below, and in Section 3 of this report.

- Finally, the third group of HMOs are the LIMITED LICENSE HEALTH PLANS, those provider-sponsored organizations that have a Knox-Keene license with waivers. Some of those are small or inactive. Only three still had enrollees in 2005: Heritage Provider Network, PrimeCare Medical Network, and Scripps Health Plan Services in San Diego.

Exhibit 3 shows the market share of California HMOs as of December 2005. Kaiser Permanente remains the largest plan in the state, with 34.8 percent of enrollment. Blue Cross is second largest, with 15.7 percent. Blue Shield grew in 2004 by adding CalPERS members, though it lost some of them when its hospital network was downsized. Blue Shield now has 13.0 percent of the HMO market in the state. Health Net has 9.5 percent and PacifiCare is in fifth place with 8.7 percent.

Of the remaining five large HMOs in the state, four are serving only public programs, including Medi-Cal and Healthy Families. While CalOptima and Inland Empire operate in only one or two counties, Molina Healthcare has public program enrollment in several counties. Molina has grown in San Diego County, for example, by acquiring the Medi-Cal and Healthy Families enrollment of two other plans.

Compared to the other states analyzed by the author, the HMO market in California is above average for concentration. At the end of 2005, the four largest HMOs had 73.3 percent of the HMO enrollment. The sidebar, "HMO Market Concentration" on page 16, 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 so that it is now among the more highly concentrated states.

The largest health plans have significant impacts on many aspects of California's market. Kaiser Permanente controls more than one-third of the HMO market in the state and is far and away the largest HMO overall. It is still common practice for medium and large employers to offer two HMO options: Kaiser and one of the large network model HMOs like PacifiCare or Blue Shield. In addition, Kaiser is the largest Medicare HMO in the state, with more than 780,000 seniors at the end of 2005. Kaiser has only a small program for Medi-Cal.

EXHIBIT 2. California HMOs at a Glance, 2005

Plan Web Site/Historical Notes	Headquarters	Owner/Manager/Other Affiliation	Year Begun as an HMO	HMO Enrollment December 2005*	Change from 2004	2005 Net Income (Loss)	Margin
Standard Plans							
Aetna Health of California www.aetna.com Acquired Prudential Health Care in 1999.	San Ramon	Aetna Health, Inc. Hartford, CT	1981	294,903	– 3.3%	$68,797,570	7.3%
Blue Cross of California www.bluecrossca.com Acquired membership of Omni Healthcare (Sacramento) in 1999.	Woodland Hills	WellPoint Health Networks Thousand Oaks, CA	1993	2,960,786	1.4%	680,397,000	6.0%
Blue Shield of California www.blueshieldca.com Organized and licensed as California Physicians' Service; acquired CareAmerica in 1998.	San Francisco	California Physicians' Service	1978	2,458,689	– 0.7%	329,492,000	4.4%
Care 1st Health Plan www.care1st.com	Alhambra		1995	192,429	19.4%	5,483,072	1.8%
CareMore Insurance Services www.caremoremedical.com Doing business as California Health Plan and California Medicare Advantage.	Cerritos	CareMore Medical Group	2002	20,078	9.0%	18,146	9.3%
Chinese Community Health Plan www.cchphmo.com	San Francisco		1987	12,540	12.8%	1,171,668	1.9%
CIGNA HealthCare of California www.cigna.com Formerly Ross Loos Health Plan and Equicor.	Glendale	CIGNA Healthcare, Inc. Philadelphia, PA	1978	79,562	– 0.5%	13,141,643	1.5%
Community Health Group www.chgsd.com	Chula Vista		1985	99,660	– 0.5%	– 1,413,277	– 1.2%
Community Health Plan www.ladhs.org/chp	Los Angeles	LA County Department of Health Services	1985	160,056	– 0.3%	15,690,799	7.8%
Great-West Health Care www.mygreatwest.com	San Jose	Great-West Life Assurance Co., Englewood, CO	1996	60,131	2.3%	6,011,727	3.6%
Health Net www.health.net Merged with Foundation Health of California.	Woodland Hills	Health Net	1979	1,788,238	– 4.4%	174,631,467	2.7%
Honored Citizens Choice Health Plan, Inc.	Los Angeles		2004	164	NA	– 993,260	NA
Inter Valley Health Plan www.ivhp.com Only Medicare business	Pomona		1979	12,996	– 4.7%	4,432,113	3.8%
Kaiser Foundation Health Plan, Inc. www.kaiserpermanente.org	Oakland		1977†	6,588,510	2.0%	1,009,019,000	3.2%
Molina Healthcare of California www.molinahealthcare.com	Long Beach	Molina Healthcare, Inc.	1994	320,223	26.7%	1,127,225	0.3%
On Lok Senior Health Plan www.onlok.org	San Francisco		1999†	936	– 0.7%	1,805,999	3.0%
PacifiCare of California www.pacificare.com Acquired FHP, which had acquired TakeCare in 1994. Was acquired by UnitedHealth Group in 2005.	Cypress	PacifiCare Health Systems	1975	1,644,098	– 4.9%	200,269,000	3.0%
SCAN Health Plan www.scanhealthplan.com	Long Beach		1984	78,493	19.9%	141,681,085	14.2%
Sharp Health Plan www.sharp.com	San Diego		1992	51,346	– 58.6%	23,181,531	15.6%

EXHIBIT 2. California HMOs at a Glance, 2005, cont.

Plan Web Site/Historical Notes	Headquarters	Owner/Manager/Other Affiliation	Year Begun as an HMO	HMO Enrollment December 2005*	Change from 2004	2005 Net Income (Loss)	Margin
Standard Plans, cont.							
Sistemas Medicos Nacionales, S.A. de C.V. www.simnsa.com	San Diego	Simnsa Health Care Tijuana, Mexico	2000	0	– 100.0%	NA	NA
Universal Care www.universalcare.com	Signal Hill	Howard E. Davis	1985	266,073	– 8.5%	$4,446,395	1.0%
Includes enrollees absorbed from Great American Health Plan and Health Max America/HMO California.							
Valley Health Plan http://claraweb.co.santa-clara.ca.us/vhp/	San Jose	Santa Clara County	1985	57,180	– 1.5%	485,950	0.5%
Formed to serve Santa Clara County employees and retirees.							
Ventura County Health Care Plan www.vchca.org/hcp/index.htm	Ventura	Ventura County	1996	9,888	– 2.3%	14,507	0.1%
WATTSHealth (UHP Healthcare) www.uhphealthcare.com	Los Angeles	WATTS Health Foundation	1978	88,070	– 4.2%	5,141,000	2.8%
State regulators took control in August 2001. Conservatorship was terminated by court order in November 2003. Re-entered bankruptcy in 2005.							
Western Health Advantage www.westernhealth.com	Sacramento	Sponsored by Mercy Healthcare Sacramento, NorthBay Healthcare System and the University of California – Davis Health System	1997	82,033	– 18.0%	3,355,074	1.7%
County Organized Health Systems and Local Initiative Plans							
Alameda Alliance for Health www.alamedaalliance.com	Alameda	Alameda County	1995	92,949	0.4%	– $5,652,656	– 4.0%
CalOptima www.caloptima.org	Orange	Orange County Organized Health System	2000	303,225	1.6%	– 24,374,130	– 3.0%
Formal name is Orange Prevention and Treatment Integrated.							
Central Coast Alliance for Health www.ccah-alliance.org	Santa Cruz	Santa Cruz-Monterey Managed Medical Commission	2000	85,789	2.3%	– 17,405,750	– 7.5%
Contra Costa Health Plan www.cchealth.org/health_plan/	Martinez	Contra Costa County Health Services Department	1973	64,123	1.4%	327,977	0.2%
Inland Empire Health Plan ww2.iehp.org/iehp	San Bernardino	Joint powers agreement agency created by San Bernardino and Riverside Counties	1996	302,224	8.8%	6,344,129	1.9%
Kern Health Systems	Bakersfield		1995	90,842	– 2.0%	– 141,107	– 0.1%
L.A. Care (Local Initiative Health Authority) www.lacare.org	Los Angeles	Local Initiative Health Authority for Los Angeles County	1997	797,487	68.1%	14,102,090	1.5%
Partnership Health Plan of California www.partnershiphp.org	Suisun City	Solano-Napa Commission on Medical Care	1994	84,629	3.2%	NA	NA
Also serves Medi-Cal recipients in Yolo County.							
San Francisco Health Plan www.sfhp.org	San Francisco	San Francisco Health Authority	1996	50,049	6.5%	11,364,781	13.6%
San Joaquin County Health (Health Plan of San Joaquin) www.hpsj.com	Stockton	San Joaquin County Health Commission	1996	74,793	28.4%	2,840,898	3.3%
San Mateo Health Commission (Health Plan of San Mateo) www.hpsm.org	South San Francisco	San Mateo Health Commission	1998	57,527	1.5%	– 1,486,497	– 1.1%
Santa Barbara Health Initiative www.sbrha.org	Goleta	Santa Barbara County Special Healthcare Authority	2000	56,744	1.8%	1,891,937	1.2%
Santa Clara Family Health Plan www.scfhp.com	San Jose	Santa Clara County Health Authority	1996	96,092	– 0.6%	1,761,464	1.3%

EXHIBIT 2. California HMOs at a Glance, 2005, cont.

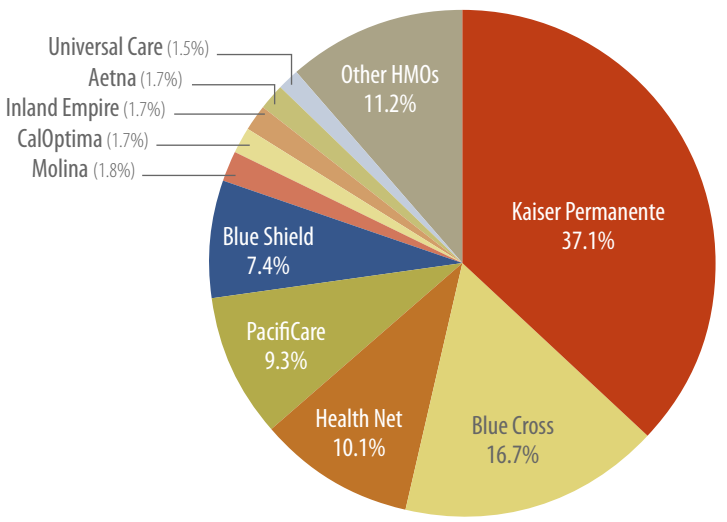
Plan Web Site/Historical Notes	Headquarters	Owner/Manager/Other Affiliation	Year Begun as an HMO	HMO Enrollment December 2005*	Change from 2004	2005 Net Income (Loss)	Margin
Limited License Health Plans							
Heritage Provider Network www.heritageprovidernetwork.com	Reseda		1997	257,882	5.2%	$2,725,614	0.4%
PrimeCare Medical Network www.nammcal.com	Ontario	North American Medical Management, California	1998	230,814	0.5%	1,668,713	1.6%
Scripps Clinic Health Plan Services www.scrippshealth.org	La Jolla	Scripps Clinic	1999	38,326	– 46.2%	67,497	0.1%

NA: Not available.
*See Exhibit 5 notes for adjustments made to reported enrollment.
†On Lok Senior Health Services commenced business in 1971, Kaiser in 1955.

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

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

EXHIBIT 3. Market Share for California HMOs, 2005 — Total Enrollment: 17,778,137



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

Kaiser had strong net income in the past three years and has embarked on a multi-billion dollar program of constructing or reconstructing its hospitals and health centers. In addition, it is investing in information technology, including electronic medical records. On the benefit design side, it is marketing benefit plans with higher deductibles in an effort to retain or win accounts with employers who think that comprehensive HMO coverage is too costly.

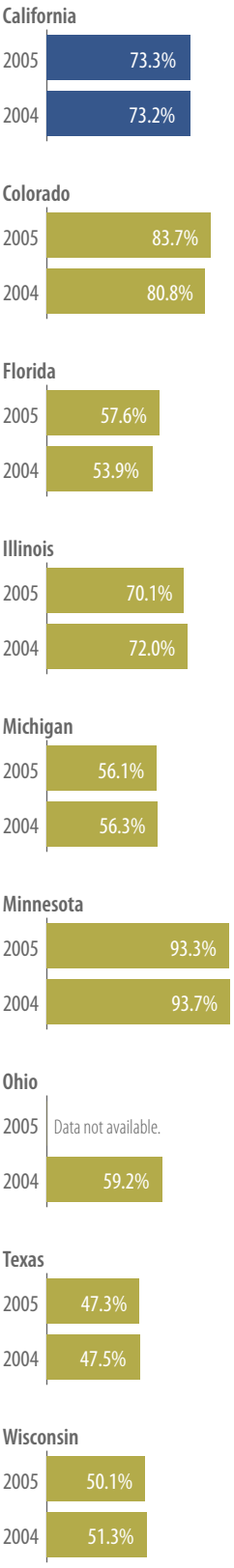
The Kaiser system is also one of the biggest provider organizations in the state. Although its strategy has not always been consistent, Kaiser's central strategy today is to do as much as possible with its own providers. As it opens new medical centers and hospitals, it is notifying members that they will have to see Permanente Medical Group doctors and be admitted to Kaiser Foundation hospitals. This development is taking business away from established providers that Kaiser had previously relied upon. For example, in places like Ventura County and the Inland Empire, Kaiser had contracted with independent physician groups to serve its members, and in other parts of the state, it had admitted its members to non-Kaiser hospitals.

Kaiser received significant negative attention in 2006 when it was discovered that its kidney transplant program in northern California, opened in 2004, was not serving patients well, and had blocked some of them from getting compatible organs through transplant programs at University of California medical centers. State regulators imposed large fines on Kaiser and it agreed to shut down its San Francisco transplant program and transfer Kaiser patients back to the other transplant programs in the area.

Wellpoint, Inc., the parent of Blue Cross of California, has grown its California operations and continued its national expansion. In 2004 it was acquired by Anthem Blue Cross Blue Shield to form a $21.8 billion company based in Indianapolis, with 26 million enrollees. Soon afterwards, it added the largest Blue Cross plan in New York. For a short time, WellPoint was the largest health insurance company in the country,

HMO Market Concentration

Portion of HMO enrollees in selected states enrolled in the four largest HMOs at the end of 2004 and 2005.



leaping over UnitedHealthcare. However, United regained the number one position with its acquisition of PacifiCare. WellPoint operates Blue Cross Blue Shield licenses in states from New England to Georgia, from Colorado to Missouri, and north to Wisconsin. It operates health plans under the UniCare name in states where there is a competing Blue Cross plan.

What might the future hold for WellPoint, Inc.? And how will providers and employers in California be affected? In California, WellPoint has distinguished itself through its successful operations of Medicaid managed care (it is by far the largest plan here), and in designing and marketing plans to small businesses. Anthem has now acquired a Medicaid HMO in Cleveland and sought other contracts in Ohio, and has expressed interest in adding contracts in other states. WellPoint is also exporting some other California Blue Cross products to other states. The Anthem plan in Colorado, for example, is marketing Tonik, a limited benefits insurance plan for "20-somethings" launched originally in California.

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

UnitedHealthcare's acquisition of PacifiCare will change the California market in several ways. First, United is changing its approach to employers in the state. Several years ago, preferring to operate in California with its UniPrise business unit administering benefit plans to large, self-funded employers operating in multiple sites, United dropped out of the state's HMO market and began to rent the Blue Shield provider network. Now, with the acquisition of PacifiCare and its extensive provider network, United will no longer work with Blue Shield. In turn, Blue Shield will compete more aggressively for companies that are now United customers.

In addition, the PacifiCare acquisition was seen as complementing United in key geographic areas (California, Colorado, and Texas) and with PacifiCare's strong senior plans. United has now reorganized its senior plans, including Medicare Advantage and Part D prescription drug plans, into a company using PacifiCare's senior brand name of Secure Horizons. It has created a company within a company to develop and market the full range of senior products, one that will provide formidable competition to other health plans.

In interviews with hospital executives, several expressed concerns that authority in WellPoint and PacifiCare seems to have left the state, forcing hospitals to deal with people who take their directions from Minnesota or Indiana. Another concern is that the WellPoint and PacifiCare teams in California are not getting adequate direction from Minnesota or Indiana during the transition period, leaving everyone confused. Hospital leaders also commented that their power in health plans negotiations has waned compared to recent years, and that they are facing strong pricing pressures from WellPoint and United.

California has experienced several major health plan insolvencies so far in this decade. Five plans were liquidated or closed their doors since 2000: Health Plan of the Redwoods, Lifeguard, Maxicare of California, and Tower Health are out of business. WATTSHealth recovered briefly, but returned to bankruptcy protection in 2005.

PPOs

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

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

A larger employer may find it advantageous to self-fund its plans for several reasons. It can profit from the "float" of its benefit dollars, meaning that it can hold on to those funds and earn interest until it is time to pay the claims. In addition, the employer has more flexibility to design its benefit plans since self-funded plans are generally exempt from state laws mandating benefits (such as coverage of inpatient care for chemical dependency, or access to certain providers such as chiropractors). By self-funding its benefit plan, a company with locations in several states can also simplify plan administration and offer a national benefit plan without having to work with separate insurance companies or HMOs in each state. Some health plan companies, including UnitedHealthcare and some of the Blue Cross plans, focus on that market segment, competing for business from those large, self-funded employers that operate in more than one state.

While the move to a PPO has some clear advantages to employers, the benefit to consumers is less clear. Whether in a self-funded or insured plan, an enrollee in a PPO arrangement is likely to pay higher co-payments or deductibles when accessing care. However, enrollees may also have easier access to physicians, particularly specialists.

State Regulation

Two state agencies have authority for oversight of health insurance in California:

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

Although the CDI's jurisdiction is somewhat limited in statute, it provides its commissioner with a "bully pulpit" to advocate on health policy matters in general or on specific issues. For example, the department had a significant impact on the final details of Anthem's acquisition of WellPoint Health Networks. After Anthem had secured approvals from all other federal and state regulators, including the DMHC, the CDI announced that it would not approve the transaction, saying that it was too costly to California consumers. Anthem sued to overturn that decision, but eventually reached an agreement with the CDI that allowed the deal to be completed.

From time to time legislators and others have proposed that all health insurance regulation be combined in a single agency, so that state government would provide consistent oversight and speak with one voice. So far, those proposals have not prevailed. More recent proposals would give the CDI more authority to set standards for the benefit plans that it oversees.

The DMHC responded vigorously in two recent cases that involved allegations of health plan misconduct on a broad scale. In the first case, Kaiser Permanente had established an organ transplant program in northern California and had required Kaiser members waiting for transplants to leave other transplant centers. After identifying deficiencies in the program, the DMHC forced Kaiser to close the program and transfer patients back to academic health centers. It also imposed a $2 million fine on Kaiser. In the second instance, former enrollees of Blue Cross complained that the insurer retroactively rescinded their coverage, citing undisclosed pre-existing conditions, after those enrollees had incurred large expenses for procedures that were covered by their Blue Cross plans. The DMHC imposed a fine of $200,000 on Blue Cross in one case and initiated an administrative rulemaking procedure to clarify an HMO's obligations during underwriting and claims processing.

The DMHC and legislators have sought at different times to provide more aggressive oversight of the financial health of physician organizations in the state. A 1999 statute (AB 260) had established four criteria for the finances of certain physician groups. The Department's original reporting requirements,

Who Represents Providers in California?

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

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

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

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

based on its reading of the statute, were blocked by a lawsuit brought by the California Medical Association in 2002. The CMA argued that the DMHC, by posting financial data on medical groups online, had exceeded its authority and that the disclosures of medical group finances would put physicians at a disadvantage in their health plan negotiations. The DMHC revised its administrative rules and launched a limited program of oversight and reporting in 2005. The first reports collected from the medical groups are now available at the DMHC Web site (www.dmhc.ca.gov).

Some of that data has been added to the physician organization tables in Section 4.0 of this report.

2.3 Hospital Systems and Networks

The emergence of hospital systems and networks was the key development of the 1990s and the beginning of this century. That consolidation gave hospitals significant economic power in their dealings with health plans and physicians. There is wide variation in how hospitals are connected, including types of governance, ownership, integration of administration and of clinical services, and so on.

Hospital SYSTEMS, as compared to hospital networks, are more tightly integrated in some aspects of operation such as ownership and administrative governance. Administration is largely centralized — e.g., the system will have a single chief financial officer instead of each hospital having one. 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.

A NETWORK of hospitals is more loosely affiliated than a hospital system, and usually maintains separate ownership and board governance for participating hospitals. Networked hospitals come together for specific administrative functions, which usually include negotiation of managed care contracts. It is not unusual for networks of hospitals to break up 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 previously lost to HMOs. During the heyday of HMOs, hospitals and physicians worried that they would lose access to patients if they did not accept HMO contracts, even when they thought that payment was inadequate. Through system-building and more strategic negotiation, hospitals now send the message to managed care companies that the HMOs need those hospitals in order to sell insurance, either because of the hospitals' geographic dominance, their brand names, or sometimes both.

Hospital systems and networks have used their renewed economic power in a variety of ways. First, they have pressed HMOs to negotiate system-wide contracts and agree to use all hospitals and services in the system or network. This was a way of leveraging the position of critical hospitals to gain contracts for hospitals less critical to HMO networks.

Second, hospitals have used their economic power to change the terms of contracts. Most of the major hospital systems in California limited their acceptance of risk several years ago by ending their participation in global capitation arrangements in which they and local medical groups shared in health plan payments, downside risk, and upside rewards. That willingness by hospitals to share risk was once the rule and is now the exception.

But hospitals are also facing significant challenges. Staffing is a perennial challenge, as large numbers of nurses and other health workers prepare to retire or find they can pursue their careers in less stressful settings. Another issue, as was mentioned earlier, is the inflation in building materials that is ballooning the cost of hospital construction projects. Still, given the pressure of seismic retrofit legislation deadlines, new construction

continues in full swing. Finally, Kaiser's expansion of its own hospitals and medical centers is creating significant new competition.

System affiliations change through acquisitions and through decisions to end affiliations. In the last few years, the major for-profit hospital systems have undergone significant changes. Tenet Health, battered from national and local scandals on Medicare billings and other issues, has sold off several of its hospitals in southern California where it still has sizable market share. HCA: The Healthcare Company has also closed or sold some of its California hospitals. In addition, some entrepreneurs have seen an opportunity to build new networks by acquiring Tenet and HCA hospitals. For example, AHMC, a physician-owned hospital company, bought four of Tenet's hospitals in southern California. Plymouth Health of Sherman Oaks was formed to buy Tenet's Alvarado hospital in San Diego.

The following analysis examining California's hospital systems 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 2004. (It takes almost a year until the data from each reporting year are submitted, reviewed, and then made available to the public.) This analysis is generally limited to acute care hospitals and does not include specialty hospitals for rehabilitation, long-term care, or mental health; state facilities for people with mental illness or developmental disabilities; or hospitals operated by the U.S. Department of Veterans Affairs or other federal agencies.

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

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

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 and specialized products. For example, the geographic market for specialized pediatric care in children's hospitals might be different than the geographic market for other acute care services. For the most part, this analysis uses relatively broad geographic areas for the local market analysis and does not attempt to distinguish the market for specialty services. More detailed information on the acute care hospitals, including their revenues, net income, occupancy, and payer mix, is presented in Section 4.0, Regional Submarkets and Provider Systems.

Major Hospital Systems

Exhibit 4 provides an overview of the largest hospital systems in California. Measured by inpatient hospital days or staffed beds, the two largest hospital systems in California in 2004 were Catholic Healthcare West (CHW) and Tenet Health. However, if the systems were compared based on net patient revenues (hospital charges less discounts and bad debts), the two largest systems were Kaiser Foundation and Sutter Health.

Of the largest systems, CHW and Kaiser came closest to a statewide presence. CHW has its headquarters in San Francisco. It was formed by Catholic health organizations that retained ownership of their hospitals but created CHW to gain operating efficiencies and brand recognition. Similar Catholic systems have formed in other parts of the country. CHW now has about 34 hospitals in the state.

Many of Kaiser's 28 hospitals are in the San Francisco Bay Area and Los Angeles, though it also has hospitals in other areas including Sacramento, Fresno, Santa Rosa, and San Diego. Where it doesn't have its own hospital, Kaiser

Provider Representives, cont.

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

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

EXHIBIT 4. Largest California Hospital Systems at a Glance, 2004

System and Locations	Staffed Beds	Inpatient Days	Inpatient Occupancy	Outpatient Visits	Net Patient Revenue	Net Income (Loss)	Margin
Adventist www.adventisthealth.org	1,927	541,496	62.6%	1,789,710	$1,237,268,955	$1,536,790	0.1%
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 and Health Center (Deer Park), Ukiah Valley Medical Center, White Memorial Medical Center (Los Angeles), San Joaquin Community Hospital (Bakersfield)							
Catholic Healthcare West www.chwhealth.com	6,867	1,716,351	60.4%	3,628,088	3,900,373,179	59,468,205	1.5%
35 Bakersfield Memorial Hospital, California Hospital Medical Center (Los Angeles), Community Hospital of San Bernardino, Dominican Santa Cruz Hospital–Soquel, Glendale Memorial Hospital, La Palma Intercommunity Hospital, Long Beach Community Medical Center, Marian Medical Center (Santa Maria), Mark Twain St. Joseph's Hospital (San Andreas), Martin Luther Hospital Medical Center (Anaheim), Mercy General Hospital, Mercy Hospital and Health Services (Merced), Mercy Hospitals (Bakersfield, Folsom and Mt. Shasta), Mercy Medical Center (Redding), Mercy San Juan Hospital (Carmichael), Mercy Westside Hospital (Taft), Methodist Hospital of Sacramento, Northridge Hospital Medical Center, Northridge Hospital Medical Center Sherman (Van Nuys), Oak Valley District Hospital (Oakdale), San Gabriel Valley Medical Center, Sequoia Hospital (Redwood City), Sierra Nevada Memorial Hospital (Grass Valley), St. Bernardine Medical Center (San Bernardino), St. Dominic's Hospital (Manteca), St. Elizabeth Community Hospital (Red Bluff), St. Francis Medical Center (Santa Barbara), St. Francis Memorial Hospital (San Francisco), St. John's Pleasant Valley Hospital (Camarillo), St. John's Regional Medical Center (Oxnard), St. Joseph's Behavioral Health Center (Stockton), St. Joseph's Medical Center of Stockton, St. Mary Medical Center (Long Beach), St. Mary's Medical Center (San Francisco), Woodland Memorial Hospital							
Daughters of Charity Health System www.dochs.org	1,446	400,212	63.4%	816,445	873,680,101	(30,833,848)	–3.5%
7 O'Connor Hospital (San Jose), Robert F. Kennedy Medical Center (Hawthorne), Seton Medical Center (Daly City), Seton Medical Center–Coastside (Moss Beach), St. Francis Medical Center (Lynwood), St. Louise Health Center (Gilroy), St. Vincent Medical Center (Los Angeles)							
HCA: The Healthcare Company www.hcahealthcare.com	770	273,707	59.1%	489,769	827,288,024	(39,618,219)	–4.8%
5 Good Samaritan Hospital (San Jose), West Hills Medical Center, Los Robles Regional Medical Center, Regional Medical Center (San Jose), San Jose Medical Center							
Kaiser Foundation www.kaiserpermanente.org/locations/california	4,436	1,439,778	63.4%	472,279	7,892,258,449	1,042,161,885	13.2%
25 Kaiser Foundation Hospitals in Anaheim, Baldwin Park, Bellflower, Fontana (Chemical Dependency Program), Fresno, Harbor City, Hayward, Los Angeles (Sunset), Oakland Campus, Panorama City, Redwood City, Riverside, Sacramento, San Diego, San Francisco (Geary), San Jose (Santa Teresa Community Hospital), San Rafael, Santa Clara, Santa Rosa, South Sacramento, South San Francisco, Vallejo, Walnut Creek, West Los Angeles, Woodland Hills							
St. Joseph www.stjhs.org	970	235,172	63.4%	653,219	763,571,615	85,418,939	11.2%
10 Mission Hospital Regional Medical Center (Mission Viejo), North Coast Health Care Center-Sotoyom (Santa Rosa), Petaluma Valley Hospital (Petaluma), Queen of the Valley Hospital (Napa), Redwood Memorial Hospital (Fortuna) Santa Rosa Memorial Hospital, St. Joseph Hospital (Eureka), St. Joseph Hospital (Orange), St. Jude Medical Center (Fullerton), St. Mary Regional Medical Center (Apple Valley)							
Scripps www.scrippshealth.org	894	320,477	69.5%	497,825	911,179,825	37,693,696	4.1%
5 Green Hospital of Scripps Clinic (La Jolla), Scripps Memorial Hospitals (Chula Vista, Encinitas and La Jolla), Scripps Mercy Hospital (San Diego)							
Sharp www.sharp.com	1,661	457,334	72.9%	1,015,587	953,605,967	13,840,021	1.5%
7 Grossmont Hospital (La Mesa), Sharp Cabrillo Hospital (San Diego), Sharp Chula Vista Medical Center, Sharp Coronado Hospital and Healthcare Center, Sharp Healthcare Murrieta, Sharp Mary Birch Hospital For Women (San Diego), Sharp Memorial Hospital (San Diego)							
Sutter www.sutterhealth.org	4,701	1,236,149	65.8%	3,835,976	4,302,406,745	421,266,359	9.8%
24 Alta Bates Medical Center (Berkeley), California Pacific Medical Center (San Francisco), Eden Medical Center (Castro Valley), Laurel Grove Hospital (Castro Valley), Marin General Hospital (Greenbrae), Memorial Hospital Modesto, Mills-Peninsula Medical Center (Burlingame), Novato Community Hospital, St. Luke's (San Francisco), Sutter Amador Hospital (Jackson), Sutter Auburn Faith Hospital, Sutter Center For Psychiatry (Sacramento), Sutter Coast Hospital (Crescent City), Sutter Davis Hospital, Sutter Delta Medical Center (Antioch), Sutter General Hospital (Sacramento), Sutter Lakeside Hospital (Lakeport), Sutter Maternity and Surgery Center (Santa Cruz), Sutter Medical Center of Santa Rosa, Sutter Memorial Hospital (Sacramento), Sutter Merced Medical Center, Sutter Roseville Medical Center, Sutter Solano Medical Center (Vallejo), Sutter Tracy Community Hospital							

EXHIBIT 4. Largest California Hospital Systems at a Glance, 2004, cont.

System and Locations	Staffed Beds	Inpatient Days	Inpatient Occupancy	Outpatient Visits	Net Patient Revenue	Net Income (Loss)	Margin
Tenet www.tenethealth.com	7,074	1,640,203	62.4%	2,654,584	$3,740,685,294	($159,998,306)	– 4.3%
39 Alvarado Hospital Medical Center (San Diego), Brotman Medical Center (Culver City), Centinela Hospital Medical Center (Inglewood), Century City Hospital (Los Angeles), Chapman Medical Center (Orange), Coastal Communities Hospital (Santa Ana), Community and Mission Hospitals (Huntington Park), Community Hospital of Los Gatos, Daniel Freeman Marina Hospital (Marina Del Ray), Daniel Freeman Memorial Hospital (Marina Del Ray), Desert Regional Medical Center (Palm Springs), Doctors Hospital of Manteca, Doctors Medical Center, Doctors Medical Center (Pinole and San Pablo), Encino Tarzana Regional Medical Center (Encino), Encino Tarzana Regional Medical Center (Tarzana), Fountain Valley Regional Hospital and Medical Center – Euclid (Fountain Valley), Garden Grove Hospital and Medical Center, Garden Grove Garfield Medical Center, Monterey Park Greater El Monte Community Hospital, South El Monte Irvine Medical Center (Irvine), John F. Kennedy Memorial Hospital (Indio), Lakewood Regional Medical Center – South, Los Alamitos Medical Center, Midway Hospital Medical Center (Los Angeles), Monterey Park Hospital, North Hollywood Medical Center, Placentia – Linda Community Hospital (Placentia), Queen of Angels – Hollywood Presbyterian Medical Center (Los Angeles), Rancho Springs Medical Center (Murrieta), Redding Medical Center, San Diego Rehabilitation Institute, San Dimas Community Hospital, San Ramon Regional Medical Center, Santa Ana Hospital Medical Center, Sierra Vista Regional Medical Center (San Luis Obispo), St. Luke Medical Center (Pasadena), Suburban Medical Center (Paramount) Tustin Rehabilitation Hospital, Twin Cities Community Hospital (Templeton), University of Southern California University Hospital (Los Angeles), Valley Community Hospital (Santa Maria), Western Medical Center (Anaheim), Western Medical Center (Santa Ana), Whittier Hospital Medical Center							
University of California*	3,040	793,796	70.1%	3,315,187	3,707,713,009	(141,590,717)	– 3.8%
8 Medical Center at the University of California (San Francisco), Langley Porter Psychiatric Institute (San Francisco), UCLA Medical Centers (Santa Monica and Los Angeles), UCLA Neuro-psychiatric Hospital (Los Angeles), University of California – San Diego Medical Center, University of California – Davis Medical Center (Sacramento), University of California Irvine Medical Center (Orange)							

*In their audited financial statements for 2004, the University of California Medical Centers reported positive net income of $180,155,000. The difference in the results is explained in the text accompanying this Exhibit and in notes to Exhibits 30, 34, 40, and 49.

Source: Author's analysis of annual financial report worksheet data prepared by the Office of Statewide Health Policy and Development. Data are for fiscal years ending between January 1 and December 30, 2004. System affiliations reflect arrangements in 2004.

contracts with community hospitals for inpatient care. For example, in northern San Diego County, it uses the two Palomar Pomerado hospitals for inpatient care (though it has never ruled out adding its own hospital there in the future).

During a brief period in the late 1990s Kaiser reduced its investment in new facilities and contracted out as necessary for member care. More recently, Kaiser has switched direction and launched very ambitious plans to construct new facilities in the state. It plans major expansions to several of its hospital locations including Sacramento, and is building new hospitals in some communities where it has had difficulty negotiating rates with locally dominant hospitals.

In 2004, the Kaiser hospitals increased their net income from $673.2 million to $1.042 billion on patient revenues of $7.9 billion. In its financial reports to the state, Kaiser combines the financial data for its hospitals into two reports, one for northern California and one for southern California. Due to Kaiser's reporting method, it is not possible to compare the net income of individual Kaiser hospitals or even to isolate the Kaiser hospitals in the Bay Area or Los Angeles for analysis.

Most of Tenet's 39 California hospitals (as of 2004) were in Los Angeles County and Orange County, although Tenet also had (and continues to have) a few locations in other parts of the state. Around the country, most Tenet hospitals are smaller community facilities. In 2004 and 2005, Tenet sold several of its California hospitals as part of a national strategy of downsizing. It has been in deep legal difficulties at the corporate level and at some of its local facilities, including charges of overbilling the Medicare program for outliers (extremely high-cost Medicare cases). At Alvarado hospital in San Diego, the chief executive and the hospital faced charges of paying kickbacks to physicians to refer Medicare patients to the hospital. In 2004, Tenet's California hospitals suffered a loss of $160 million, compared to net income of $706.7 million in 2003. Tenet has replaced many of its leaders and negotiated a comprehensive settlement with federal prosecutors. It hopes to put its troubles well behind it.

Sutter hospitals have 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 25 hospitals with 4,700 staffed beds. Sutter hospitals had net patient revenue in 2004 of $4.3 billion and net income of $421 million.

Other Hospital Systems

Smaller hospital systems in the state have been able to exert significant power in local sub-markets where they control a large proportion of the hospital capacity or have developed brand recognition. For example, the two John Muir hospitals provide much of the hospital care in Walnut Creek and nearby communities. A third John Muir hospital is planned in the eastern part of Contra Costa County.

The other major investor-owned (for-profit) hospital system in the state is HCA: The Healthcare Company (formerly Columbia/HCA). In 2004, HCA had 190 hospitals nationwide and $21.8 billion in net patient revenue. In 2004 and 2005 HCA sold some of its properties in California (and in other states), resulting in a new crop of investor-owned hospital companies doing business in the state, including Pacific Health Corporation. HCA is now down to five California hospitals with about 770 staffed beds. They reported net patient revenues of $827.3 million in 2004 and a net loss of $39.6 million. California has not been a strong state for the company and it plans to further reduce its presence here. HCA closed San Jose Medical Center in December 2004. In 2006, HCA was sold to a group of investors including some of its top executives.

Exhibit 4 groups the eight University of California medical centers, including two specialty facilities. They are major providers of care to Medi-Cal recipients and patients without any coverage, and receive a large share of the state's special payments for hospitals serving poor patients. Combined, the hospitals reported net losses of $141.6 million on $3.7 billion in net patient revenue. This is based on the annual hospital reports prepared for OSHPD. Note that in their audited financial statements for 2004, the University of California medical centers reported positive net income of $180,155,000.

There are two main reasons for the difference of $322 million in reported financial results. First, three of the University of California hospitals (Davis, Irvine, and San Diego) made intergovernmental transfer (IGT) payments in 2004 that totaled $168 million. These payments are used to leverage federal funds that benefit these hospitals and other Medi-Cal providers. Even though the IGT dollars are not available to the medical centers, the transfers do not appear on their financial statements as expenses that reduce net income.

Second, different financial reporting systems are used by the UC hospitals and by the OSHPD. California hospitals reporting to OSHPD apply Generally Accepted Accounting Principles (GAAP) as promulgated by the Financial Accounting Standards Board. The University of California medical centers prepare their own financial statements using the accounting and reporting principles of the Government Accounting Standards Board. They then make adjustments to conform to the OSHPD reporting requirements. For example, the IGT payments and certain pension contributions or obligations are expensed on the OSHPD filings, reducing net income, but are treated as changes to net assets under the system used to prepare the UC hospitals' statements. The two methods reach the same results in the end. For each of the UC hospitals, net assets at the beginning of the year, changes to net assets and net assets at the end of the year are the same in their audited financial statements and in the OSHPD reports.

2.4 Physician Organizations

Risk sharing through capitation and medical management by physicians are two fundamentals of managed care that have largely disappeared in many parts of the United States. Those systems are still very prominent in California, although not to the same degree as in the past. According to various sources, there are between 250 and 350 organized physician groups in the state. Data from the Cattaneo & Stroud consulting firm show that ten organizations plus the two Permanente groups have contracts to provide care for almost 80 percent of managed care enrollees.

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. Physician groups deal with many if not most of these health plan wholesalers; by having large numbers of patients, medical groups are able to manage risk effectively and make investments in administrative and medical management.

However, that financial model may not work for a physician organization that is serving a growing proportion of PPO patients. As is noted elsewhere in this report, enrollment in commercial HMO plans is steadily declining, which has created a significant challenge for physician organizations: To what degree should they continue to provide the physician education and care management that are key elements of managing a capitated patient base? Physician groups will need to evaluate whether their investment in managing capitated patients is justified as their PPO patient base grows. Some medical groups interviewed for this report found that patients switched to a PPO specifically because they wanted to get away from what they saw as "HMO medicine" practiced in these medical groups. By "HMO medicine," they mean more restrictions on referrals to specialists, more limits on hospital admissions and lengths of stay, and more use of mid-level practitioners.

Medicare enrollees are important to many of these medical groups, and some are marketing Medicare Advantage plans to their patients. The payments have markedly improved in the past

few years, rekindling the interest of medical groups in taking risk for that population.

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

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

   Variations of the Kaiser model in California include combinations of employed physicians and contracted clinics. Molina Healthcare of California uses a combination of its own clinics and contracted physicians. Other health plans, including CIGNA in California and Florida, began with staff clinics, but later sold those clinics and switched to contracting for physician services.

   In recent years, Kaiser has added or planned new clinics and hospitals in several areas of the state where it previously did not have providers. It had previously relied on local clinics and hospitals to serve Kaiser members, but has steadily moved to reduce those relationships. In a recent example, it announced that it would open new clinics in Ventura County and terminate contracts with local medical groups. That development took an interesting twist when one of the medical groups that was about to lose its Kaiser patients decided to sell its practice to Kaiser.
2. CALIFORNIA DELEGATED MODEL. In the world outside of Kaiser, this model predominates. HMOs contract with medical groups or independent practice associations (IPAs) and delegate significant responsibilities to the physicians along with some financial risk. The HMO agrees to pay a capitated (fixed) monthly rate for every enrollee who chooses a primary care clinic within that group, retaining some percentage of the premium for administrative costs and profit.

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

More information about trends in the use of capitation is found in Section 3.9.

Physician Group Structures

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

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

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

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

Prominent medical groups include Healthcare Partners (www.healthcarepartners.com) in Los Angeles; Camino Medical Group (www.caminomedicalgroup.com), which is now affiliated with the Palo Alto Medical Foundation; San Jose Medical Group (www.sjgsmedgrp.com); Bright Medical Associates in the Los Angeles area; and Beaver Medical Group (www.beavermedgrp.com) in the Inland Empire of San Bernardino and Riverside Counties.

3. INDEPENDENT PRACTICE ASSOCIATIONS (IPAS). An IPA is an administrative vehicle for independent physicians or clinics that practice in their own private offices in the community. These physicians contract with the IPA, and the IPA, acting on behalf of the physicians, signs network contracts with one or more health plans. Physicians typically contract with more than one IPA and each IPA may account for only a small percentage of their patients. IPAs are especially common in northern California.

   Prominent California IPAs include the Brown and Toland Medical Group (www.brownandtoland.com) in San Francisco; Alta Bates Medical Group (www.altabatesmedicalgroup.com) in Oakland; Affinity Medical Group, Inc. (www.affinitymd.com, a "super-IPA" in the East Bay that includes a number of smaller IPAs); and Hill Physicians Medical Group, Inc. (www.hillphysicians.com) in the East Bay area. In many instances, the IPA contracts with a management services organization (MSO). In these cases, the IPA is the publicly visible doctors' group, and the MSO works in the background. For example, PriMed Management Consulting is the MSO for Hill Physicians in northern California.

   MSOs are discussed separately in number 5.

4. FOUNDATION MODEL. California law generally bars the corporate practice of medicine, so other structures were devised in which a hospital can have close ties to physicians. In the foundation model a hospital creates a foundation, which in turn purchases a physician practice. It is similar to a group practice in some respects, because the physicians are employed by the foundation and contract with health plans only through the foundation. A board governs the foundation with representatives of both the physicians and the hospital. The hospital may provide capital to the physicians through the foundation. Foundation model examples include John Muir/Mt. Diablo Health Network Foundation (www.jmmdhs.com) in the East Bay; Palo Alto Medical Foundation (www.pamf.org) in the South Bay; Scripps Clinic (www.scrippsclinic.com) in San Diego; and Adventist Health Southern California Medical Foundation.
5. MANAGEMENT SERVICE ORGANIZATIONS (MSOS). An MSO is not a physician organization as such, but provides administrative services to participating groups. Many physician groups, especially IPAs, contract with a management service organization that handles services including billing, collection, and administrative support. Some MSOs offer a full menu of services, including health plan contracting, quality management, utilization management, provider relations, member services, and claims processing.

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

   Tables in Section 4.0, Regional Sub-Markets and Provider Systems, present more detailed information about the largest physician groups in California.

Rewarding Physician Performance

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

C-section deliveries) are performed in different areas of the country. More troubling are recent findings that more money spent on care is likely to have worse, not better outcomes.

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

In the past three years a great deal of attention has been focused on the California Pay for Performance initiative launched by the Integrated Healthcare Association (IHA) and endorsed by six large health plans in the state, which have nearly 7 million commercial enrollees: Aetna, Blue Cross, Blue Shield, CIGNA, Health Net, and PacifiCare. Under the initiative (also known as P4P), these health plans evaluate medical groups in the state, based upon an agreed-upon set of measures. Some of the measures are clinical and correspond to HEDIS measures. Other measures are related to enrollee satisfaction as measured by the California Consumer Assessment Survey (CAS).

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 3.12 of this report.

Starting in 2004, performance bonuses have been paid to those physician groups that meet the P4P initiative's criteria. Each health plan decides for itself the size of the bonuses and exactly how they are distributed. While the health plans all use the combined data set, they all structure their incentive payments differently.

Bonuses paid in 2004 were between 2 percent and 5 percent of the base payments. The IHA estimated that more than $40 million was paid in bonuses through the initiative. In addition, Blue Cross has distributed additional bonuses to physicians and medical groups with both HMO and PPO contracts, using its own criteria. In 2004, these additional bonuses totaled $56.9 million paid to 134 medical groups. The medical groups interviewed for this report all said that Blue Cross probably accounted for at least half of their incentive payments. Further, much of those payments resulted from performance on two measures specific to Blue Cross, namely formulary compliance and generic prescribing rates.

The involved parties have announced some changes to the criteria for medical group operations and payments in 2005. More emphasis will be placed on information technology capabilities of the medical groups and some new clinical measures will be added.

Physicians have received the Pay for Performance initiative with enthusiasm mixed with a healthy dose of skepticism. How much money would be available for incentive payments and whether all of it would be "new money" are among the questions yet to be resolved. In seeking new money, physician groups don't want to collect bonuses paid from dollars they might have negotiated as base payment rates or that have been reassigned from previous incentive payment plans. In presentations at recent conferences, medical groups say that they are getting between 1 and 5 percent of revenues in the P4P payments. Is that significant? Yes, they say, especially when margins of 2 to 6 percent are typical. Are the incentive payments enough now to really influence how physicians practice? Most said probably not, though they pointed out that it depends on how the incentive dollars flow through the group, how much reaches individual doctors, and how the distributions are made.

While several questions remain unanswered, it appears that medical groups are beginning to diverge in their responses to the challenge posed by P4P. Some have embraced it, knowing that their performance scores will bring in a significant share of the available bonuses. Others are prepared to bypass it altogether and have passed on offers to "practice test" their data in enrollee satisfaction surveys. About 160 medical groups did participate in the enrollee satisfaction survey last year.

The California Pay for Performance 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 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 27, "Sources of Comparative Information on Health Plan and Provider Quality," lists several Web sites where consumers can obtain comparative information about health plans and physician groups in California.

Future Challenges, Future Relationships

The biggest challenge for physician organizations is maintaining and growing their patient base, particularly in light of the steady decline of enrollees with capitated HMO coverage. They need to invest in information technology such as electronic medical records and to spread the cost of those and other improvements across a broad base of patients.

Some physician groups have responded by trying to increase the number of patients with PPO coverage, but have been unsuccessful, or have had to change the medical management and administrative systems that they constructed for their capitated HMO contracts (discussed above). Others are showing renewed interest in Medicare patients at a time when Medicare HMOs have started to grow once more. Some physician groups have expanded their partnering with Medicare HMO plans, trading off lower payments or additional risk in anticipation of more patients. Others are skeptical that the new patients will materialize.

3.0 Trend Review

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

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

3.1 About This Analysis

The analysis in this section generally follows the template developed by the author in analyzing health plan markets in eight other states. (Ohio data for 2005 were not complete in time for this publication.) A series of sidebars in this section compares California HMOs with their counterparts in the other states (Colorado, Florida, Illinois, Michigan, Minnesota, Ohio, Texas, and Wisconsin) on measures such as commercial premium trend, profitability, use of capitation and so on. The data used in this analysis are generally available from public (state agency) sources, except that the HEDIS data are licensed through NCQA.

This analysis of HMO enrollment and finances is based on the annual and quarterly statements submitted by licensed health plans to the Department of Managed Health Care (DMHC). Portions of those reports are available to the public and can be downloaded in PDF format from the DMHC Web site. The tables in this section report data for health plan fiscal years ending in 2005. Commercial HMOs generally have fiscal years ending December 31 of each year, but almost all of the limited license plans and county-sponsored plans have June 30 year-ends.

California HMOs file annual and quarterly (and sometimes monthly) statements on forms prescribed by the DMHC. These statements are different from the ones used by HMO regulators in other states and the forms prescribed by the National Association of Insurance Commissioners (NAIC). California health plans also complete certain supplementary reports. One is used to calculate tangible net equity (TNE), a measure of the adequacy of a health plan's net worth, which is tied to, among other things, its sharing of risk with provider organizations.

To make the exhibits more useful, data on the six largest plans in the state are presented at the top of each table. Data on the smaller plans follow in alphabetical order. The county-sponsored Medi-Cal health plans appear in a separate group. Finally, data on the limited license plans are shown at the bottom of the table. Specific issues regarding data sources or methodology are addressed within individual sections.

3.2 HMO Enrollment

Several issues arise in analyzing California HMO enrollment. First is the question of whom to count: Should PPO members and self-funded ASO members reported by Blue

Sources of Comparative Information on Health Plan and Provider Quality

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

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

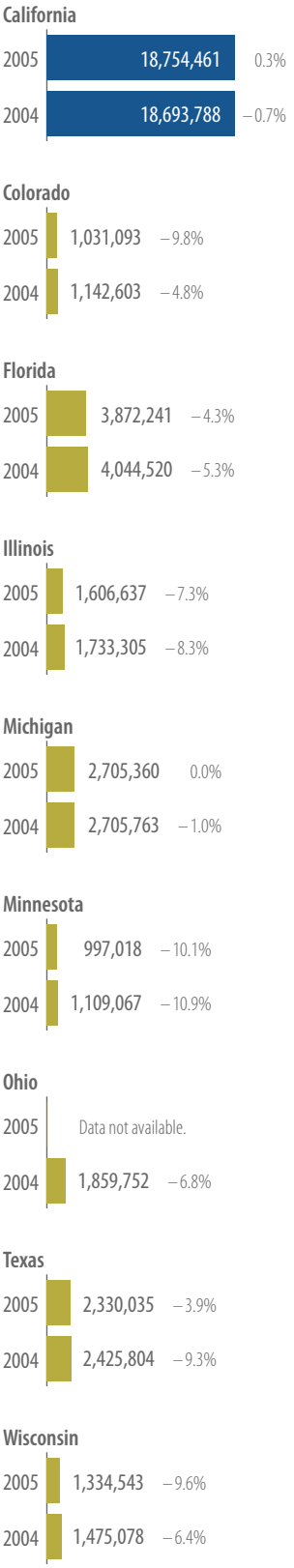
California Institute for Health System Performance
PEP-C survey, the Patients' Evaluation of Performance in California
www.calhospitals.org

Integrated Healthcare Association
Pay for Performance Report Cards
http://iha.org/p4prptcd.htm

Office of Public Advocate
2006 Quality of Care Report Card
www.opa.ca.gov/report_card

HMO Enrollment Growth

Selected state HMO enrollment in 2004 and 2005 and percentage change from the previous year.



Cross, Blue Shield, and CIGNA be counted as HMO enrollees? This analysis tries to draw the line at the separation between insured and self-funded, although the distinction is not always apparent in the health plan statements. So, PPO members for Blue Cross or Blue Shield are included in the tables and the calculations.

Second, there is a strong potential for double-counting enrollment: Some health plans subcontract many or all of their enrollees to other health plans, yet both report those members on their enrollment reports. For example, L.A. Care Health Plan, the local initiative plan run by Los Angeles County, subcontracts most of its 729,000 Medi-Cal enrollees to "health plan partners," namely these HMOs: Blue Cross, Care 1st, Community Health Plan, Kaiser Permanente, and WATTSHealth/United Health Plan (currently under state supervision). However, it does manage full risk for a much smaller number of enrollees in the Healthy Families Program. For that reason, L.A. Care is listed separately in some of the enrollment tables in this section, and its Medi-Cal enrollees are not included in the total row of those tables. In this report, enrollment was adjusted based on information that the health plans gave about their subcontracting arrangements.

There is also potential for double-counting enrollees who are reported by the limited license plans (Knox-Keene license with waivers health plans). For example, PacifiCare or Kaiser Permanente can contract out 100 percent of the care for a group of enrollees to a limited license plan. Each 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.

Enrollment data in the annual statements were supplemented by other sources. For Medi-Cal enrollment, monthly reports from the California Department of Health Services (DHS) were used to supplement the data in the HMOs' annual statements. The DHS reports list enrollment by plan and county. For Medicare enrollment, quarterly reports from the federal Centers for Medicare and Medicaid Services (CMS) on enrollment in Medicare HMOs by county and by plan were used. The author's estimates of commercial enrollment by region and plan were compared to the April 2005 survey results reported by the Cattaneo and Stroud consulting firm.

As shown in *Exhibit 5,* overall enrollment in California HMOs rose slightly in 2005. A year earlier enrollment had dropped by about 100,000 lives. Commercial enrollment declined for the fourth straight year, decreasing by almost 200,000 members in 2005. However, enrollment in Medicare HMO plans grew by 9.3 percent.

Because there is no comparable data on PPOs, it is not known where these former HMO members went. The survey data cited earlier supports the notion that many of them moved into PPO arrangements. And, as the percentage of the population with employer-sponsored health benefits continues to decline, it may be that some number of them have become uninsured altogether. Membership in Medi-Cal and Healthy Families HMO plans was basically flat in 2005.

Among the large HMOs, Kaiser added 127,000 lives, including nearly 100,000 commercial lives. It also added senior members to its Medicare Advantage and Cost plans. Molina added Medi-Cal and Healthy Families members in the San Diego area and moved into the ranks of large HMOs. Blue Cross also gained members, but Aetna, Blue Shield, and Health Net saw their HMO membership decline in 2005. Among smaller plans, Care 1st added new Medi-Cal members in Los Angeles County, and SCAN Health Plan, which is primarily a Medicare HMO, added about 13,000 new members. Only two of the county health plans did not gain enrollment in 2005. L.A. Care, Inland Empire, and San Joaquin County reported the biggest increases.

EXHIBIT 5. Enrollment in California HMOs, 2004 to 2005

Plan	Commercial	Medi-Cal/ Healthy Families	Medicare*	TOTAL	2004	2004 to 2005 Change %	2004 to 2005 Change Number
Largest HMOs							
Aetna Health	269,429	0	25,474	294,903	304,944	– 3.3%	– 10,041
Blue Cross	1,530,596	1,166,746	263,444	2,960,786	2,919,925	1.4%	40,861
Blue Shield	2,370,344	53,037	35,308	2,458,689	2,476,689	– 0.7%	– 18,000
Health Net	1,238,185	456,635	93,418	1,788,238	1,870,523	– 4.4%	– 82,285
Kaiser Permanente	5,679,385	711,612	197,513	6,588,510	6,461,779	2.0%	126,731
Molina Healthcare	0	320,223	0	320,223	252,737	26.7%	67,486
PacifiCare	1,289,000	0	355,098	1,644,098	1,728,838	– 4.9%	– 84,740
Universal Care	91,001	169,576	5,496	266,073	290,743	– 8.5%	– 24,670
Smaller HMOs							
California Health Plan (CareMore)	0	0	20,078	20,078	18,421	9.0%	1,657
Care 1st Health Plan	0	150,113	42,316	192,429	161,150	19.4%	31,279
Chinese Community Health Plan	6,637	0	5,903	12,540	11,115	12.8%	1,425
CIGNA Healthcare	79,562	0	0	79,562	79,994	– 0.5%	– 432
Community Health Group	6,460	93,200	0	99,660	100,114	– 0.5%	– 454
Community Health Plan	45,807	114,249	0	160,056	160,524	– 0.3%	– 468
Great West Health Care	60,131	0	0	60,131	58,800	2.3%	1,331
Honored Citizens	164	0	0	164	NA	NA	164
Inter Valley Health Plan	0	0	12,996	12,996	13,643	– 4.7%	– 647
On Lok Senior Health Services	0	34	902	936	943	– 0.7%	– 7
SCAN Health Plan	0	4,000	74,493	78,493	65,482	19.9%	13,011
Sharp Health Plan	51,346	0	0	51,346	124,108	– 58.6%	– 72,762
Sistemas Medicos Nacionales	0	0	0	0	14,102	– 100.0%	– 14,102
Valley Health Plan	9,497	38,280	9,403	57,180	58,066	– 1.5%	– 886
Ventura County	6,970	2,918	0	9,888	10,120	– 2.3%	– 232
WATTSHealth Plan	5,444	73,173	9,453	88,070	91,892	– 4.2%	– 3,822
Western Health Advantage	65,795	14,158	2,080	82,033	71,664	14.5%	10,369
County Health Plans and System							
Alameda Alliance for Health	5,536	87,413	0	92,949	92,580	0.4%	369
CalOptima	0	303,225	0	303,225	298,484	1.6%	4,741
Central Coast Alliance	0	84,874	915	85,789	83,877	2.3%	1,912
Contra Costa Health Plan	15,105	43,886	5,132	64,123	63,257	1.4%	866
Inland Empire Health Plan	1,488	290,685	10,051	302,224	277,741	8.8%	24,483
Kern Health Systems	0	90,842	0	90,842	92,689	– 2.0%	– 1,847
L.A. Care	0	68,393	0	68,393	40,687	68.1%	27,706
Partnership Health Plan	0	84,629	0	84,629	82,003	3.2%	2,626
San Francisco Health Plan	7,088	37,387	5,574	50,049	46,981	6.5%	3,068
San Joaquin County Health	3,118	64,212	7,463	74,793	58,270	28.4%	16,523
San Mateo Health Commission	6,444	51,083	0	57,527	56,655	1.5%	872
Santa Barbara Health Initiative	0	56,506	238	56,744	55,725	1.8%	1,019
Santa Clara Family Health Plan	12,623	83,469	0	96,092	96,665	– 0.6%	– 573
2005 TOTAL	**12,787,424**	**4,182,730**	**1,784,307**	**18,754,461**	**18,693,788**	**0.3%**	**60,673**
2004 TOTAL	12,982,005	4,079,163	1,632,620	18,693,788			
Change	– 1.5%	2.5%	9.3%	0.3%			
2005 Distribution by Program	68.2%	22.3%	9.5%				
2003 Distribution by Program	67.9%	23.1%	8.9%				

EXHIBIT 5. Enrollment in California HMOs, 2004 to 2005, cont.

Plan	Commercial	Medi-Cal/ Healthy Families	Medicare*	TOTAL	2004	2004 to 2005 Change %	2004 to 2005 Change Number
Limited License Plans and Other							
Heritage Provider Network	194,274	52,905	10,703	257,882	245,055	5.2%	12,827
L.A. Care (subcontracted Medi-Cal)	0	0	729,084	729,084	730,425	– 0.2%	– 1,341
PrimeCare Medical Network	207,803	23,011	0	230,814	229,743	0.5%	1,071
Scripps Clinics	23,671	14,655	0	38,326	71,193	– 46.2%	– 32,867

*Medicare includes Medicare Advantage, Cost and Supplement plans for 2004 and 2005.

Notes on adjustments from reported data:
Enrollment in ASO, PPO, and other self-funded plans adjusted out for Blue Cross (1,589,426 lives), Blue Shield (262,792 ASO and 1,136,380 PPO), and CIGNA (262,901 in FlexCare). Medi-Cal subcontracting adjusted for CalOptima, Health Net, and L.A. Care. Dental plan enrollment adjusted for WATTSHealth and Universal. Kaiser dual eligibles added to Medicare Risk and Deductible HMO added to Commercial groups.

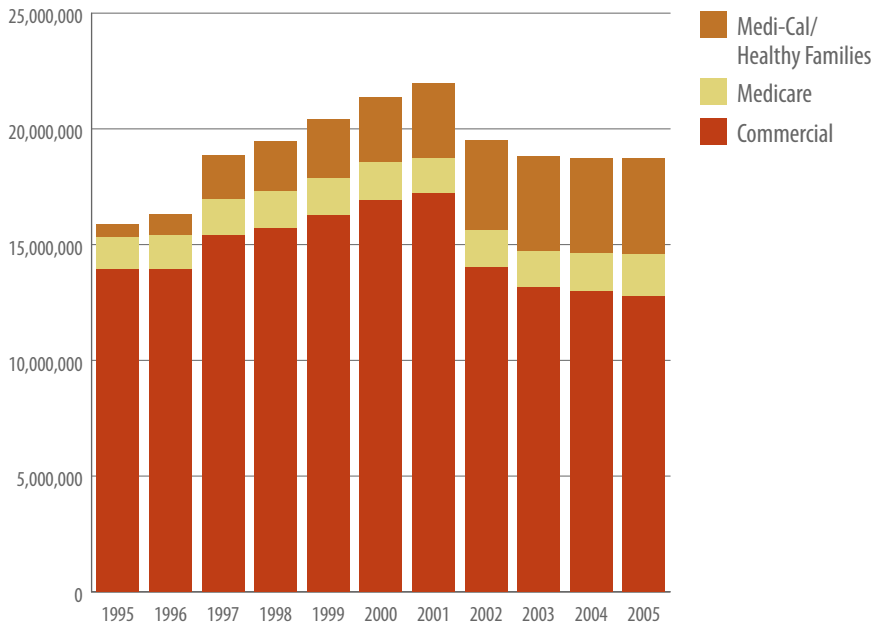
Source: Author's analysis of HMO annual statements, Report No. 4: Enrollment and Utilization Table.

Exhibit 6 tracks the growth of HMO enrollment through 2001 and the general decline since then. Between 2003 and 2005, enrollment in commercial plans dropped by 350,000 lives. There are no comparabley 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 employer health benefit surveys, discussed above, support the notion that enrollment in PPO plans in California is increasing.

One way to gauge the growth of non-HMO plans is through the annual reports that insurers file with state insurance commissioners. The sidebar "Health Premium Revenues for Major Insurance Companies, 2004 and 2005" on page 31 shows the premiums collected by major health insurers for plans outside of their HMOs in California in 2004 and 2005. Most of the companies listed here showed increases in premium revenue from 2004 to 2005.

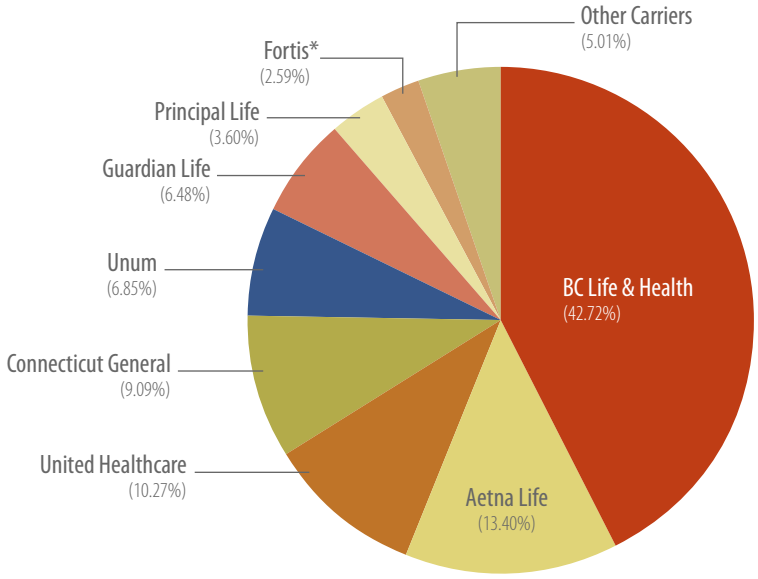
Collecting the largest amount of premiums by far is BC Life & Health, which is the Blue Cross-owned insurance company over which the Commissioner of Insurance has jurisdiction. Other companies with significant health insurance premiums are CIGNA (Connecticut General), Aetna Life, and UnitedHealthcare's insurance company. The 15 or so largest health insurers collected about $5.3 billion in California health premiums in 2005. *Exhibit 7* shows the market share of those companies based on their annual statements. BC Life & Health has 42.7 percent of those premium dollars, followed by Aetna Life, UnitedHealthcare Insurance, and Connecticut General.

EXHIBIT 6. Enrollment Trends in California HMOs, 1995 to 2005



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

EXHIBIT 7. Health Insurance Revenues of Major Carriers in California, 2005



*Currently known as Union Security and Time Insurance Company.

Source: Based on author's analysis of NAIC annual statements for 2005, Schedule T.

3.3 Medicare HMO Plans

The Medicare Modernization Act of 2003 started the third cycle of Medicare managed care arrangements in the past 20 years. Each cycle begins with the federal government promoting new Medicare HMO plans and the private market responding. But after a few years of enrollment growth, government payment rates do not increase enough to keep up with medical inflation or the profitability expectations of the health plans. Providers end their contracts and HMOs reduce the supplemental benefits, increase the enrollee co-premiums, reduce service areas, or sometimes just leave the program. A few years pass and the new administration in Washington again wants to promote private sector approaches to Medicare, and the cycle begins again. Seniors who have lived through these cycles and tried Medicare HMOs can be totally disillusioned by the whole experience.

When the Medicare+Choice program was created in the 1990s, many new Medicare plans entered the California market. By 1999, there were about 20 HMOs offering Medicare+Choice plans in California. HMOs competed vigorously, offering plans with significant benefits not offered by traditional Medicare, including prescription drugs, hearing aids, and transportation to appointments. The federal payment rates were generous enough that the HMOs at first charged only a small amount or even zero in enrollee co-premiums. California seniors responded to the promise of good benefits and joined Medicare+Choice plans in large numbers in the late 1990s. In some parts of the state, almost half of all seniors were in Medicare HMOs.

Many HMOs subsequently dropped out of the Medicare+Choice program as their provider networks began to fray or their plans began to lose money. These changes were less drastic in California than in other states. Still, the number of participating HMOs declined. Those HMOs that stayed generally reduced the supplemental benefits and sharply increased enrollee co-premiums. For example, a prescription drug benefit with few limits in 1999 might by 2005 provide an annual benefit limited to $1,250 worth of generic drugs.

Health Premium Revenues for Major Insurance Companies, 2004 and 2005

Aetna Life
2005 $709,436,855
2004 $569,577,880

BC Life & Health
2005 $2,262,353,962
2004 $1,815,333,282

CIGNA (Connecticut General)
2005 $481,159,185
2004 $456,336,165

Great-West Life & Annuity
2005 $85,184,764
2004 $83,023,375

Guardian Life Insurance Company
2005 $343,193,520
2004 $326,695,878

Humana Insurance Company
2005 $18,283,312
2004 $27,551,668

Mutual of Omaha
2005 $48,776,572
2004 $53,469,819

Principal Life Insurance
2005 $190,808,126
2004 $186,074,974

Prudential
2005 $78,841,649
2004 $64,969,397

Time (Fortis) Insurance Company
2005 $30,579,972
2004 $27,951,540

UniCare Life & Health Insurance Co.
2005 $34,302,582
2004 $39,359,095

Union Security (Fortis Benefits)
2005 $106,649,204
2004 $96,731,045

UnitedHealthcare Insurance Co.
2005 $543,852,315
2004 $509,370,901

Unum
2005 $362,764,959
2004 $378,370,838

TOTAL
2005 $5,296,186,977
2004 $4,636,749,230

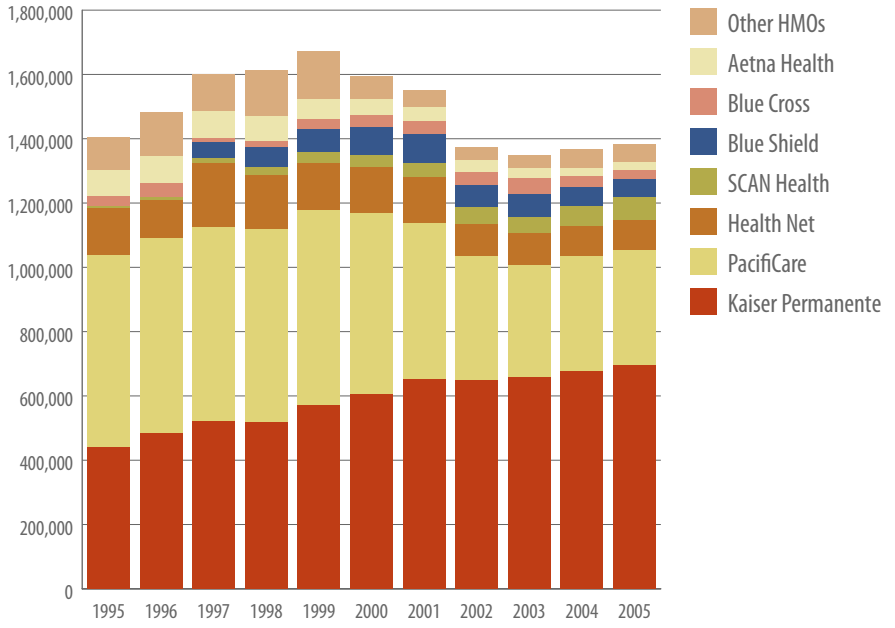
Source: NAIC annual statements. Schedule T.

Many Medicare HMOs in California and other states also reduced their service areas, particularly when hospital systems decided that they would no longer accept capitation risk from Medicare HMOs.

Fast forward to the Medicare Modernization Act of 2003 and the creation of Medicare Advantage. As with the Medicare+Choice program, the idea behind Medicare Advantage is to give seniors private market options that mirror the kind of options that are available to commercial groups: HMO, PPO, fee-for-service, and so on. In enacting the 2003 law, Congress and the Bush Administration expressed a clear preference for moving seniors into private plans and backed that with a commitment of significant new dollars for participating health plans. Still, there is a concern that budget deficits may lead Congress to take back some of this new money. And after the 2006 elections, some wonder whether the new Democratic Congress might be less interested in maintaining the profitability of these plans for insurance companies.

According to demographic data from the California Department of Finance, about 3.6 million Californians were 65 or older in 2000, or 10.7 percent of the population. In 2003, about 36 percent of them were enrolled in a Medicare HMO. As shown in *Exhibit 8,* enrollment in Medicare HMOs grew through 1999 but then began to decrease. Enrollment went from 1.4 million in 1995 to a peak of more than 1.674 million in 1999. It then declined to 1.348 million in 2003 but has now bounced back to 1.383 million at the end of 2005. PacifiCare's Secure Horizons was once the largest Medicare HMO in California, but its enrollment declined and Kaiser's grew. PacifiCare used to have 600,000 seniors in its California Medicare plans, but enrollment dropped to 355,000 by the end of 2005. Kaiser expanded its Medicare risk plan from 440,000 seniors in 1995 to nearly 700,000 in 2005. (Kaiser also has another 20,000 seniors in other Medicare plans.)

EXHIBIT 8. Enrollment in Medicare Advantage Plans in California, 1995 to 2005



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

Exhibit 9 shows that out of 23 counties selected for analysis, four counties show a penetration of Medicare HMO plans above 40 percent: Contra Costa, Placer, Riverside, and San Bernardino. Even with the withdrawals of plans a few years ago, there are still three or four Medicare HMOs competing in much of the Bay Area, and eight to ten plans in much of southern California. In fact, some counties are seeing more Medicare HMO options in 2006. At least one new HMO (Caremore) was formed for the California Medicare market, and it is understood that others are preparing to enter the California market. There is not as much start-up activity here as in Florida, where nine Medicare HMOs have started business in the past five years and where several have recently been acquired.

The prospects for additional growth are strong, largely because the federal government has infused significant new dollars into Medicare HMO payment rates. The rates were increased twice in 2004 and again in 2005. The base rate increased by 4.8 percent for 2006. Note that an increasing portion of the rate is now based on risk adjustment—HMOs that enroll persons with more conditions will be paid more. A few companies have emerged that believe that they can capitalize on this equation.

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

EXHIBIT 9. Medicare Advantage Payment Rates, Plan Choices, and Penetration in Selected Counties, 2005 to 2006

County	2006 AAPCC	Increase Over 2005	Number of HMOs 2005	Number of HMOs 2006	Eligible Seniors	Seniors Enrolled	Penetration Rate
Alameda	$802.14	4.8%	3	3	168,516	62,826	37.3%
Contra Costa	818.05	4.8%	4	3	130,481	53,829	41.3%
Fresno	685.62	4.8%	2	3	100,497	20,421	20.3%
Kern	738.31	4.8%	5	7	85,260	27,041	31.7%
Los Angeles	852.29	4.8%	11	13	1,088,582	362,788	33.3%
Marin	743.37	4.8%	1	1	38,481	12,774	33.2%
Monterey	743.56	4.8%	0	0	45,548	446	1.0%
Napa	792.99	4.8%	1	1	22,758	6,692	29.4%
Orange	806.32	4.8%	10	10	329,533	120,143	36.5%
Placer	685.62	4.8%	4	4	45,786	20,906	45.7%
Riverside	785.94	4.8%	8	8	237,743	102,473	43.1%
Sacramento	696.19	4.8%	4	4	171,868	68,047	39.6%
San Bernardino	784.16	4.8%	9	10	191,354	82,386	43.1%
San Diego	717.25	4.8%	4	4	365,136	141,299	38.7%
San Francisco	758.73	4.8%	4	4	124,802	35,943	28.8%
San Joaquin	685.62	4.8%	1	2	76,564	15,077	19.7%
San Mateo	714.00	4.8%	3	3	97,327	32,375	33.3%
Santa Barbara	685.62	4.8%	2	3	58,204	10,341	17.8%
Santa Clara	732.74	4.8%	3	3	187,630	65,747	35.0%
Santa Cruz	702.51	4.8%	1	1	29,879	3,997	13.4%
Solano	736.54	4.8%	2	2	46,748	16,657	35.6%
Sonoma	705.12	4.8%	1	3	67,334	20,048	29.8%
Stanislaus	747.00	4.8%	2	2	62,184	22,004	35.4%

Note: Some HMOs may offer more than one benefit plan per county or may offer a plan in only a portion of the county.

Source: Author's analysis of reports and data available from Centers for Medicare and Medicaid Services at www.medicare.gov.

co-pays in some counties and eliminated monthly premiums in others.

In addition, the new Medicare drug benefit has increased the overall level of interest in Medicare plans. Some seniors, needing to choose some form of drug coverage, have decided that the more comprehensive benefits of a Medicare HMO plan are a better option for them. HMOs would likely agree—they would rather manage $900 per month of Medicare Advantage premium than the $125 in monthly Part D plan premium.

Still, Medicare Advantage HMOs remain a somewhat risky proposition. Depending on Medicare as a key customer means relying on the federal government and how much or how little it chooses to increase payments each year. And the financial model also requires favorable discounts from or risk-sharing with major providers. Whether the payment increases can or will be sustained into the future is a debatable proposition, especially given the pressure to contain the growth of the Medicare budget and to do that without directly cutting provider payments.

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

There is a good deal of uncertainty about the future of the three kinds of plans outlined under the Medicare Modernization Act (MMA), which include:

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

Exhibit 10 shows how California seniors get their drug coverage in 2006—whether through employers, Medicare Advantage, or Medicare Part D plans. The sidebar titled "Medicare Part D Prescription Plans, 2007" on page 34 lists the 24 companies offering these plans in the state in 2007.

Some analysts believe that the business opportunities will generally be strongest for the Medicare Advantage HMO plans, since they will have control over their service areas and will be rewarded for effective medical management. There is less interest in the PPO plans and some concern that the Part D prescription drug plans will not be able to create incentives and rewards for effective medical management.

Medicare Part D Prescription Plans, 2007 (number of levels)

Aetna Medicare Rx (3)

Blue Cross of California MedicareRx (3)

Blue Shield of California Medicare Rx (2)

Bravo by Elder Health Bravo (2)

CIGNA HealthCare CIGNATURE Rx (3)

Coventry AdvantraRx (3)

EnvisionRx Plus (2)

First Health Select

Health Net Orange (3)

HealthSpring Prescription Drug Plan

Humana Insurance Company (3)

Medco YOURx PLAN

MEMBERHEALTH Community Care Rx (3)

NMHC Group Solutions Medicare PDP

Pennsylvania Life Insurance Company Prescription Pathway (3)

RxAmerica Advantage (2)

SAMAscript

SierraRx (3)

SilverScript (3)

Unicare MedicareRx Rewards (2)

United American Insurance Company UA Medicare Part D Rx (2)

UnitedHealthcare
AARP MedicareRx Plan (2)
Rx Basic (S5921-003) (2)
(Enhanced: $42.30, Generics: $0)

WellCare (3)

Source: CMS, "Landscape of Plan Options in California, Stand-Alone Prescription Drug Plans" www.medicare.gov/medicarereform/local-plans-2007.asp.

EXHIBIT 10. Medicare Beneficiaries with "Creditable" Prescription Drug Coverage by Type, June 2006

Beneficiaries with Creditable Drug Coverage	**3,553,569**	**82.1%**
Medicare Advantage Members with Prescription Drugs (MA-PDs)	1,292,709	29.9%
Dual Eligibles (Auto-Enrolled into PDPs)	924,354	21.4%
Stand-Alone PDP Members	570,138	13.2%
Employer Plan Members Taking Retiree Drug Subsidies	433,835	10.0%
Estimated Federal Retirees (Tricare, FEHB)	332,533	7.7%
Beneficiaries without an Identified Source of Creditable Drug Coverage	**772,292**	**17.9%**
TOTAL	4,325,861	100.0%

Source: Kaiser Family Foundation, State Health Facts (http://kff.org/medicare/rxdrugbenefit.cfm).

3.4 Medi-Cal Managed Care

The California Department of Health Services (DHS), working with county agencies, administers the Medi-Cal and Medi-Cal managed care programs. A separate program offering subsidized health insurance for children in low-income families is the Healthy Families Program, which is administered by a different state agency, the Managed Risk Medical Insurance Board. Most of the data and discussion that follow are limited to Medi-Cal managed care enrollment, as opposed to the Healthy Families Program.

Background

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 for the Medicaid program, or at least setting limits on the states' obligations. When patients have a primary care home, they can be expected to use hospital emergency departments less often and to 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 usually set payments at 5 to 10 percent below what they calculate the equivalent cost would be if providers were paid the state's fee-for-service rates.

California introduced managed care for Medi-Cal more than 20 years ago. As in other states, it focused on recipients that were also receiving cash assistance through AFDC (Aid to Families with Dependent Children, now called TANF, Temporary Aid to Needy Families). Medi-Cal recipients with disabilities or seniors in nursing homes have generally been exempt from any mandate to enroll in an HMO. However, proposals are offered from time to time to enroll aged and disabled Medi-Cal recipients into some form of managed care. In 2005, the state proposed a major expansion of Medi-Cal managed care as part of a renewal of a federal waiver.

While persons with disabilities are a small percentage of Medi-Cal recipients, they consume a significant portion of the total budget. Of the 6.5 million persons who received Medi-Cal benefits in California in 2005, seniors and adults with disabilities accounted for 23 percent of enrollment and 61 percent of expenditures.

Source: CHCF report, "Medi-Cal Budget and Cost Drivers," January 2006. (www.chcf.org/topics/medi-cal/index.cfm?itemID=102647)

Evolution of Models

Since the early 1990s, California has moved to three managed care models in which it contracts with HMOs or with county health authorities that have organized their own HMO. They are: (1) the two-plan model, (2) county organized health systems (COHSs), and (3) geographic managed care (GMC). The two-

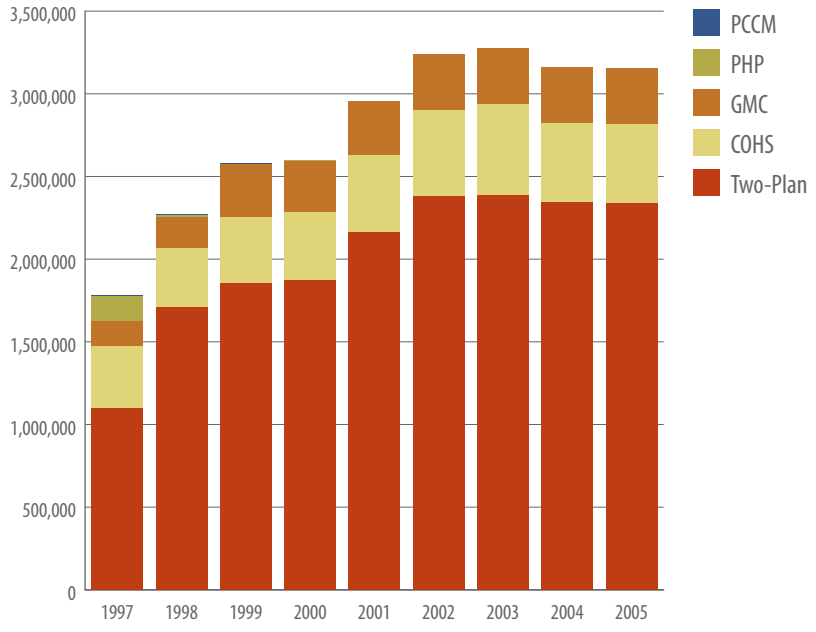
plan model was first developed by the DHS in 1992, and geographic managed care was authorized in Sacramento in that same year. The smallest of the three models, the county organized health system model, has a longer history and was first authorized in 1982. Two older models, primary care case management and prepaid health plans, have largely disappeared.

- In the TWO-PLAN MODEL, a county-sponsored health plan and a commercial HMO compete for Medicaid enrollees. Los Angeles, Riverside, San Francisco, and Alameda are examples of two-plan counties, although these counties have each taken different approaches. In part, the two-plan model was intended to protect the interests of public hospitals in those counties that were serving Medi-Cal recipients and wanted to protect their patient base and revenues. In Alameda County, for example, 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. In the 12 counties that have a two-plan system, the county-sponsored plans have two-thirds of the enrollees.
- In a COUNTY ORGANIZED HEALTH SYSTEM, a county authority, sometimes partnering with one or two nearby counties, manages a health plan-like arrangement. There are eight counties in five county organized health systems. Orange, Santa Barbara, Monterey, and Napa Counties are examples. Some of those county authorities also enroll aged and disabled Medicaid recipients. Federal rules limit the percentage of a state's Medicaid managed care enrollees that can be in the COHS.
- In the two counties with GEOGRAPHIC MANAGED CARE, competing health plans vie for enrollees within a county, but there is no designated county government plan. Geographic managed care arrangements operate in Sacramento and San Diego Counties, with five or six HMOs competing. In San Diego, the number of competitors dropped to five when Molina Healthcare took over the San Diego County Medi-Cal and Healthy Families enrollment of two of the HMOs there, Sharp Health Plan and Universal Care.

Exhibit 11 shows the growth and decline of Medi-Cal recipients in managed care, reflecting enrollment in different managed care arrangements. In 2005, there were about 2.3 million Medi-Cal recipients in two-plan arrangements, down from 2.4 million in 2003. Budget cuts enacted in 2003 and 2004 required recipients to re-qualify for their eligibility more often, resulting in people dropping out of Medi-Cal. About 483,000 enrollees were in the five COHS arrangements at the end of 2005, and 333,000 were in the San Diego and Sacramento GMC arrangements.

Exhibit 12 shows enrollment by county in the two-plan, county organized health system, and geographic managed care models. During the next year, Medi-Cal managed care will be extended into 13 counties. In all cases, that will be

EXHIBIT 11. Enrollment in Medi-Cal Managed Care by Program, 1997 to 2005



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

EXHIBIT 12. Enrollment in Medi-Cal Managed Care Programs by County, 2004 and 2005

County	Plans	December 2004 Enrollment	December 2005 Enrollment	December 2005 Share
2-Plan Systems		**2,342,693**	**2,335,851**	**74.1%**
Alameda	Alameda Alliance	79,132	77,534	72.7%
	Blue Cross	28,987	29,124	27.3%
	County Total	108,119	106,658	100.0%
Contra Costa	Contra Costa Health Plan	43,740	43,411	80.1%
	Blue Cross	9,503	10,814	19.9%
	County Total	53,243	54,225	100.0%
Fresno	Blue Cross	136,120	139,229	83.8%
	Health Net	27,395	26,827	16.2%
	County Total	163,515	166,056	100.0%
Kern	Kern Heath Systems	84,776	91,013	79.9%
	Health Net	25,036	22,847	20.1%
	County Total	109,812	113,860	100.0%
Los Angeles*	L.A. Care	739,749	729,134	61.1%
	Health Net	478,971	464,475	38.9%
	County Total	1,218,720	1,193,609	100.0%
Riverside	Inland Empire Health Plan	113,542	115,085	76.4%
	Molina Healthcare	39,705	35,603	23.6%
	County Total	153,247	150,688	100.0%
San Bernardino	Inland Empire Health Plan	134,048	131,578	70.6%
	Molina Healthcare	55,871	54,770	29.4%
	County Total	189,919	186,348	100.0%
San Francisco	San Francisco	32,955	31,999	71.2%
	Blue Cross	14,626	12,918	28.8%
	County Total	47,581	44,917	100.0%
San Joaquin	Health Plan of San Joaquin	57,790	55,634	67.5%
	Blue Cross	24,324	26,778	32.5%
	County Total	82,114	82,412	100.0%
Santa Clara	Santa Clara Family Health	71,130	70,255	67.6%
	Blue Cross	33,105	33,665	32.4%
	County Total	104,235	103,920	100.0%
Stanislaus	Blue Cross	29,873	47,540	76.3%
	Health Net	0	11,268	23.7%
	County Total	29,873	47,540	100.0%
Tulare	Blue Cross	66,921	69,944	81.7%
	Health Net	15,394	15,674	18.3%
	County Total	82,315	85,618	100.0%
	Total Local Initiative Plans	**1,589,776**	**1,602,356**	**68.6%**
	Total Commercial Plans	**752,917**	**733,495**	**31.4%**
County Organized Health Systems		**479,796**	**483,239**	**15.3%**
Monterey/Santa Cruz	Central Coast Alliance	82,941	83,432	100.0%
Napa/Solano-Yolo	Partnership Health Plan	82,003	85,318	100.0%
Orange	CalOptima	295,814	295,834	100.0%
San Mateo	Health Plan of San Mateo	48,395	47,893	100.0%
Santa Barbara	Santa Barbara Regional Health Authority	53,584	54,194	100.0%

*In Los Angeles County, L.A. Care subcontracts all its Medi-Cal enrollees to other HMOs, and Health Net subcontracts a portion of its Medi-Cal enrollees to other HMOs.

accomplished by expanding GMC and COHS arrangements into contiguous counties. County organized health systems will be extended into Ventura, San Luis Obispo, and Napa Counties, among others. This expansion is part of a broader Medi-Cal redesign that has been in the works for the past two years. The state renegotiated its federal Medicaid waiver to reduce the use of inter-governmental transfers, a current concern of federal authorities. To replace some of those dollars, a Special Care Fund was created to support hospitals serving large numbers of uninsured and low-income households.

In another section of the updated waiver, California agreed that it would prepare and adopt a plan to mandate managed care for some portion of the recipients that are aged, blind, or disabled. As of this writing, the state had not complied with that requirement and has forfeited a substantial amount of federal funds.

California has relied on waivers from federal authorities to make major changes in its Medi-Cal program. A handful of states, including Kentucky and Idaho, have begun to implement ambitious redesigns of their Medicaid programs using new authority from the Deficit Reduction Act of 2005. Among other things, states can amend their state Medicaid plans to bypass requirements that benefits and eligibility be uniform in all parts of the state. States can implement somewhat higher co-payments for prescription drugs and can create incentives in the form of supplemental benefits for enrollees that comply with personal health improvement plans.

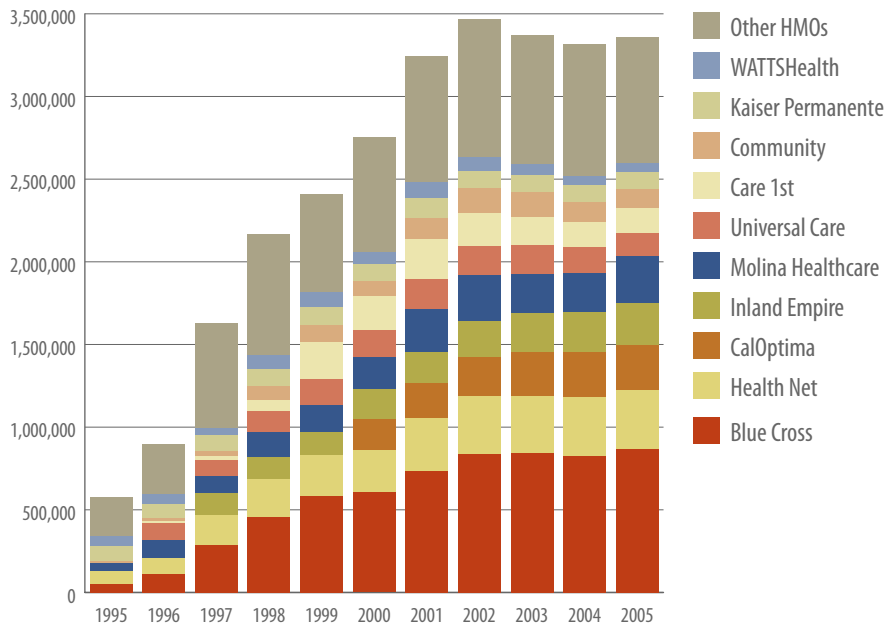
Exhibit 13 compares contracting HMOs on their Medi-Cal enrollment between 1995 and 2005, based on their annual statements to the Department

EXHIBIT 12. Enrollment in Medi-Cal Managed Care Programs by County, 2004 and 2005, cont.

County	Plans	December 2004 Enrollment	December 2005 Enrollment	December 2005 Share
Geographic Managed Care		336,160	333,581	10.6%
Sacramento	Blue Cross	79,450	81,305	49.3%
	Care 1st	0	3,045	1.8%
	Health Net	32,125	29,915	18.1%
	Kaiser Permanente	19,745	19,677	11.9%
	Molina Healthcare	19,918	17,845	10.8%
	Western Health Advantage	14,340	13,048	7.9%
	County Total	165,578	164,835	100.0%
San Diego	Blue Cross	17,517	21,450	12.7%
	Care 1st	0	52	0.0%
	Community Health Group	71,186	70,699	41.9%
	Health Net	10,381	13,972	8.3%
	Kaiser Permanente	7,685	9,719	5.8%
	Sharp Health Plan	49,853	0	0.0%
	Molina Healthcare	0	52,854	31.3%
	Universal Care	13,960	0	0.0%
	County Total	170,582	168,746	100.0%
	TOTAL ENROLLMENT	3,158,649	3,152,671	

Source: Author's analysis of Department of Health Services Monthly Enrollment Reports.

EXHIBIT 13. Enrollment in Medi-Cal Managed Care by Health Plan, 1995 to 2005



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

of Managed Health Care. Five HMO plans had more than 200,000 Medi-Cal enrollees, and three others had between 100,000 and 200,000 enrollees. At the end of 2005, Blue Cross was the largest plan for these programs. It reported almost 866,000 enrollees in Medi-Cal plus 293,000 in Healthy Families.

WellPoint, Inc., the parent of Blue Cross of California, also operates Medicaid managed care plans in other states, including Oklahoma and Puerto Rico, and has looked at contracts or acquisitions in more states. It is one of the few Blue Cross plans around the country that has any significant amount of Medicaid business. As was noted earlier, the new WellPoint, Inc. has already begun to add Medicaid contracts in other states. Earlier this year it acquired the Medicaid enrollees of QualChoice, a hospital-owned HMO in Cleveland with 61,000 Medicaid members.

3.5 HMO Enrollment by Region

As HMO enrollment has declined and the state's population has grown, HMO penetration in the state has also declined. *Exhibit 14* presents two views of HMO health plan enrollment and market share in California in 2005. Part A summarizes total HMO enrollment, estimated population, and penetration in the 14 health planning regions (Health Service Areas, or HSAs) of California. Part B looks at which HMOs, county systems, and local initiatives account for the enrollees in those regions. To simplify the presentation, some of the health planning regions have been combined in the second half of the table. The far northern counties in the state, where there is little managed care activity, are combined in this table with Sacramento and surrounding counties, where there is a good deal of managed care activity. Three Health Service Areas are also combined in the Bay Area, and Los Angeles and Orange Counties are combined in the south.

In previous years, there were four regions of the state where HMO penetration exceeded 60 percent. In 2005 that declined to three regions: Sacramento, Sonoma/Napa, and the East Bay. Penetration is in the high 50 percent range in Orange County, the Inland Empire of Riverside and San Bernardino Counties, and the Bay Area (west). The lowest penetration rates are in the far north and the central coast, including the Santa Cruz and Monterey areas. The northern part of the state does not have HMOs for Medi-Cal, although there is some HMO activity for the Healthy Families Program. The expansion of Medi-Cal managed care will boost penetration rates in those parts of the state.

The central coast does use county-sponsored HMOs for Medi-Cal, but the hospitals and physician groups in the region have historically been inhospitable to commercial and senior managed care, and were reluctant to offer favorable discounts or accept capitation risk. Commercial and Medicare 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 all but three regions of the state — namely the central coast, the Central Valley, and Santa Barbara. Blue Cross is the largest in the Central Valley and the Santa Barbara area and is second largest in Los Angeles and Orange Counties. The three HMOs that are next in size — Blue Shield, Health Net, and PacifiCare — all have many more enrollees in southern California and fewer in the north. For example, more than half of PacifiCare's enrollment is in the Los Angeles/Orange and San Diego areas and only about one-sixth of its enrollees are in northern California. Only about 30 percent of Blue Shield's members are in northern California. Similarly, half of Health Net's enrollees are in the Los Angeles/Orange and San Diego areas.

EXHIBIT 14A. Estimated HMO Enrollment and Penetration by Region, 2005

	HSA	2005 Estimated HMO Enrollment	2005 Estimated Population	Estimated HMO Penetration
1	North	67,431	946,514	7.1%
2	Sacramento	1,485,086	2,296,056	64.7%
3	Sonoma / Napa	627,219	1,030,994	60.8%
4	San Francisco Bay West	982,449	1,764,427	55.7%
5	East Bay Area	1,608,999	2,519,329	63.9%
6	North San Joaquin	680,585	1,543,935	44.1%
7	San Jose / South Bay	903,633	1,752,653	51.6%
8	Central Coast	244,388	1,002,753	24.4%
9	Central Valley	1,013,414	2,357,181	43.0%
10	Santa Barbara	387,908	1,228,751	31.6%
11	Los Angeles	5,376,290	10,166,417	52.9%
12	Inland Empire	2,178,510	3,871,234	56.3%
13	Orange	1,772,651	3,047,054	58.2%
14	San Diego	1,397,277	3,200,898	43.7%
	TOTAL	18,725,840	36,728,196	51.0%

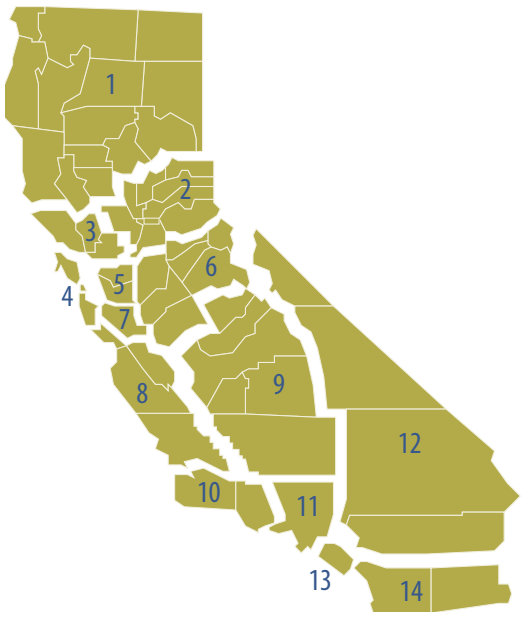


EXHIBIT 14B. Estimated HMO Enrollment by Plan and Region, 2005

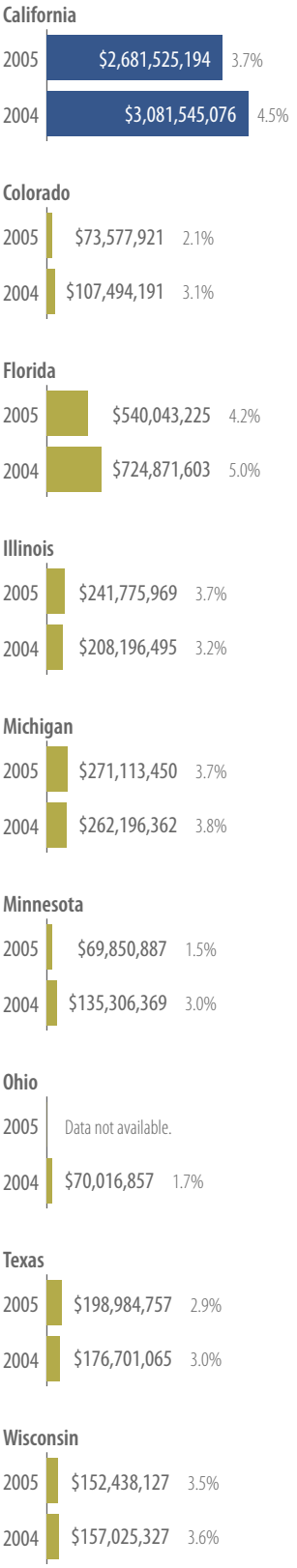
Plan	1, 2	3	4, 5, 7	6	8	9	10	11, 13	12	14	TOTAL
Largest HMOs											
Aetna Health	322	1,819	49,804	6,754	1,140	1,542	10,161	144,120	42,323	36,917	**294,903**
Blue Cross	179,034	19,284	294,131	121,625	45,722	332,318	96,915	1,442,571	277,715	151,470	**2,960,786**
Blue Shield	285,494	57,383	375,254	94,003	53,471	139,538	83,727	943,868	282,539	143,413	**2,458,689**
Health Net*	176,217	53,777	332,462	58,913	17,984	108,504	62,330	672,805	155,401	149,845	**1,788,238**
Kaiser Permanente	677,500	401,690	1,882,488	257,699	13,456	221,799	65,135	1,896,837	669,733	502,173	**6,588,510**
Molina Healthcare	25,043	0	0	0	0	0	0	172,059	123,122	0	**320,223**
PacifiCare	105,457	20,572	168,116	80,560	25,382	36,664	20	635,596	254,974	316,756	**1,644,098**
Smaller HMOs											
AIDS HC	0	0	0	0	0	0	0	834	0	0	**834**
California Health Plan	0	0	0	0	0	0	0	2,004	1,346	0	**3,350**
Care 1st Health Plan	0	0	0	0	0	0	0	192,429	0	0	**192,429**
Chinese Community Health Plan	0	0	12,559	0	0	0	0	0	0	0	**12,559**
CIGNA Healthcare	5,648	1,000	17,171	1,908	489	2,857	1,962	34,618	7,513	6,396	**79,562**
Community Health Group	0	0	0	0	0	0	0	99,188	472	0	**99,660**
Community Health Plan	0	0	0	0	0	0	0	160,056	0	0	**160,056**
Great West	1,413	1,408	14,189	1,940	956	797	492	24,130	4,062	10,742	**60,131**
Honored Citizens	0	0	0	0	0	0	0	164	0	0	**164**
Inter Valley Health Plan	0	0	0	0	0	0	0	6,065	6,950	11	**13,026**
On Lok Senior Health Services	0	0	936	0	0	0	0	0	0	0	**936**
Valley Health Plan	0	0	0	57,180	0	0	0	0	0	0	**57,180**
SCAN Health Plan	11	0	0	0	0	26	22	55,493	22,840	100	**78,492**
Sharp Health Plan	0	0	0	0	0	0	0	0	0	51,346	**51,346**
Universal Care	0	0	0	0	0	3,750	502	214,884	24,846	22,091	**266,073**
Ventura County	0	0	0	0	0	0	9,888	0	0	0	**9,888**
WATTSHealth Plan	0	0	0	0	0	0	11	79,517	2,525	6,016	**88,069**
Western Health Advantage	72,867	9,166	0	0	0	0	0	0	0	0	**82,033**
County Health Plans											
Alameda Alliance for Health	1	0	92,948	4	0	0	0	0	0	0	**92,953**
CalOptima*	0	0	0	0	0	0	0	303,225	0	0	**303,225**
Central Coast Alliance	0	0	0	0	85,789	0	0	0	0	0	**85,789**
Contra Costa Health Plan	0	0	64,123	0	0	0	0	0	0	0	**64,123**
Inland Empire Health Plan	0	0	0	0	0	0	0	76	302,148	0	**302,224**
Kern Health Systems	0	0	0	0	0	90,833	0	9	0	0	**90,842**
L.A. Care	0	0	0	0	0	0	0	68,393	0	0	**68,393**
Partnership Health Plan	23,509	61,120	0	0	0	0	0	0	0	0	**84,629**
San Francisco Health Plan	0	0	50,049	0	0	0	0	0	0	0	**50,049**
San Joaquin County Health	0	0	8	0	0	74,785	0	0	0	0	**74,793**
San Mateo Health Commission)	0	0	57,527	0	0	0	0	0	0	0	**57,527**
Santa Barbara	0	0	0	0	0	0	56,744	0	0	0	**56,744**
Santa Clara Family Health Plan*	0	0	83,314	0	0	0	0	0	0	0	**83,314**
TOTAL	1,552,518	627,219	3,495,081	680,585	244,388	1,013,414	387,908	7,148,941	2,178,510	1,397,277	**18,725,840**

*See Exhibit 4 for notes on adjustments to reported enrollment for subcontracting arrangements.

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

HMO Net Income

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



3.6 HMO Revenues and Net Income

HMOs in California and in the comparison states have enjoyed very strong profits in the past two years, even as their employer group enrollment declines. As will be discussed below, they have been able to extract large premium increases from employers, enough to stay ahead of increases in their payments to providers.

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).

Exhibit 15 shows net income for California HMOs in 2005. California HMOs had net income (after taxes of $826.2 million and including investment income of $421.5 million) of $2.682 billion, or 3.7 percent of revenues of $73.1 billion. That is very strong, though not quite as good as in 2004, when California HMOs had net income of $3.2 billion. On average, California HMOs had net income of $10.74 per member per month in 2005.

Kaiser Foundation reported the highest net income of $1 billion, or 3.2 percent of revenues. In 2004, the Kaiser HMO had net income of $1.6 billion. Blue Cross also had strong results, with 2005 net income of $680.4 million after taxes, or 6.0 percent of revenues. Blue Shield had a very good year in 2005, with net income of $329.5 million, compared to $334.2 million in 2004.

Among smaller HMOs, all but four reported positive net income in 2005. SCAN Health Plan in Long Beach, a special health plan for seniors, had 2005 net income of $141.7 million, about the same as in 2004. Community Health Plan, a unit of the Los Angeles County Department of Health serving Medi-Cal patients, had net income of $15.7 million, up from $7.7 million in 2004.

The county-sponsored Medi-Cal HMOs have seen their net income decline in the past four years. As a group they reported net income of almost $75 million in 2002. That decreased in 2003 to $46.9 million and a loss of $10.4 million in 2005. CalOptima and Central Coast Alliance had the largest losses in that group.

In the five years from 2001 through 2005, California HMOs had net income of $9.4 billion. As *Exhibit 16* shows, some of the large HMOs have had consistently strong earnings since 1995. Net income for the group declined in 2001, but has recovered strongly since then.

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, health plans raised their premiums faster than the anticipated increase in health care costs in order to improve profitability.

Commercial HMO premiums in California have historically been lower than in comparison states. (The most recent data from the Center for Studying Health Systems Change shows that the average cost of HMO family coverage in California in 2005 was $765 per month compared to a national average of $871.) This 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 counterparts in other states might have received. Relatively lower rates of inpatient hospital utilization in the state have helped hold down premium rates. There are geographic differences within the state as well. Based on interviews with health plans and consultants, HMOs in northern California face higher payment rates from dominant hospital systems, forcing their prices upward in recent years.

EXHIBIT 15. HMO Revenues and Net Income, 2005

Plan	Revenue	Net Income (Loss) Pre-Tax	Taxes Paid	Net Income (Loss) After Tax	Margin	Net Income (Loss) Per Member Per Month	Net Income (Losses) 2001–2005
HMOs							
Aetna Health	$936,506,303.00	$107,394,702.00	$38,597,132.00	$68,797,570.00	7.3%	$19.83	$176,521,733.00
Blue Cross	11,397,615,000	1,140,223,000	459,826,000	680,397,000	6.0%	19.21	2,547,338,000
Blue Shield	7,476,654,000	392,441,000	62,949,000	329,492,000	4.4%	10.10	899,392,672
CIGNA Health	895,546,628	20,255,923	7,114,280	13,141,643	1.5%	3.12	9,907,062
Health Net	6,397,416,774	287,444,752	112,813,285	174,631,467	2.7%	7.02	629,136,877
Kaiser Permanente	31,404,648,000	1,044,156,000	0	1,009,019,000	3.2%	12.85	3,617,914,000
Molina Healthcare	341,613,515	2,098,178	970,953	1,127,225	0.3%	0.32	52,265,812
PacifiCare	6,697,314,000	327,514,000	127,245,000	200,269,000	3.0%	10.03	757,221,332
AIDS HC	$122,841,655	$2,955,611	$0	$2,955,611	2.4%	NA	$2,955,611
California Health Plan	194,777	30,846	12,700	18,146	9.3%	$0.90	18,449
Care 1st	298,503,709	11,704,096	6,221,024	5,483,072	1.8%	2.39	32,177,651
Central Health Plan	45,708	(1,825,220)	800	(1,826,020)	NA	NA	(2,721,583)
Chinese Community	60,885,627	1,891,273	719,605	1,171,668	1.9%	8.30	4,377,879
Community Health Group	122,829,835	(1,413,277)	0	(1,413,277)	– 1.2%	(1.18)	(12,101,221)
Community Health Plan	200,904,248	15,690,799	0	15,690,799	7.8%	8.16	66,009,563
Great-West	167,535,188	10,422,875	4,411,148	6,011,727	3.6%	8.80	14,886,558
Honored Citizen	272,329	(993,260)	0	(993,260)	NA	NA	(1,018,060)
Inter Valley Health Plan	116,602,528	4,432,113	0	4,432,113	3.8%	27.90	4,983,856
Medcore	1,788,073	(1,025,991)	800	(1,026,791)	– 57.4%	NA	(1,026,791)
On Lok Senior Health	60,562,903	1,805,999	0	1,805,999	3.0%	159.54	17,186,614
SCAN Health Plan	997,791,858	141,681,085	0	141,681,085	14.2%	161.78	434,497,416
Sharp Health Plan	148,360,902	23,181,531	0	23,181,531	15.6%	19.30	12,887,739
Valley Health	89,020,329	485,950	0	485,950	0.5%	0.70	2,207,977
Universal Care	450,220,514	1,099,717	2,856,407	4,446,395	1.0%	0.79	(9,436,656)
Ventura County	17,695,464	14,507	0	14,507	0.1%	0.12	(257,353)
WATTSHealth	184,835,000	5,141,000	0	5,141,000	2.8%	4.87	29,559,000
Western Health Advantage	201,617,540	4,392,002	1,036,928	3,355,074	1.7%	3.64	6,761,153
County Health Plans							
Alameda Alliance for Health	$142,448,771	($5,652,656)	$0	($5,652,656)	– 4.0%	($5.00)	($31,220,431)
CalOptima	816,332,420	(24,374,130)	0	(24,374,130)	– 3.0%	(6.22)	(10,100,392)
Central Coast Alliance	232,888,090	(17,405,750)	0	(17,405,750)	– 7.5%	(16.85)	6,389,956
Contra Costa Health Plan	143,558,484	327,977	0	327,977	0.2%	0.43	4,878,810
Inland Empire Health Plan	335,582,404	6,344,129	0	6,344,129	1.9%	1.83	23,053,780
Kern Health System	119,871,771	(141,107)	0	(141,107)	– 0.1%	(0.52)	22,300,213
L.A. Care	949,332,400	14,102,090	0	14,102,090	1.5%	1.49	93,301,280
San Francisco Health Plan	83,599,797	11,364,781	0	11,364,781	13.6%	19.28	23,016,690
San Joaquin County Health	85,546,134	2,840,898	0	2,840,898	3.3%	3.12	17,122,009
San Mateo	133,312,960	(1,486,497)	0	(1,486,497)	– 1.1%	(2.16)	(11,829,516)
Santa Barbara	156,747,125	1,891,937	0	1,891,937	1.2%	2.80	8,890,601
Santa Clara Family Health Plan	133,054,464	2,761,464	0	1,761,464	1.3%	1.51	16,308,672
Limited License Plans							
Heritage Provider Network	$696,587,152	$3,013,877	$288,263	$2,725,614	0.4%	$0.91	$7,296,866
PrimeCare Medical Network	101,956,221	2,796,851	1,128,138	1,668,713	1.6%	2.43	16,020,142
Scripps Clinic	132,151,213	67,497	0	67,497	0.1%	0.14	148,710
TOTAL	**$73,052,791,813**	**$3,537,650,572**	**$826,191,463**	**$2,681,525,194**	**3.7%**	**$10.74**	**$9,424,409,615**

NA: Not applicable.
Source: Author's analysis of HMO annual statements, Report No. 2: Statement of Revenue, Expenses and Net Worth.

HMO Premium Trend

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

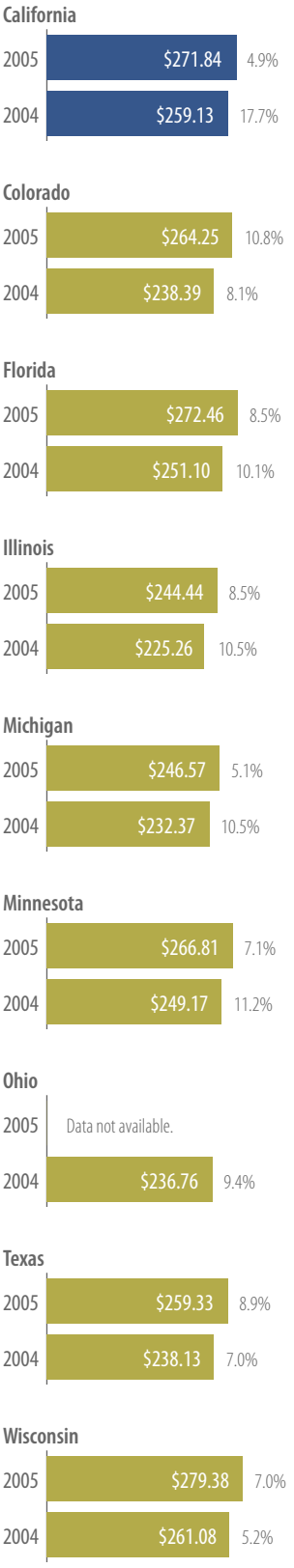
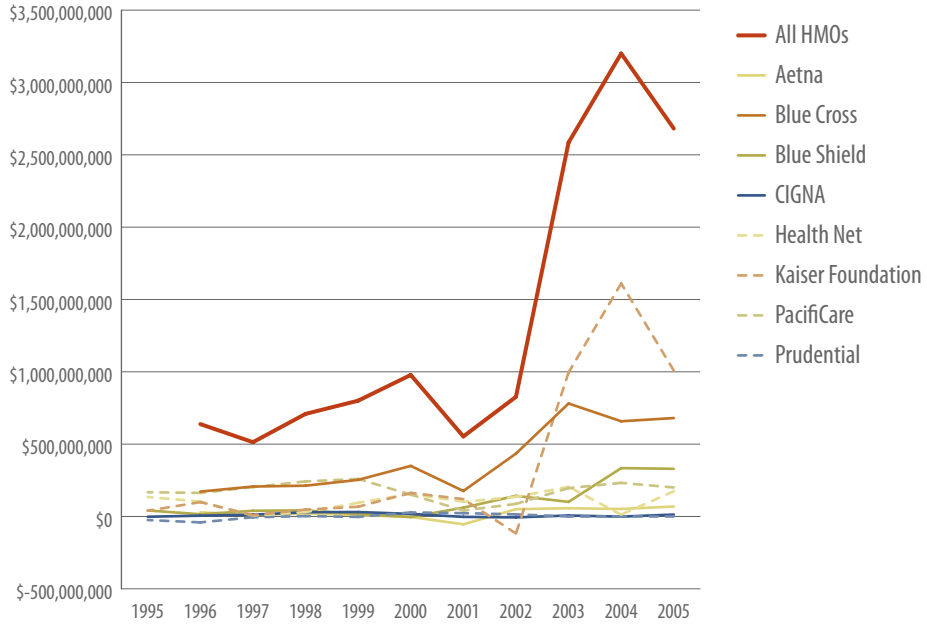


EXHIBIT 16. Net Income After Taxes for Largest HMOs, 1995 to 2005



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

The analysis looks at HMO premium revenue trends in three ways: First it looks at premium revenues collected for commercial HMOs in California *(Exhibit 17)*. To show this trend, the amount of commercial premium revenue for each HMO is calculated, then converted to a per-member per-month (PMPM) amount. Second, California HMO premium revenues are compared to their counterparts in eight comparison states *(Exhibit 18)*. Third, an exhibit presents data on premiums paid for commercial HMO and PPO plans organized through CalPERS *(Exhibit 19)*. Note that CalPERS has now begun to use a regional pricing system that makes very clear the differences in medical costs between northern and southern California.

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

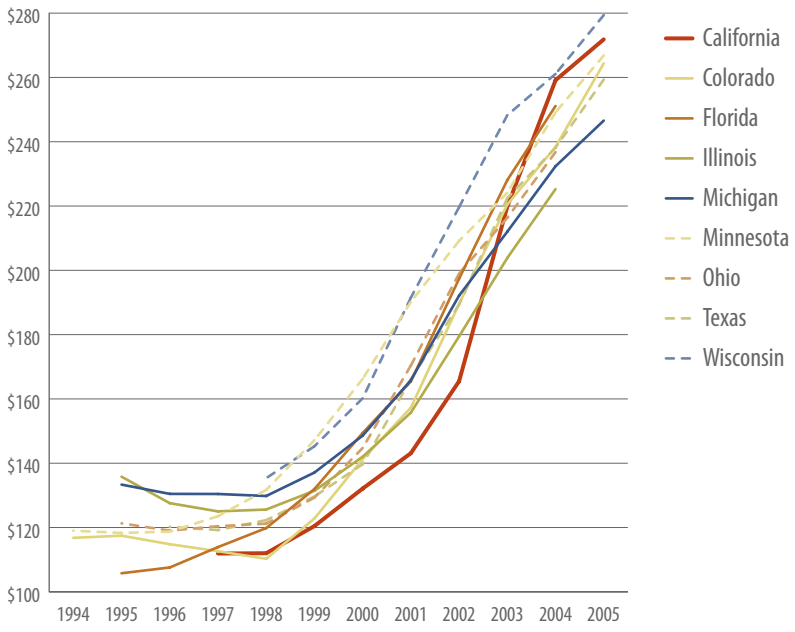
As shown in *Exhibit 17*, the average commercial premium revenue, per member per month, increased relatively modestly in 2005. It grew by an average of 4.9 percent, from $259.13 to $271.84. That followed three consecutive years of high increases. The average increase in 2002 was 15.7 percent, the average in 2003 was 32.9 percent, and the average in 2004 by this calculation was 17.7 percent. The range of PMPM premiums for the large HMOs goes from PacifiCare at $192.69 at the low end to Kaiser Permanente at $322.16 at the high end.

EXHIBIT 17. Commercial HMO Premium Revenues, Per Member Per Month, 1997 to 2005

HMO	1997	1998	1999	2000	2001	2002	2003	2004	2005	Change 2004 to 2005
Aetna Health	$112.93	$112.53	$115.44	$124.36	$139.30	$152.42	$174.65	$192.18	$206.66	7.5%
Blue Cross	108.25	112.91	121.77	132.68	152.09	183.86	210.39	235.53	258.18	9.6%
Blue Shield	104.23	108.43	117.86	137.49	122.47	146.33	172.11	218.12	226.04	3.6%
Health Net	111.08	116.74	124.91	133.1	155.34	184.92	237.56	267.41	276.95	3.6%
Kaiser Permanente	112.54	112.61	122.07	133.96	144.78	163.44	258.59	311.95	322.16	3.3%
PacifiCare	135.37	109.99	116.74	123.58	135.29	149.92	171.95	190.88	192.69	0.9%
Smaller HMOs										
Chinese Community Health Plan	$125.66	$135.55	$117.44	$124.99	$127.05	$151.61	$175.97	$195.58	$211.24	8.0%
CIGNA Health	—	—	—	—	—	—	—	235.4	244.64	3.9%
Great West	117.08	132.78	153.23	142.08	155.68	146.81	169.09	194.87	234.92	20.5%
Sharp Health Plan	133.88	103.85	107.49	107.53	82.63	119.41	197.38	221.86	211.08	– 4.9%
Universal Care	86.69	65.41	86.93	95.65	101.45	135.27	169.37	199.21	212.43	6.6%
Western Health Advantage	—	149.19	103.36	111.84	141.86	139.41	164.5	193.37	222.43	15.0%
TOTAL	**$111.91**	**$112.00**	**$120.49**	**$132.11**	**$143.11**	**$165.60**	**$220.13**	**$259.13**	**$271.84**	**4.9%**
Annual Change	—	0.1%	7.6%	9.6%	8.3%	15.7%	32.9%	17.7%	4.9%	

Source: Author's analysis of HMO annual statements.

EXHIBIT 18. Commercial HMO Premium Revenue Trends in California and Selected States, 1994 to 2005



Source: Author's analysis of HMO annual statements.

The most recent California survey from the Center for Studying Health Systems Change confirms a significant increase in HMO premiums in the state, but one that has recently moderated. According to that survey, the average cost for HMO family coverage in California increased by 12.3 percent in 2004 and 15.6 percent in 2003, but only 8 percent in 2005.

Exhibit 18 compares the premium revenue trend in California with the PMPM trend in eight comparison states where the author publishes annual market analyses. Historically, PMPMs in California trailed behind those in other states, which meant that employers were getting a relatively good deal. However, the large average increase in 2003 has propelled California HMOs into the upper tier of states for this analysis. This analysis does not adjust for differences in demographics or in benefit design. For example, in states where HMOs are permitted to market plans with

EXHIBIT 19. Family Premium Rates for Active CalPERS Participants in HMO and PPO Plans, 1996 to 2006

Plan	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	Increase 2006/2005
HMOs												
Aetna Health	$406.80	$406.80	$420.14	$436.11	$464.46	$504.40	NA	NA	NA	NA	NA	NA
Blue Shield HMO	406.00	394.00	409.71	442.28	479.87	523.04	$563.32	$694.86	$819.57	$923.08	$1,002.64	8.6%
CIGNA Healthcare	398.06	398.06	410.41	424.77	448.48	481.78	NA	NA	NA	NA	NA	NA
Health Net	384.80	384.80	403.66	427.48	469.67	512.88	534.25	NA	NA	NA	NA	NA
Health Plan of the Redwoods	395.00	395.00	409.04	431.52	476.83	517.84	537.11	NA	NA	NA	NA	NA
Kaiser Permanente	393.94	376.87	486.96	428.57	478.56	525.75	563.32	673.95	794.09	872.64	$948.82	8.7%
Lifeguard	413.91	413.91	437.38	457.84	507.81	558.08	NA	NA	NA	NA	NA	NA
Maxicare	390.00	390.00	391.74	415.24	431.60	460.33	NA	NA	NA	NA	NA	NA
PacifiCare	407.60	407.60	417.79	428.05	453.73	489.24	534.25	NA	NA	NA	NA	NA
Universal Care	NA	NA	NA	NA	419.87	434.15	438.39	NA	NA	NA	NA	NA
Western Health Advantage	NA	NA	NA	NA	NA	NA	NA	543.14	729.07	838.42	920.58	9.8%
PPOs												
PERS Care	$666.00	$666.00	$705.00	$710.00	$764.00	$892.00	$1,167.00	$1,425.00	$1,416.40	$1,595.85	$1,751.59	9.8%
PERS Choice	408.00	400.00	416.00	426.00	452.00	556.00	647.00	770.00	908.47	951.81	1,041.51	9.4%
Association Plans												
CCPOA, North	NA	NA	NA	NA	NA	NA	NA	$725.19	$834.25	$896.00	$994.34	11.0%
CCPOA, South	NA	NA	NA	NA	NA	NA	NA	654.65	693.31	740.00	821.22	11.0%
Highway Patrolmen	$469.88	$469.88	$469.88	$469.88	$488.68	$579.60	$671.17	798.02	909.00	990.81	1,096.23	10.6%
Peace Officers Research	489.62	489.62	499.00	518.00	549.00	599.00	699.00	847.00	931.00	950.00	950.00	0.0%
State Employer Contribution	**410.00**	**410.00**	**410.00**	**432.00**	**452.00**	**452.00**	**452.00**	**589.00**	**661.00**	**661.00**	**661.00**	**0.0%**

NA: Not applicable.

Source: Author's analysis of CalPERS data. These rates apply to state employees. Beginning in 2006, CalPERS added five regional rates for employees of other public agencies.

significant enrollee cost sharing, that might be reflected in a lower premium revenue trend. In those states, an HMO can offer a renewal quote with a 14 percent increase, for example, then suggest that the employer adopt a plan design that includes an annual deductible or a co-payment for hospital admissions. In exchange for the additional enrollee cost sharing, the HMO can offer the employer a smaller premium increase.

During much of the 1990s, CalPERS had very good success in negotiating low rate increases (some would say forcing low increases), but then went through a series of years with relatively high increases. As *Exhibit 19* shows, average family premiums for CalPERS participants selecting HMO plans increased by less than 10 percent for 2006. While CalPERS staff have frequently proposed increases in enrollee cost sharing in order to hold down annual premium increases, employee representatives on the board have successfully opposed most of those proposals. Premiums for the PERS Choice, the larger of the two PPO plans, increased by 9.4 percent in 2006.

3.8 HMO Medical Loss Ratios

In their annual and quarterly statements, California HMOs divide their expenses into two main categories, medical/hospital and administration. The medical loss ratio is calculated as the total amount of medical/hospital expenses (for the entire plan), net of reinsurance recoveries, divided by all premium revenues. Investment income and taxes are not included in the calculation. Caution is required in using these data as HMOs have a great deal of latitude in how they allocate expenses between the medical/hospital and administration categories. For example, publicly traded HMO companies might allocate certain expenses to administration in order to report lower health care costs, since that would appeal to stock analysts. HMOs that are part of national corporations or affiliated with hospitals can shift revenues and expenses across those organizations.

EXHIBIT 20. Medical Loss Ratios for California HMOs (entire plan), 1997 to 2005

Plan	1997	1998	1999	2000	2001	2002	2003	2004	2005
Larger HMOs									
Aetna Health	89.3%	86.4%	87.0%	88.5%	94.0%	86.2%	82.1%	84.5%	81.4%
Blue Cross	76.5%	77.9%	77.4%	76.4%	78.8%	78.9%	79.9%	79.1%	78.9%
Blue Shield	78.7%	81.5%	84.0%	84.5%	NA	83.5%	86.4%	83.5%	85.0%
CIGNA Healthcare	85.4%	83.5%	82.5%	82.7%	83.3%	84.6%	85.1%	88.3%	94.0%
Health Net	85.9%	87.9%	86.4%	84.6%	87.8%	86.3%	84.6%	90.0%	86.3%
Kaiser Permanente	96.3%	97.9%	96.4%	96.3%	96.0%	97.7%	93.2%	91.5%	93.9%
Molina Healthcare	93.2%	87.9%	80.5%	77.8%	80.7%	83.0%	83.3%	86.1%	88.6%
PacifiCare	84.5%	84.3%	84.7%	88.1%	91.1%	88.4%	84.2%	85.5%	86.7%
Smaller HMOs									
California Health Plan	—	—	—	—	—	—	—	83.0%	64.6%
Care 1st Health Plan	75.5%	82.8%	84.6%	86.0%	83.9%	85.8%	85.9%	86.7%	86.3%
Chinese Community Health Plan	76.4%	80.0%	80.9%	82.7%	81.8%	84.6%	93.8%	85.5%	84.8%
Community Health Group	78.1%	78.1%	86.1%	81.6%	84.4%	89.4%	84.4%	96.1%	91.5%
Community Health Plan	93.6%	93.6%	92.8%	89.5%	89.7%	81.0%	91.0%	87.7%	81.9%
Great-West Health	73.9%	65.0%	54.5%	91.6%	88.6%	86.9%	82.4%	78.0%	82.3%
Honored Citizen	—	—	—	—	—	—	—	—	114.6%
Inter Valley Health Plan	87.0%	88.6%	88.2%	87.8%	91.3%	NA	89.7%	88.5%	87.3%
On Lok Senior Health	—	—	87.5%	99.2%	84.9%	84.9%	87.8%	89.2%	91.1%
Valley Health Plan	—	—	—	87.6%	89.5%	89.7%	89.7%	90.8%	92.1%
SCAN Health Plan	79.6%	79.2%	81.2%	84.8%	88.5%	81.2%	73.8%	74.4%	79.9%
Sharp Health Plan	85.5%	87.3%	91.4%	85.3%	95.2%	95.0%	92.9%	93.6%	77.7%
Universal Care	86.7%	88.9%	89.2%	92.1%	94.4%	91.9%	90.5%	86.9%	88.3%
Ventura County	95.3%	89.2%	89.3%	61.5%	90.3%	93.3%	87.8%	88.9%	88.1%
WATTSHealth Foundation (UHP Healthcare)	77.6%	82.1%	82.5%	92.5%	NA	84.3%	84.5%	93.1%	82.8%
Western Health Advantage	88.0%	86.1%	84.3%	84.7%	87.4%	88.0%	89.4%	89.2%	88.8%
County Health Plans									
Alameda Alliance for Health	71.7%	71.7%	79.3%	78.0%	102.4%	94.0%	99.3%	99.8%	94.8%
CalOptima	—	—	—	90.0%	93.9%	93.5%	96.3%	97.2%	99.8%
Central Coast Alliance	86.3%	NA	NA	81.0%	88.1%	92.4%	97.4%	92.0%	101.5%
Contra Costa Medical Services	93.3%	93.6%	NA	71.9%	95.8%	92.5%	89.1%	92.4%	92.7%
Inland Empire Health Plan	84.3%	85.8%	89.3%	90.4%	90.7%	89.5%	90.4%	92.0%	90.4%
Kern Health Systems	72.9%	72.8%	67.9%	76.9%	80.1%	79.3%	92.2%	91.8%	93.6%
L.A. Care	85.1%	93.9%	94.7%	95.2%	94.4%	94.2%	93.8%	94.0%	94.9%
San Francisco Health Plan	87.4%	84.0%	86.8%	96.6%	86.7%	86.1%	86.5%	85.3%	78.0%
San Joaquin County Health	79.4%	75.3%	79.4%	79.2%	84.0%	84.8%	85.6%	86.8%	87.7%
San Mateo Health Commission	—	92.3%	81.5%	98.7%	102.0%	91.3%	92.7%	92.8%	93.0%
Santa Barbara Health Authority	—	—	—	81.7%	95.1%	95.3%	87.4%	91.1%	92.6%
Santa Clara Family Health Plan	87.4%	84.1%	NA	75.2%	83.1%	82.6%	84.7%	86.7%	87.0%
Limited License Plans									
Heritage Provider Network	84.9%	93.7%	93.7%	96.7%	97.3%	99.1%	93.0%	92.1%	92.3%
PrimeCare Medical Network	97.5%	91.6%	NA	90.0%	95.3%	87.5%	86.6%	87.2%	83.3%
Scripps Clinic	—	—	—	96.5%	97.5%	95.9%	94.6%	95.1%	95.3%
TOTAL	**87.6%**	**88.4%**	**87.8%**	**88.1%**	**90.2%**	**89.3%**	**88.0%**	**87.7%**	**88.8%**

NA: Not applicable.

Source: Author's analysis of HMO annual statements.

What Is Capitation?

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

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

Exhibit 20 compares California HMOs on their medical loss ratios from 1997 to 2005. The average ratio in 2005 was 88.8 percent, up from 87.7 percent in 2004 but down from 89.3 percent in 2002 and 90.2 percent in 2001. Average loss ratios have stayed within a relatively narrow range in the past 10 years, except for 2001 when they exceeded 90 percent. Profitability has moved up and down with the loss ratios. California HMOs enjoyed their most profitable year in 2004, when the average loss ratio was down to 87.7 percent.

Nonprofit plans prefer to report a high loss ratio to consumers and physicians. Kaiser Permanente has consistently reported high medical loss ratios although its ratios have been lower over the past three years. Kaiser's high medical loss ratio is partly the result of how it allocates expenses between the medical/hospital and administration categories. For example, Kaiser may say that clinic computer systems used for scheduling appointments or tracking laboratory tests are an expense of clinic operation and therefore a medical expense. Other HMOs that have their own clinics sometimes follow similar allocation practices.

Among the largest plans, Blue Cross has consistently shown the lowest medical loss ratios, below 80 percent almost every year. Aetna's ratio dropped to 81.4 percent in 2005 and its net income increased. PacifiCare had medical loss ratios of 84 to 85 percent from 1997 to 1999, but then saw its ratios increase to 88 percent and 91 percent, until 2003 when it declined by four percentage points. PacifiCare's medical loss ratio has since crept upward, reaching 86.7 percent in 2005.

The county-sponsored Medi-Cal plans have seen their medical ratios climb upward in the last five years and their net income has suffered. In 2000, five of the county-sponsored HMOs had medical loss ratios below 80 percent. In 2005, only one had a ratio below 80 percent and nine of them had ratios of 90 percent or higher.

3.9 Capitation Payments

Shifting risk from health plans to providers is another of the original fundamentals of managed care. In California, a relatively high but decreasing proportion of medical expenses is paid to providers through capitation arrangements. While many physician groups in the state are strongly committed to accepting and managing capitation contracts, hospitals largely exited their capitation arrangements in the past five years.

Because of reporting differences, the analysis of California HMO capitation data in this report may not be strictly comparable to what is reported in comparison states. Since 2002, annual statements (the revenue and expense exhibit) for California HMOs have divided medical expenses into capitation subcategories and fee-for-service subcategories. In other states that use the NAIC's 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.

Exhibit 21 shows that, on average, HMOs paid 35.1 percent of their medical payments through capitation in 2005. That is down from 42.1 percent of medical expenses in 2002. Health plans paid providers the rest through a variety of discounted fee-for-service methods or methods such as case rates or per diems that shift a limited measure of risk to hospitals.

There is wide variation in the extent to which California HMOs use capitation. PacifiCare has consistently capitated more than 60 percent of its medical expenses, particularly for Secure Horizons. That is a much different approach than that of UnitedHealthcare, PacifiCare's new owner. Health Net capitated more than half of its medical expenses in 2002 but that ratio has dropped to 40.2 percent in 2005. Similarly, Kaiser Permanente went from 58 percent in 2002 to 33 percent capitated in 2005. Blue Cross is at the low end, capitating about 16 percent of its medical expenses in the past four years.

EXHIBIT 21. Use of Capitation Payments by California HMOs, 2005

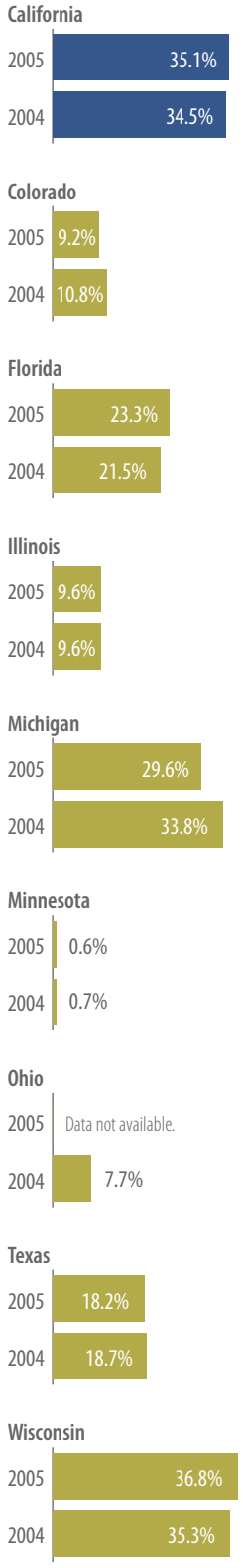
Plan	2005 Capitated Payments	2005 Total Medical Costs	Share of Medical Costs Paid Through Capitation 2005	2004	2003	2002
Largest HMOs						
Aetna Health	$415,978,147.00	$736,995,357.00	56.4%	54.8%	54.8%	49.6%
Blue Cross	1,478,385,000	8,997,496,000	16.4%	16.5%	16.3%	16.7%
Blue Shield	1,408,085,000	6,236,628,000	22.6%	22.6%	23.7%	24.6%
CIGNA Healthcare	296,087,628	$836,811,147	35.4%	33.0%	35.3%	37.2%
Health Net	2,205,797,942	5,485,937,966	40.2%	38.2%	42.4%	55.1%
Kaiser Permanente	9,628,541,000	29,213,869,000	33.0%	31.4%	40.3%	58.0%
Molina Healthcare	129,476,988	301,967,692	42.9%	48.5%	34.4%	33.0%
PacifiCare	3,675,784,000	5,769,849,000	63.7%	63.9%	65.6%	65.2%
Smaller HMOs						
California Health Plan	$17,878	$125,377	14.3%	42.5%	—	—
Care 1st Health Plan	107,619,964	255,950,500	42.0%	41.8%	43.3%	48.0%
Chinese Community Health Plan	38,564,439	51,447,361	75.0%	74.1%	74.5%	75.8%
Community Health Group	26,315,243	112,324,645	23.4%	21.0%	22.1%	44.6%
Community Health Plan	140,442,684	164,036,819	85.6%	82.0%	85.5%	86.1%
Great West Health	21,524,552	135,838,407	15.8%	19.4%	13.6%	13.1%
Honored Citizens	66,442	280,301	23.7%	NA	NA	NA
Inter Valley Health Plan	90,056,628	101,703,230	88.5%	82.6%	75.0%	NA
On Lok Senior Health Services	30,472,881	54,515,539	55.9%	55.3%	15.1%	16.2%
Santa Clara County (Valley Health Plan)	77,353,393	81,548,849	94.9%	93.2%	93.5%	94.6%
SCAN Health Plan	480,880,166	783,940,793	61.3%	62.6%	61.4%	50.8%
Sharp Health Plan	75,936,996	114,731,530	66.2%	52.9%	46.6%	43.7%
Universal Care	75,936,996	396,290,680	19.2%	49.7%	36.5%	38.5%
Ventura County	559,016	15,470,587	3.6%	4.1%	4.6%	4.5%
WATTSHealth Foundation	62,708,000	152,379,000	41.2%	38.7%	43.3%	36.4%
Western Health Advantage	140,654,842	179,003,167	78.6%	78.5%	78.0%	77.3%
County Health Plans						
Alameda Alliance for Health	$46,133,627	$134,635,484	34.3%	33.6%	34.8%	35.4%
CalOptima	285,752,903	810,259,023	35.3%	36.8%	38.2%	49.2%
Central Coast Alliance	6,984,538	234,649,055	3.0%	3.7%	4.3%	4.6%
Contra Costa Health Plan	53,883,032	132,540,466	40.7%	42.3%	6.0%	5.2%
Inland Empire Health Plan	136,915,699	302,996,729	45.2%	48.6%	69.1%	66.6%
Kern Health Systems	3,287,466	110,361,682	3.0%	3.3%	2.3%	0.0%
L.A. Care	864,323,791	896,964,615	96.4%	99.1%	98.9%	99.2%
San Francisco Health Plan	55,830,749	64,725,811	86.3%	73.3%	76.7%	80.7%
San Joaquin County Health	10,298,032	74,078,114	13.9%	56.9%	14.6%	15.6%
San Mateo Health Commission	6,282,423	123,227,104	5.1%	5.2%	5.4%	5.3%
Santa Barbara	4,361,825	144,385,152	3.0%	3.0%	3.3%	3.0%
Santa Clara Family Health Plan	74,913,998	114,929,164	65.2%	66.5%	63.7%	67.5%
TOTAL	**$22,251,047,279**	**$63,405,527,960**	**35.1%**	**34.5%**	**33.4%**	**42.1%**
Limited License Plans						
Heritage Provider Network	$277,885,191	$639,101,631	43.5%	41.3%	39.2%	47.9%
PrimeCare Medical Network	41,188,522	84,739,053	48.6%	47.5%	44.6%	52.7%
Scripps Clinic Health Plan Services	78,238,631	125,533,571	62.3%	55.7%	60.3%	57.1%

NA: Not applicable.

Source: Author's analysis of HMO annual statements.

HMO Capitation

Portion of dollars paid to providers through capitation arrangements.



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

EXHIBIT 22. Outpatient Prescription Drug Expenses for California HMOs (all lines of business)

Plan	2005 Expenses	PER MEMBER PER MONTH EXPENSE 2003	2004	2005	Change 2005/2004
Largest HMOs					
Aetna Health	$83,944,664	$18.38	$22.10	$24.20	9.5%
Blue Cross of California	1,351,436,000	20.27	22.68	24.60	8.4%
Blue Shield of California	903,072,000	16.55	28.44	19.57	– 31.2%
CIGNA Healthcare	78,512,036	17.11	16.83	18.65	10.8%
Health Net	581,324,750	19.25	21.43	23.38	9.1%
Kaiser Foundation	3,254,513,000	37.38	40.26	41.46	3.0%
Molina Healthcare	32,685,123	9.58	8.24	9.17	11.4%
PacifiCare	487,022,000	19.02	22.13	24.39	10.2%
Smaller HMOs					
Care 1st Health Plan	$29,939,599	$9.54	$13.06	$13.05	0.0%
Chinese Community Health Plan	4,612,176	25.28	30.09	32.66	8.5%
Great West	14,656,355	18.57	20.07	21.46	6.9%
Inter Valley Health Plan	8,144,083	61.18	52.23	51.28	– 1.8%
On Lok Senior Health Services	2,050,684	148.16	169.35	181.16	7.0%
SCAN Health Plan	64,152,363	55.11	64.42	73.25	13.7%
Sharp Health Plan	16,410,870	17.32	19.43	13.66	– 29.7%
Universal Care	45,598,008	12.50	8.08	8.10	0.2%
Ventura County	2,811,208	20.53	20.39	22.81	11.8%
WATTSHealth Foundation	17,092,000	14.72	17.72	16.18	– 8.7%
Western Health Advantage	30,148,492	27.05	30.17	32.72	8.4%
County Health Plans					
Alameda Alliance for Health	$19,273,110	$14.75	$16.27	$17.04	4.7%
CalOptima	185,590,722	41.73	43.78	47.37	8.2%
Central Coast Alliance	54,899,201	46.72	50.27	53.15	5.7%
Community Health Group	18,177,941	14.82	16.60	15.17	– 8.6%
Community Health Plan	14,896,855	7.47	7.84	7.75	– 1.2%
Contra Costa Health Plan	18,913,911	25.34	25.14	24.69	– 1.8%
Inland Empire Health Plan	57,683,048	14.60	16.26	16.61	2.1%
Kern Health Systems	21,858,013	17.53	21.06	20.14	– 4.3%
San Francisco Health Plan	1,052,301	17.16	16.15	1.79	– 88.9%
San Joaquin County Health	12,493,321	15.86	16.27	13.74	– 15.5%
San Mateo Health Commission	43,146,278	63.73	62.98	62.79	– 0.3%
Santa Barbara	38,807,791	68.38	62.38	57.42	– 8.0%
Santa Clara Family Health Plan	12,374,044	10.06	10.15	10.63	4.7%
TOTAL	$7,507,304,005	$24.33	$27.94	$28.01	0.3%

Source: Author's analysis of HMO annual statements.

Going forward, it will be interesting to compare the use of capitation among California HMOs. In interviews with executives at health plans and hospitals, it was clear that they are seeing less use of capitation, particularly in hospital contracts. And the evolving rebranding of PacifiCare may change the future of the capitated model for that organization. However, there is interest, even by hospitals, in exploring variations on capitation. It is understood that some health plans are willing to pay extra if hospitals and physicians are willing to play a significant role in managing inpatient utilization. And there is reason to expect that growth in senior plan enrollment will lead to more physician capitation, as it did during the 1990s.

3.10 Prescription Drugs

Outpatient prescription drugs have been a key driver of overall health costs and insurance premiums in recent years. *Exhibit 22* and *Exhibit 23* show outpatient prescription drug expenses using two sources. *Exhibit 22* uses an exhibit from the HMO annual and quarterly statements, which now have specific lines for prescription drugs paid by capitation and other methods. That data, for the entire health plan, shows that HMOs spent $7.5 billion on outpatient prescription drugs in 2005, which was $28.01 per member per month (PMPM), compared to $24.33 PMPM in 2003. The range among plans is quite wide and most likely reflects inconsistency in reporting.

Among the large commercial plans, CIGNA and Blue Shield reported relatively low expenses in 2005, while Kaiser's PMPM expense was higher than the rest of the health plans. In general, the PMPM expenses were lower for Medi-Cal plans in 2005. Some of the variation, such as the very low spending by San Francisco

EXHIBIT 23. Outpatient Prescription Drug Expense Per Member for Commercial Health Plans

HMO	Average Number Prescribed Per Year	AVERAGE COST PER MONTH 2004	2003	2002	2001
Aetna Health	6.0	NR	NR	NR	NR
Blue Cross	6.82	$28.79	$30.34	$38.85	$23.14
Blue Shield	9.83	38.63	35.11	30.08	NR
CIGNA Healthcare	8.08	NR	NR	24.57	21.59
Health Net	9.16	38.08	34.78	33.01	28.78
Kaiser Permanente, Northern California	12.14	25.53	24.87	21.58	18.82
Kaiser Permanente, Southern California	11.36	23.76	22.73	19.69	17.43
PacifiCare	8.79	35.39	32.86	30.63	26.36
Universal Care	6.32	25.85	24.17	NR	NR
Western Health Advantage	9.08	41.35	NR	NR	NR
U.S. Median	10.0	47.42	43.61	38.41	32.45
California Average	8.26	NA	NA	NA	NA

NA: Not available. NR: Not reported.

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

Health Plan, may reflect inconsistencies in reporting.

Exhibit 23 uses 2004 HEDIS data for commercial plans only and compares the PMPM prescription drug expense calculated from that data with the PMPM for recent years. Blue Shield showed the highest PMPM in this group at $38.63. These California HMOs were all below the U.S median of $47.42.

3.11 Administrative Expenses

HMO administrative expenses include compensation, marketing, and office expenses. *Exhibit 24* 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 2005, HMOs reported spending $5.1 billion in administrative costs for all lines of business. On average, they spent 7.6 percent of their revenues on administration, and $20.73 PMPM. That is an increase from $19.89 PMPM in 2004 and $15.37 in 2002.

Of the large HMOs, Kaiser Permanente and Molina Health report relatively low administrative costs per member per month. Kaiser had costs of $14.61 PMPM in 2005 while Molina had expenses of $10.54. Most of the county health plans also had relatively low administrative expenses on a per-member per-month basis. However, most of them were above average when administrative expenses were calculated as a percentage of expenses or of revenues.

3.12 Utilization and Effectiveness of Care Measures

As employers and health plans search for value, the need for improvements in measuring and reporting data on provider performance becomes more essential. Even with significant investment by health plans and providers in recent years, it is not clear how much progress has been made. The HEDIS (Health Plan and Employer Data Information Set) measures have eclipsed most of the competition and are seen as the standard for evaluative measures. HEDIS is administered by the National Committee for Quality Assurance (NCQA) in Washington, D.C. In addition to the HEDIS measures, the NCQA administers programs for accreditation of managed care organizations. Some states

NCQA Accreditation Status of California Health Plans

Aetna Health
Commercial/HMO & POS: *Excellent*
Medicare/HMO: *Commendable*

Blue Cross of California*
Commercial/HMO & POS: *Excellent*
Medicaid/HMO: *Excellent*

Blue Shield of California
Commercial/HMO & POS: *Excellent*
Medicare/HMO: *Commendable*

CIGNA HealthCare
Commercial/HMO & POS: *Excellent*

Community Health Group
Medicaid/HMO: *Commendable*

Health Net
Commercial/HMO & POS: *Excellent*
Medicare/HMO/Medicaid (scheduled): *Commendable*

Inland Empire Health Plan
Medicaid/HMO: *Excellent*

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

Molina Healthcare
Medicaid/HMO: *Commendable*

PacifiCare
Commercial/HMO & POS: *Excellent*
Medicare/HMO: *Excellent*

Western Health Advantage
Commercial/HMO: *Excellent*

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

RATING DEFINITIONS

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

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.

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.

Source: www.ncqa.com (Accessed June 2006).

EXHIBIT 24. Administrative Expenses for California HMOs, 2005

Plan	Administrative Expense	As a % of Revenues	As a % of Expenses	PER MEMBER PER MONTH 2005	2004
Largest HMOs					
Aetna Health	$92,116,244.00	10.0%	11.0%	$26.55	$23.92
Blue Cross	1,259,896,000	11.9%	13.1%	22.93	22.48
Blue Shield	847,585,000	12.4%	13.2%	28.79	27.48
Health Net	624,034,056	10.1%	10.1%	25.10	23.90
Kaiser Permanente	1,146,623,000	4.1%	3.9%	14.61	13.21
Molina Healthcare	37,547,645	13.8%	14.6%	10.54	7.91
PacifiCare	599,951,000	9.5%	10.1%	30.05	27.59
Smaller HMOs					
Care 1st Health Plan	$30,849,113	10.1%	10.6%	$13.45	$13.65
Chinese Community Health Plan	7,546,993	14.2%	14.6%	53.44	46.64
CIGNA Healthcare	38,479,558	3.3%	3.3%	40.94	26.85
Community Health Group	11,918,467	9.8%	9.0%	9.95	12.55
Community Health Plan	21,176,630	10.6%	11.0%	11.02	9.50
Great West Health Plan	21,273,906	15.8%	17.1%	31.15	30.39
Inter Valley Health Plan	10,467,185	NA	9.2%	65.90	61.27
On Lok Senior Health Services	4,241,365	7.2%	7.6%	374.68	332.53
SCAN Health Plan	72,169,980	9.1%	11.1%	82.41	84.94
Sharp Health Plan	10,447,841	5.2%	5.1%	8.70	9.92
Universal Care	52,830,117	11.9%	11.9%	9.38	9.66
Valley Health Plan	6,985,530	8.7%	8.7%	10.00	10.65
Ventura County	2,210,370	13.1%	13.1%	17.93	14.97
WATTSHealth Foundation	27,315,000	13.2%	12.6%	25.86	21.27
Western Health Advantage	18,222,371	11.3%	11.4%	19.78	19.13
County Health Plans					
Alameda Alliance for Health	$13,465,943	9.7%	8.9%	$11.91	$11.95
CalOptima	30,447,527	3.8%	3.8%	7.77	10.94
Central Coast Alliance	15,644,785	7.0%	7.2%	15.15	13.80
Contra Costa Health Plan	10,690,041	7.8%	7.8%	13.95	13.78
Inland Empire Health Plan	26,241,546	8.3%	8.3%	7.55	7.64
Kern Health Systems	9,651,196	9.3%	9.4%	8.89	10.45
San Francisco Health Plan	7,509,205	10.6%	11.2%	12.74	11.96
San Joaquin County Health	8,627,122	10.6%	11.0%	9.49	9.05
San Mateo Health Commission	11,572,353	8.8%	8.8%	16.84	14.33
Santa Barbara	10,470,036	6.8%	7.0%	15.49	14.08
Santa Clara Family Health Plan	15,363,836	12.0%	12.3%	13.20	12.23
TOTAL	**$5,141,836,656**	**7.6%**	**7.7%**	**$20.73**	**$19.89**

Source: Author's analysis of HMO annual statements.

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 sell insurance benefits to them.

The accreditation status of California HMOs as of July 2006 is reported in the sidebar on page 49: "NCQA Accreditation Status of California Health Plans." Most of the large health plans in the state have had the highest level of accreditation, which is Excellent. At times, the Department of Managed Health Care has examined the possibility of using NCQA accreditation as a substitute for some of its own reporting and regulatory requirements. That might free up state resources to focus on problem areas and might save money for the health plans.

A sidebar on page 27 titled "Sources of Comparative Information on Health Plan and Provider Quality" lists several public resources on the Internet. In addition, the California HealthCare Foundation (CHCF) sponsors a hospital report card with comparative data on hospital performance. An expanded version of the CHCF hospital information site will include ratings on treating heart conditions and pneumonia, delivering babies, and preventing infections. The updated Web site, which is scheduled to be launched in early 2007, will provide information on how patients rate their treatment.

Another resource is the California Cooperative Healthcare Reporting Initiative (CCHRI), a collaborative of prominent employers, providers, and health plan companies. The CCHRI is committed to standardized, comparable reports on health care performance so that consumers and other users are able to compare health plans on an "apples to apples" basis. The data comparisons are

posted at the California HealthScope Web site (www.healthscope.org), sponsored by the Pacific Business Group on Health. Those comparisons usually will display one to five stars as a way of showing meaningful differences between health plans. The tables in this report present the actual scores.

This section of the report 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 2004. Note that the data here are for all commercial lines of business that they operate, including point-of-service plans, which may go beyond the commercial enrollment reported on the state filings. Kaiser Permanente uses only its HMO enrollment.

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

Inpatient hospital care is a major health care expenditure and a key driver of increases in health care costs. Hospital expenses are the product of utilization and payment rates. When both go up, the result is higher health care costs.

Exhibit 25 compares California's major HMOs on their rates of acute care inpatient hospital utilization for commercial enrollees in 2004. The rates reported are acute inpatient days per 1,000 members, inpatient discharges per 1,000 members, and average length of inpatient stay. Two columns show inpatient care rates for mental health and chemical dependency care, which are not HEDIS measures, but which were calculated from other measures.

The California average inpatient hospital utilization rate is much lower than the U.S. median, except for mental health and chemical dependency inpatient care. California HMOs continue to report relatively low rates of inpatient hospital utilization, with all those reporting here falling well below the national median. The national median has generally increased in the past four years. However, the picture is mixed in California. Utilization rates for some HMOs, like Health Net and PacifiCare, have increased significantly between 2001 and 2004. Blue Cross also grew by about 12 days per 1,000 enrollees. But the two Kaiser plans had lower rates in 2004 than in 2001.

The Quality Compass® data set includes four measures of ambulatory care utilization: outpatient visits, emergency room visits, ambulatory

EXHIBIT 25. Inpatient Hospital Utilization Rates for Commercial Health Plans, 2004

	ACUTE DAYS PER 1,000 MEMBERS					DAYS PER MEMBER	DAYS PER 1,000 MEMBERS	
HMO	2004	2003	2002	2001	Discharges	Average Length of Stay	Chemical Dependency	Mental Health
Aetna Health	159.05	180.76	139.79	163.43	43.49	3.66	7.54	13.91
Blue Cross of California	146.80	142.97	142.42	134.96	42.76	3.43	8.89	64.40
Blue Shield of California	178.55	182.19	176.35	NR	52.42	3.41	2.39	12.79
CIGNA Healthcare	166.13	154.14	137.12	NR	47.25	3.52	3.35	8.48
Health Net	161.73	151.42	137.82	121.45	44.39	3.64	ND	ND
Kaiser Permanente, Northern California	149.34	153.94	154.63	154.40	46.76	3.19	4.46	14.27
Kaiser Permanente, Southern California	150.10	157.21	158.06	150.57	44.72	3.36	2.69	15.36
PacifiCare	167.95	164.81	156.47	138.94	48.02	3.50	5.53	13.18
Universal Care	162.48	165.42	NR	NR	45.77	3.55	2.64	10.63
Western Health Advantage	163.21	NR	NR	NR	46.09	3.54	2.01	14.22
U.S. Median	212.38	214.62	208.61	206.98	58.46	3.64	5.22	16.70
California Average	163.37	NA	NA	NA	46.39	3.53	5.95	20.67

NA: Not available. ND: No data, meaning that the HMO did not have enough members to meet NCQA standards of statistical significance or to protect privacy of individual members. NR: Not reported.

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

surgery, and observation room visits. In *Exhibit 26*, the numbers of visits and procedures are presented as rates per 1,000 members. Commercial enrollees in PacifiCare used an average of 2,813 outpatient (office) visits per 1,000 members, higher than in 2002 and 2001. The Kaiser Permanente plan for southern California came in with an average of 4,348 visits, higher than the northern Kaiser rate of 3,528 visits.

The average rate of emergency room use for California commercial health plans is lower than the national average. As in previous years, the southern California Kaiser enrollees had higher rates of emergency room usage than their counterparts in northern California.

Exhibit 27 compares HMOs on seven effectiveness of care measures and one utilization of care measure. The results vary quite a bit, with some HMOs scoring very high on some measures and low on others. The range is widest on the well-child visits—even the two Kaiser plans reported quite different results on that measure. In northern California, 74 percent of Kaiser enrollees met the standard of six well-child visits, but only

EXHIBIT 26. Ambulatory Utilization Measures Per 1,000 Members for Commercial Health Plans, 2004

HMO	Outpatient Visits	Ambulatory Surgery Procedures	Observation Room Stays	Emergency Room Visits 2004	Emergency Room Visits 2003
Aetna Health	2,316.66	46.49	4.16	163.34	190.75
Blue Cross	NR	NR	NR	128.58	153.89
Blue Shield	2,980.73	68.63	6.25	151.36	130.37
CIGNA Healthcare	2,865.62	54.74	3.10	110.93	119.59
Community Health Group	NR	NR	NR	NR	209.11
Health Net	3,054.57	82.32	3.06	121.88	125.74
Kaiser Permanente, North	3,527.57	29.97	7.14	161.35	170.24
Kaiser Permanente, South	4,347.65	24.98	8.21	180.09	203.04
PacifiCare	2,813.04	74.20	3.58	133.43	139.40
Universal Care	2,997.97	59.25	3.52	131.66	135.95
Western Health Advantage	3,135.48	91.55	1.72	131.08	NR
U.S. Median	3,578.96	116.41	8.97	176.20	179.27
California Average	2,806.12	65.28	4.03	134.92	NA

NA: Not available. NR: Not reported.

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

EXHIBIT 27. Selected Effectiveness of Care Measures for Commercial Health Plans, 2004

HMO	Product	Beta Blocker Treatment After a Heart Attack	Cancer Screening		Comprehensive Diabetes Care Eye Exams	Controlling High Blood Pressure	Immunization Status - Combo 1		Well-Child Visits (6 or more in the first 15 months)
			Cervical	Breast			Childhood	Adolescent	
Aetna Health	HMO & POS	95.65	80.51	72.78	55.16	71.58	77.00	65.96	29.75
Blue Cross	HMO & POS	94.38	83.33	74.12	54.59	75.28	76.69	68.45	NR
Blue Shield	HMO & POS	95.63	81.53	79.04	57.18	67.34	75.97	70.42	33.58
CIGNA Healthcare	HMO & POS	95.39	83.68	74.27	50.85	77.06	78.27	72.02	38.41
Community Health Group	HMO	NA	71.05	57.20	24.89	44.38	71.43	48.24	NR
Health Net	HMO & POS	97.54	83.03	75.63	51.45	71.36	77.81	62.12	52.02
Kaiser Foundation, North	HMO	100.00	82.75	74.80	66.18	73.26	86.76	79.08	60.70
Kaiser Foundation, South	HMO	99.09	79.08	73.02	64.06	56.78	80.37	77.37	74.32
PacifiCare	HMO & POS	97.95	85.47	74.05	54.48	68.12	76.86	66.13	40.55
Universal Care	HMO	96.67	83.15	70.89	41.53	74.13	74.47	61.28	NR
Western Health Advantage	HMO	NR	80.51	71.84	37.71	64.23	67.88	52.55	68.47
U.S. Median	HMO & POS	96.49	81.37	73.65	50.75	67.50	76.72	64.37	69.52
California Average	HMO & POS	96.09	82.93	74.98	53.95	71.79	77.10	67.51	38.86

Explanation of Measures: *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. *Breast Cancer Screening* identifies women ages 52 through 69 who had one or more mammograms during the reporting year or the prior year. *Comprehensive Diabetes Care Eye Exams* identifies members ages 18 to 75 with diabetes who received a retinal exam during the report year. *Controlling High Blood Pressure* measures control of blood pressure (less than or equal to reading of 140/90 for adults ages 46 to 85 years who are diagnosed with hypertension). *Childhood Immunization Status Combo 1* 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.

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

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

61 percent of southern California Kaiser enrollees had six visits in 2004.

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

3.13 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®).

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

As in past years, ratings of health care came out higher than the ratings of health plans. Still, the gap is very narrow for southern California Kaiser. All but two of the California HMOs listed here showed an improvement from 2003 to 2004 on the rating of all health care. Health Net and Western Health Advantage both had a better than 7 percentage point improvement.

EXHIBIT 28. Enrollee Satisfaction Measures for Commercial Health Plans, 2004 CAHPS Survey Data

HMO	Customer Service	Getting Care Quickly	Getting Needed Care	Rating of Health Plan	Rating of All Health Care 2004	Rating of All Health Care 2003
Aetna Health	68.62	72.52	70.36	63.07	68.59	65.43
Blue Cross	67.05	75.49	72.46	69.82	73.35	67.10
Blue Shield	66.63	74.81	76.10	63.57	69.14	69.82
CIGNA Healthcare	64.42	70.92	67.70	54.36	67.92	68.28
Health Net	67.71	75.32	77.02	58.71	77.27	69.88
Kaiser Permanente, North	76.95	79.96	77.55	72.38	74.94	69.70
Kaiser Permanente, South	74.74	72.78	75.93	73.25	73.14	68.48
PacifiCare	72.27	75.73	75.97	69.55	76.33	70.93
Universal Care	74.64	73.34	70.41	67.80	75.11	70.62
Western Health Advantage	77.41	78.04	74.75	72.78	74.82	67.44
U.S. Median	70.88	79.96	79.79	63.88	78.06	72.97
California Average	67.75	73.98	72.42	64.42	71.68	NA

NA: Not available.

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 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 hours; (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.
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.
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.
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.

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

Seniors, Long-Term Care and Medi-Cal Redesign

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

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

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

4.0 Regional Sub-Markets and Provider Systems

To paraphrase Tip O'Neill, "All health care is local." Or is it? Most Californians in HMOs and other insurance plans are covered through national companies that are doing business across the country. And, as was pointed out earlier, recent acquisitions have meant that much of the decision-making authority in companies that were distinctly California-based has now departed for Minneapolis and Indianapolis.

Some might argue that the *delivery* of health care is local, provided by health care professionals at facilities that are closely identified with local communities. The family practice doctor, the community hospital where your neighbor sits on the board — these are what gives medicine a local feel. While this may be true, it is less so in California than in many other states. Many hospitals in California are part of national companies — Tenet and HCA, especially — and many more are part of systems that have a wide presence in many parts of the state — Kaiser, Catholic Healthcare West, and Sutter. As for physician groups, while only the Permanente groups approach having a statewide presence, many of the largest medical groups operate clinics that cover much of the large metropolitan areas.

4.1 About This Analysis

This section of the report examines provider systems and 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, including Imperial County.

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

Hospital Analysis. In this report, the analysis is limited to acute care hospitals. It does not include hospitals devoted to rehabilitation or behavioral health, or hospitals for military veterans or active duty personnel. Where data are available, the analysis does include the specialty hospitals that are focused on surgery, cardiology, and orthopedics. These are often constructed and operated by national management companies working with entrepreneurial local physicians. Their proliferation was slowed by a moratorium imposed by Congress in 2003.

The hospital analysis in this section uses financial and utilization data that the Office of Statewide Health Policy and Development (OSHPD) collects from hospitals each year. The data presented here are for hospital reporting years ending between January 1 and December 31, 2004. That data set typically becomes available in the fall of the following year. OSHPD also produces a valuable hospital discharge database each quarter that enables researchers to compare hospitals on the volume of key procedures

performed and the charges for those procedures. (Those data were not used for this report.)

The OSHPD data are used to produce two tables of hospital data for each regional section. The first table examines financial performance, including revenues, expenses, and net income. The second shows measures of inpatient occupancy and payer mix, that is, the proportion of inpatient hospital days that were expected to be paid by Medicare, the state/federal Medi-Cal program, third-party insurers (including managed care plans), and other sources. 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 stay would be attributed to Medi-Cal and not to the managed care payer.

In the tables, hospitals are grouped based on their system or network affiliation at the end of 2004. Independent hospitals, some of which are quite large, are listed after the system members. Those affiliations are not permanent — in the past four years there have been numerous hospital sales and other changes in affiliation. For example, as part of a national restructuring, Tenet sold several of its California hospitals, mostly to newly formed hospital groups. The Daughters of Charity, with seven hospitals in the state, used to be a member of Catholic Healthcare West (CHW), but pulled its hospitals away from CHW in 2002.

Pie charts in the sections for three of the regions (the Bay Area, Los Angeles/Orange, and San Diego/Imperial) show the market share of the major hospital systems and largest independent hospitals. In this analysis, regional market share for hospitals 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 2005.

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

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

Physician Organization Analysis. Each section includes a table that provides an overview of physician organizations operating in the geographic region. Mark Richardson, a Minnesota-based researcher, prepared the tables using a data set of California physician organizations. The Cattaneo & Stroud research firm compiled that data set, with support from the California HealthCare Foundation. The physician data are generally from 2005 and are as estimated and reported by the responding physician organizations.

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. This year data were added to the physician organization tables using some of the financial solvency measures assembled by the Department of Managed Health Care. Those data are reported quarterly and are available from the Department's Web site at www.dmhc.ca.gov/providers/rbo/rbo_default.asp.

Within each table, physician organizations have been grouped into four categories: integrated medical group practice, medical foundation, independent practice association (IPA), and other. These distinctions have blurred in recent years, and some organizations are now hybrids of those categories. For example, some integrated medical groups have an affiliated IPA network for which they provide administrative services. A discussion of the different forms of physician organizations in California appears in Section 2.4 of this report.

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

4.2 San Francisco Bay Area

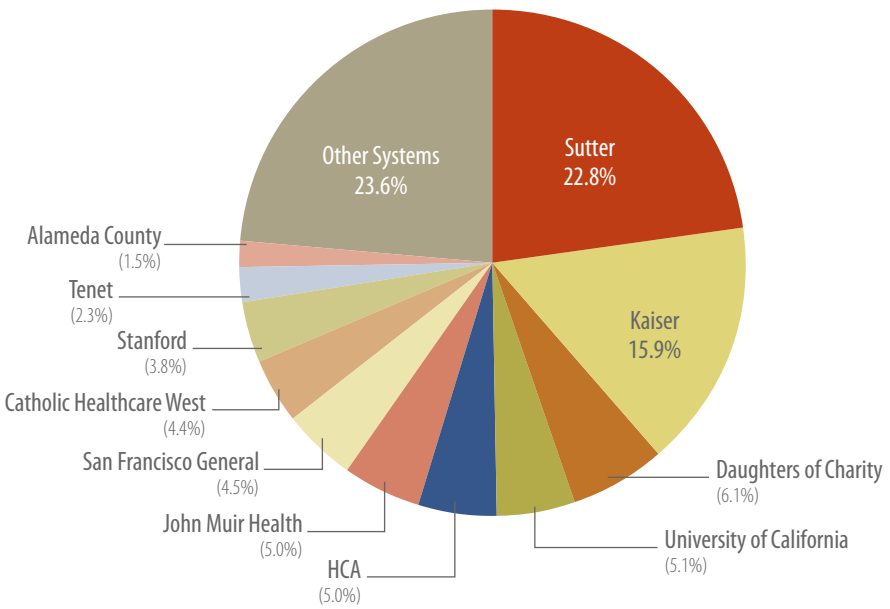
The analysis of the San Francisco Bay Area examines provider organizations and health plans in six counties: Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara. Some health care organizations, like the Kaiser and Sutter hospitals, cover almost the entire region. Others, like John Muir Health, have a dominant position in distinct submarkets.

In the exhibits that follow, hospitals are grouped into seven major systems, two large and prominent academic health centers (Stanford University in Palo Alto and University of California–San Francisco), and an "Other Hospitals" section that includes public and independent hospitals. The systems are Catholic Healthcare West, Daughters of Charity, HCA: The Healthcare Company, Kaiser Foundation, Sutter Health, Tenet Health, and John Muir Health. HCA and Tenet are for-profit companies with a relatively small presence while the other systems are organized as nonprofits. All of the region's six counties or county hospital districts operate general hospitals. (The Marin County hospital is a Sutter affiliate.)

Overview of Hospitals

Exhibit 29 shows the inpatient market share of hospitals and systems in the Bay Area, based on inpatient days in 2004. Hospitals in the area had a total of 3.2 million inpatient days in 2004. Sutter is the largest system, with 22.8 percent of the market, followed by the Kaiser Foundation hospitals in the region. The five public hospitals in the area (Alameda County, Contra Costa Regional, San Francisco General, San Mateo General and Santa Clara Valley) had 527,000 days, or 16.8 percent of the total market, in 2004.

EXHIBIT 29. Market Share of Bay Area Hospital Systems, 2004



Source: Author's analysis of annual hospital report data for year-end 2004 from Office of Statewide Health Planning and Development.

The Sutter Health hospital group in the Bay Area grew through a series of acquisitions to become the largest in the region in 2004, with a total of 2,742 beds in 10 hospitals. Sutter added St. Luke's in San Francisco in 2003 and Summit Medical Center in Oakland in 1999. The Summit acquisition was opposed because of concerns that it gave too much market power to the Sutter system in the East Bay area. Alta Bates in Berkeley and Summit in Oakland are considered as two campuses for a single hospital. The Sutter system is tied to major physician groups in the Bay Area, including the Palo Alto Medical Foundation (which in turn includes the Camino Medical Group), and the Alta Bates IPA in Oakland.

The nine Kaiser Foundation hospitals comprise the second largest hospital system in the Bay Area with a total of 1,475 beds in 2004. The largest Kaiser inpatient facility is its Oakland medical center, with 231 beds in 2004, while some of its other facilities have fewer than 100 inpatient beds. In the late 1990s, Kaiser was concerned about the amount of capital needed to retrofit its hospitals to meet seismic safety requirements. It contracted out more of its hospital services and made only modest investments in its Bay Area hospitals. Within a few years, though, Kaiser returned to its strategy of being a self-contained system relying heavily on its own hospitals. It has resumed making investments in its Bay Area hospitals and, in a project estimated to cost $500 million, plans to rebuild its Oakland hospital and medical center over the next eight years.

Catholic Healthcare West (CHW) once had seven hospitals in the Bay Area. However, the Daughters of Charity of St. Vincent de Paul—Western region, one of the members of CHW, withdrew its four Bay Area hospitals from CHW in 2002 and now operates separately in the Bay Area. (Daughters of Charity also pulled its three hospitals in Los Angeles from CHW at the same time.)

Hospitals owned by for-profit companies like HCA: The Healthcare Company and Tenet Health are much less significant in the north than in southern California. These two systems together have less than 10 percent of the inpatient hospital days in the Bay Area. HCA closed San Jose Medical Center in 2004 after consecutive years of losses. After 2004, Tenet gave up its lease of Doctors Hospital in San Pablo, which is owned by a local hospital district.

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

Financial Results

Exhibit 30 compares Bay Area hospitals on their revenues and net income. Financial results generally improved when compared to 2003. In 2004 the hospitals had $878.1 million in net income, or 5.9 percent of $14.9 billion total revenues. That is similar to 2003, when Bay area hospitals reported $780.2 million in net income, which was also 5.9 percent of total revenues of $13.1 billion. As a group they had $596.6 million in net income from operating revenue in 2004 plus an additional $329 million in net income from other sources, including investments, philanthropy, government funds, and so on.

The Sutter hospitals reported net income of $232.7 million, or 8.9 percent of total revenues. That compares to 2003 net income of $206.1 million, or 8.8 percent of total revenues. Much of the net income is generated by a single hospital, California Pacific Medical Center in San Francisco. In 2004, it had net income of $150.3 million. Peninsula Medical Center in Burlingame had net income of $34.3 million in 2004, down a little from $38.5 million in 2003. The two Alta Bates campuses lost money in 2001 and 2002 but had combined net income of $31 million in 2004 and $38.3 million in 2003. St. Luke's in San Francisco lost money in 2004 and 2003.

In 2004, the Kaiser Foundation hospitals in northern California improved their very strong results from 2003. As shown in the table, the Northern Region hospitals (including the Bay Area and its hospitals in Sacramento) had net income of $484.7 million, or 11.1 percent of total revenues of $4.4 billion. In 2003, the northern California Kaiser hospitals had net income of $284.1 million, or 8.1 percent of total revenues.

EXHIBIT 30. Revenues and Net Income for Bay Area Hospitals, 2004

System / Hospitals	City	Total Charges	Net Patient Revenue	Total Revenue	Operating Expenses	Net from Operations	Net Income (Loss)	% of Total Revenue
Catholic Healthcare West		**$1,734,549,032**	**$424,565,199**	**$449,294,516**	**$419,241,291**	**$12,089,469**	**$22,631,737**	**5.0%**
St. Francis Memorial Hospital	San Francisco	471,515,198	118,734,929	133,375,421	117,509,530	2,798,159	9,634,485	7.2%
St. Mary's Medical Center	San Francisco	613,919,639	142,321,613	149,218,418	144,146,735	1,244,996	4,304,485	2.9%
Sequoia Hospital	Redwood City	649,114,195	163,508,657	166,700,677	157,585,026	8,046,314	8,692,767	5.2%
Daughters of Charity		**$1,892,929,366**	**$457,006,495**	**$475,367,502**	**$436,373,137**	**$24,569,527**	**$34,196,338**	**7.2%**
O'Connor Hospital	San Jose	759,063,318	180,263,902	191,388,005	174,289,662	7,643,153	15,878,536	8.3%
St. Louise Regional Hospital	Gilroy	208,141,150	56,182,074	56,595,300	53,396,953	3,005,158	3,123,749	5.5%
Seton Medical Center	Moss Beach	24,755,937	11,612,383	11,989,317	14,137,507	(2,171,337)	(2,158,311)	– 18.0%
Seton Medical Center	Daly City	900,968,961	208,948,136	215,394,880	194,549,015	16,092,553	17,352,364	8.1%
HCA: The Healthcare Company		**$2,031,276,658**	**$517,894,124**	**$524,398,536**	**$576,796,832**	**($54,366,315)**	**($57,351,985)**	**– 10.9%**
Good Samaritan Hospital	San Jose	996,104,098	285,966,361	290,156,442	267,038,273	21,721,563	22,718,727	7.8%
Regional Medical Center	San Jose	563,081,364	118,755,313	119,477,298	149,491,836	(30,054,487)	(30,014,538)	– 25.1%
San Jose Medical Center	San Jose	472,091,196	113,172,450	114,764,796	160,266,723	(46,033,391)	(50,056,174)	– 43.6%
John Muir Health		**2,400,910,262**	**654,664,516**	**712,186,062**	**612,255,780**	**86,071,424**	**95,493,564**	**13.4%**
John Muir Medical Center	Concord	927,511,315	223,053,580	231,894,543	209,271,142	17,002,475	18,813,686	8.1%
John Muir Medical Center	Walnut Creek	1,439,572,980	414,636,219	462,990,718	384,483,571	70,281,549	77,880,144	16.8%
Mt. Diablo Medical Pavilion	Concord	33,825,967	16,974,717	17,300,801	18,501,067	(1,212,600)	(1,200,266)	– 6.9%

EXHIBIT 30. Revenues and Net Income for Bay Area Hospitals, 2004, cont.

System / Hospitals	City	Total Charges	Net Patient Revenue	Total Revenue	Operating Expenses	Net from Operations	Net Income (Loss)	% of Total Revenue
Kaiser Foundation, Northern Region*		**$4,374,946,299**	**$4,374,946,299**	**$4,374,946,299**	**$3,887,678,099**	**$487,268,200**	**$484,695,532**	**11.1%**
Stanford University Hospital		**$2,825,035,068**	**$1,049,301,180**	**$1,146,658,327**	**$1,041,160,945**	**$96,155,052**	**$101,304,088**	**8.8%**
Sutter Health		**$8,483,628,631**	**$2,461,192,389**	**$2,605,504,650**	**$2,355,456,847**	**$184,428,341**	**$232,651,128**	**8.9%**
Alta Bates Summit, Alta Bates Campus	Berkeley	1,579,771,517	428,791,773	444,442,898	435,102,594	5,421,238	6,194,150	1.4%
Alta Bates Summit, Hawthorne Campus	Oakland	1,382,825,306	319,085,213	352,993,429	326,355,826	20,602,421	24,807,886	7.0%
California Pacific Medical	San Francisco	2,277,939,210	745,167,312	794,323,089	644,015,148	120,260,831	150,307,941	18.9%
Eden Medical Center	Castro Valley	667,295,181	186,139,901	190,482,821	177,781,603	11,767,563	12,000,198	6.3%
Marin General Hospital	Greenbrae	686,725,341	219,820,381	239,541,323	222,324,268	3,291,903	12,780,559	5.3%
Merritt Peralta Institute	Oakland	5,330,267	780,614	824,057	4,402,071	(3,578,014)	(3,578,014)	– 434.2%
Novato Community Hospital	Novato	147,390,714	52,121,769	54,195,546	47,142,421	5,399,818	4,123,119	7.6%
Peninsula Medical Center	Burlingame	1,075,655,782	319,659,720	329,381,961	292,489,530	31,920,577	34,319,053	10.4%
St. Luke's Hospital	San Francisco	353,208,938	93,053,730	98,425,208	118,190,085	(20,886,340)	(21,165,515)	– 21.5%
Sutter Delta Medical Center	Antioch	307,486,375	96,571,976	100,894,318	87,653,301	10,228,344	12,861,751	12.7%
Tenet Health		**$1,548,558,530**	**$273,674,481**	**$279,168,573**	**$295,140,195**	**($19,676,846)**	**($19,570,441)**	**– 7.0%**
Community Hospital	Los Gatos	517,797,848	104,665,375	107,818,574	107,084,857	(1,629,968)	(2,047,031)	– 1.9%
Doctors Medical Center	San Pablo	524,840,266	64,163,579	65,155,267	85,399,450	(20,874,367)	(20,653,446)	– 31.7%
San Ramon Regional Medical	San Ramon	505,920,416	104,845,527	106,194,732	102,655,888	2,827,489	3,130,036	2.9%
UCSF Medical Center†		**$3,104,650,057**	**$1,013,972,316**	**$1,033,234,598**	**$1,049,094,414**	**($21,426,320)**	**($19,266,300)**	**– 1.9%**
Others		**$7,124,523,187**	**$2,899,656,091**	**$3,329,935,627**	**$3,127,762,544**	**($198,485,929)**	**$3,329,354**	**0.1%**
Alameda County Medical	Oakland	500,342,516	269,463,252	282,710,103	205,632,597	(47,275,078)	(41,477,205)	– 14.7%
Alameda Hospital	Alameda	210,406,111	38,474,674	44,727,413	52,241,573	(13,624,606)	(7,633,087)	– 17.1%
Children's Hospital	Oakland	434,442,363	209,386,573	270,528,848	270,146,389	(7,590,783)	(4,988,764)	– 1.8%
Chinese Hospital	San Francisco	93,957,222	51,288,964	53,097,498	49,173,196	2,928,279	3,924,302	7.4%
Contra Costa Regional	Martinez	362,732,725	209,682,185	301,433,246	259,204,283	(38,068,371)	(187,297)	– 0.1%
El Camino	Mt. View	834,208,378	253,946,689	265,871,777	241,808,777	20,424,469	24,063,000	9.1%
Fremont Hospital	Fremont	32,212,162	17,153,199	17,252,753	16,851,914	313,797	387,989	2.2%
Lucile S. Packard Children's	Palo Alto	873,278,665	377,273,847	420,043,607	373,560,577	38,714,313	46,483,030	11.1%
Menlo Park Surgical Hospital	Menlo Park	14,438,082	5,649,392	5,658,015	7,298,613	(1,647,193)	(6,219,435)	– 109.9%
St. Rose Hospital	Hayward	274,899,496	81,251,387	82,317,855	82,549,263	(231,408)	(231,408)	-0.3%
San Francisco General	San Francisco	766,185,589	393,955,632	419,229,898	407,828,267	(5,845,088)	(4,746,313)	– 1.1%
San Mateo Medical Center	San Mateo	229,740,987	100,509,857	175,883,431	172,344,471	(60,743,829)	(7,187,167)	– 4.1%
Santa Clara Valley Medical	San Jose	1,277,456,987	500,649,301	590,413,409	610,010,982	(104,880,771)	(19,597,573)	– 3.3%
Valley Memorial Hospital	Livermore	577,405,961	159,320,170	165,165,381	159,440,986	4,545,842	5,045,406	3.1%
Washington Hospital	Fremont	642,815,943	231,650,969	235,602,393	219,670,656	14,494,498	15,693,876	6.7%
	TOTAL	**$35,521,007,090**	**$14,126,873,090**	**$14,930,694,690**	**$13,800,960,084**	**$596,626,603**	**$878,113,015**	**5.9%**

*Includes all northern California hospitals for Kaiser Foundation.

†UCSF Medical Center reported a 2004 net loss of $19.3 million in its OSHPD report but net income of $55.5 million in its audited financial statements. The difference of $74.8 million is the result of other revenues that are recorded in the OSHPD report as an unspecified Other Addition to Equity item of $74.9 million.

Source: Author's analysis of data for fiscal years ending in 2004 from Office of Statewide Health Planning and Development.

The Catholic Healthcare West hospitals reported net income of 5.0 percent of total revenues, down from 6.1 percent of total revenues in 2003. The four Daughters of Charity hospitals in the Bay Area had net income of 7.2 percent in 2004, and three of the four hospitals were profitable.

The John Muir Health system hospitals in Contra Costa County had strong results in 2004. They combined for $95.5 million in net income, or 13.4 percent of total revenues. While most of that was from operations at John Muir Medical Center in Walnut Creek, the Concord campus of the John Muir Medical Center improved its profitability in 2004. In 2003, the two medical centers had net income of $65.7 million. The John Muir hospitals have a very strong geographic presence in Contra Costa County; their local competition is the Contra Costa Regional Medical Center and the Tenet hospital in San Ramon. A new John Muir hospital is planned for the eastern end of Contra Costa County, but a new Kaiser hospital will open there first. For many years, Kaiser patients would be admitted to John Muir for certain specialty services. That has declined in recent years and Kaiser has preferred to do most of that specialty work in its owned facilities.

The three HCA hospitals in the area reported a loss of $57.4 million in 2004, or 10.9 percent of total revenues. Good Samaritan Hospital has consistently made a profit, but HCA's other two hospitals in San Jose have lost money. The Tenet Health hospitals also lost money in 2004, reporting a combined loss of $19.6 million, or 7.0 percent of total revenues. A year earlier, the Tenet hospitals had $21.9 million in net income, or 6.1 percent of total revenues.

Several of the public hospitals in the region lost money in 2004: Alameda County Medical Center lost $41.5 million and Santa Clara Valley Medical Center lost $19.6 million, in both cases more than they lost in 2003. Contra Costa Regional Medical Center roughly broke even in 2004 and 2003. Public hospitals benefit from special funds for hospitals that serve a disproportionate number of uninsured patients, but they also are required to transfer funds out in order to leverage the disproportionate share funds. Those financing mechanisms for public hospitals serving large numbers of Medi-Cal enrollees and uninsured persons have changed and may significantly change financial results in future reports.

Stanford University Hospital had net income of $101.3 million in 2004, most of which was from its significant other revenues. Based on the OSHPD reports, the University of California–San Francisco (UCSF) Medical Center lost $19.3 million in 2004. However, its financial statements show net income of $455.5 million. The UCSF Medical Center does not make intergovernmental transfer (IGT) payments. The difference of $74.8 million is due to several factors. For one, the Medical Center transfers money to the University of California system for pensions and other purposes. These are shown as a reduction of net assets on the UC financial statements but as an expense in the OSHPD reports. Both Stanford and UCSF had positive net income in 2003.

Occupancy

Exhibit 31 shows inpatient occupancy for Bay Area hospitals in 2004. Inpatient occupancy rates declined slightly, averaging 63.2 percent in 2004, compared to 65.0 percent in 2003 and 63.0 percent in 2001. However, the total number of inpatient days at area hospitals increased by almost 3 percent.

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

The Kaiser Foundation in the Bay Area reported average inpatient occupancy of 62.8 percent in 2004, compared to 68.1 percent in 2003 and 61.3 percent in 2001. Inpatient hospital days at area Kaiser hospitals grew slightly in 2004, to 504,105, compared to 500,907 in 2003. CHW hospitals reported 2004 occupancy rates of 40.6 percent. (In general, the Daughters of Charity hospitals that withdrew from CHW were stronger than the CHW hospitals that remained.) The Sutter hospitals in the Bay Area had average occupancy of 65 percent in 2004, with Alta Bates in Berkeley having the highest rate in the system. As in past years, the John Muir Health hospitals had high occupancy rates.

Stanford University reported occupancy of 73.3 percent (up from 69.9 percent in 2003) and UCSF had inpatient occupancy of 77.1 percent, up from 71.4 percent in 2003. Tenet Health's Bay Area hospitals had inpatient occupancy rates of less than 50 percent, which is typical for Tenet facilities in several states. In their most profitable years, Tenet hospitals in California, Florida, and Texas had relatively low inpatient occupancy (less than 50 percent), but high net income.

Several major hospital construction projects are underway or planned in the

EXHIBIT 31. Inpatient Occupancy Rates and Payer Mix for Bay Area Hospitals, 2004

System / Hospital	Staffed Beds	Inpatient Days	Occupancy	PAYER DISTRIBUTION				
				Medicare	Other Third Parties	Medi-Cal	County Indigent	Other Payers
Catholic Healthcare West	**799**	**138,293**	**40.6%**	**58.9%**	**26.6%**	**10.5%**	**0.0%**	**4.0%**
St. Francis Memorial Hospital	239	44,961	51.4%	54.1%	22.4%	16.8%	0.0%	6.7%
St. Mary's Medical Center, San Francisco	271	49,195	34.2%	58.8%	26.6%	11.3%	0.0%	3.2%
Sequoia Hospital	289	44,137	40.3%	64.0%	30.8%	3.2%	0.0%	2.1%
Daughters of Charity	**713**	**193,603**	**66.6%**	**48.2%**	**16.9%**	**32.2%**	**0.0%**	**2.7%**
O'Connor Hospital	225	56,963	50.9%	61.8%	28.4%	8.0%	0.0%	1.7%
St. Louise Regional Hospital	89	15,825	48.6%	56.9%	28.9%	10.4%	0.0%	3.8%
Seton Medical Center, Coastside	121	39,773	89.8%	5.0%	1.6%	88.9%	0.0%	4.4%
Seton Medical Center	278	81,042	79.6%	58.1%	14.0%	25.6%	0.0%	2.3%
HCA: The Healthcare Company	**452**	**158,887**	**56.7%**	**45.4%**	**38.8%**	**13.6%**	**0.0%**	**2.2%**
Good Samaritan Hospital, San Jose	215	76,961	77.0%	36.3%	58.1%	4.7%	0.0%	0.8%
Regional Medical Center of San Jose	133	45,159	67.1%	51.8%	21.5%	24.3%	0.0%	2.5%
San Jose Medical Center	104	36,767	32.6%	56.4%	19.5%	19.2%	0.0%	4.9%
John Muir Health	**491**	**156,873**	**71.1%**	**44.7%**	**44.9%**	**7.6%**	**0.5%**	**2.3%**
John Muir Medical Center, Concord	136	48,776	63.5%	50.5%	37.7%	8.1%	0.0%	3.7%
John Muir Medical Center, Walnut Creek	284	90,150	76.5%	47.7%	43.8%	5.9%	0.9%	1.7%
Mt. Diablo Medical Pavilion	71	17,947	69.1%	14.0%	70.0%	15.0%	0.0%	1.0%
Kaiser Foundation	**1,475**	**504,105**	**62.8%**	**49.6%**	**47.9%**	**0.9%**	**0.0%**	**1.6%**
Hayward	155	66,941	56.1%	48.2%	49.1%	1.3%	0.0%	1.5%
Oakland Campus	231	77,786	53.7%	49.7%	47.0%	1.4%	0.0%	1.9%
Redwood City	119	33,580	47.8%	51.4%	46.8%	0.5%	0.0%	1.2%
San Francisco (Geary)	217	66,844	73.9%	48.6%	48.4%	0.3%	0.0%	2.7%
San Francisco (South)	72	27,409	62.4%	60.3%	36.8%	0.4%	0.0%	2.5%
San Rafael	80	24,680	56.2%	67.6%	29.5%	1.4%	0.0%	1.5%
Santa Clara	224	74,083	72.3%	47.1%	51.1%	0.4%	0.0%	1.3%
Santa Teresa Community	163	55,011	65.9%	45.7%	51.5%	1.3%	0.0%	1.4%
Walnut Creek	214	77,771	74.8%	46.7%	51.9%	0.9%	0.0%	0.6%
Stanford University Hospital	**447**	**119,881**	**73.3%**	**39.7%**	**46.1%**	**8.5%**	**0.3%**	**5.4%**
Sutter Health	**2,742**	**723,873**	**65.0%**	**45.0%**	**29.8%**	**20.2%**	**0.4%**	**4.6%**
Alta Bates Summit, Alta Bates Campus	509	146,437	78.6%	27.9%	32.9%	38.1%	0.0%	1.2%
Alta Bates Summit, Hawthorne	276	97,506	66.8%	54.6%	22.2%	21.6%	0.0%	1.5%
California Pacific Medical Center	783	184,322	64.3%	43.2%	37.5%	11.2%	0.2%	7.9%
Eden Medical Center	356	68,654	52.7%	56.9%	20.1%	11.4%	0.0%	11.6%
Marin General Hospital	146	43,731	50.8%	47.4%	32.2%	15.0%	4.3%	1.1%
Merritt Peralta Institute	20	6,820	77.6%	0.7%	85.7%	0.0%	0.0%	13.7%
Novato Community Hospital	26	8,985	52.2%	54.0%	34.1%	7.4%	4.2%	0.4%
Peninsula Medical Center	363	91,070	66.5%	60.8%	29.7%	7.2%	0.0%	2.3%
St. Luke's Hospital	153	52,556	69.4%	41.5%	9.9%	45.0%	0.0%	3.7%
Sutter Delta Medical Center	110	23,792	59.1%	43.1%	33.5%	15.8%	0.0%	7.6%

EXHIBIT 31. Inpatient Occupancy Rates and Payer Mix for Bay Area Hospitals, 2004, cont.

System / Hospital	Staffed Beds	Inpatient Days	Occupancy	PAYER DISTRIBUTION				
				Medicare	Other Third Parties	Medi-Cal	County Indigent	Other Payers
Tenet Health	**499**	**72,885**	**49.6%**	**47.5%**	**38.9%**	**10.8%**	**0.0%**	**2.9%**
Community Hospital of Los Gatos	143	28,071	53.6%	55.9%	40.1%	3.6%	0.0%	0.3%
Doctors Medical Center, San Pablo	233	23,117	46.6%	47.7%	18.6%	27.4%	0.0%	6.3%
San Ramon Regional Medical Center	123	21,697	48.2%	36.2%	59.0%	2.3%	0.0%	2.5%
UCSF Medical Center	**574**	**162,044**	**77.1%**	**30.3%**	**40.8%**	**25.2%**	**0.9%**	**2.8%**
Others	**3,421**	**938,022**	**64.9%**	**27.0%**	**39.2%**	**22.7%**	**5.0%**	**6.2%**
Alameda County Medical Center	313	111,697	64.2%	22.6%	2.6%	59.0%	6.7%	9.2%
Alameda Hospital	135	21,254	43.0%	41.5%	18.7%	37.9%	0.0%	1.9%
Children's Hospital of Oakland	133	47,546	76.4%	0.0%	34.1%	64.5%	0.0%	1.3%
Chinese Hospital	52	11,100	58.3%	80.0%	7.6%	11.5%	0.0%	0.9%
Contra Costa Regional Medical Center	126	46,118	76.8%	23.4%	7.0%	53.4%	15.9%	0.3%
El Camino	319	82,527	70.7%	39.2%	44.4%	14.9%	0.0%	1.4%
Fremont Hospital, Fremont	78	24,410	85.5%	22.3%	56.4%	6.2%	15.0%	0.1%
Lucile S Packard Children's Hospital at Stanford	253	78,860	85.2%	0.3%	66.3%	33.2%	0.0%	0.2%
Menlo Park Surgical Hospital	2	716	12.2%	10.2%	25.7%	0.0%	0.0%	64.1%
St. Rose Hospital	175	37,114	63.1%	44.6%	10.3%	39.0%	0.0%	6.1%
San Francisco General Hospital	392	143,122	57.3%	17.7%	18.4%	34.7%	7.6%	21.6%
San Mateo Medical Center	455	103,655	62.2%	40.9%	1.0%	52.2%	4.4%	1.5%
Santa Clara Valley Medical Center	510	122,135	65.4%	16.7%	15.1%	51.5%	10.3%	6.4%
Valley Memorial Hospital	167	41,692	68.2%	57.8%	33.7%	7.0%	0.0%	1.5%
Washington Hospital, Fremont	311	66,076	58.1%	49.6%	28.6%	19.7%	0.0%	2.1%
TOTAL	11,613	3,168,466	63.2%	40.3%	32.2%	21.7%	1.6%	4.1%

Source: Author's analysis of data for fiscal years ending in 2004 from Office of Statewide Health Planning and Development.

Bay Area. While much of the work is needed to bring hospitals in compliance with new seismic standards, some new capacity may be added in growing areas of the region.

A related challenge for hospitals is high inflation in construction costs. In particular, the costs of steel and wallboard have increased sharply. A project planned to be complete in two years at a cost of $100 million may wind up costing 25 percent more because of inflation in construction costs. A nonprofit hospital that has carefully designed a financing package combining bonds, philanthropy, and cash flow may be pressed to reorganize that package of financing.

Payer Mix

Exhibit 31 examines which payer is expected to pay for patients admitted to Bay Area hospitals. Commercial payers (shown in the exhibit as "Other Third Parties") include HMOs, PPOs, and other insurance plans that employers sponsor for their employees, and sometimes the dependents of their employees. For both Medicare and Medi-Cal, those government programs are considered to be the payer in this analysis, even if the patient belongs to an HMO that is contracting with Medicare or the state as a managed care plan. A few counties fund special programs for low-income families without insurance, and those admissions are shown in the column marked "County Indigent." Finally, the column headed "Other Payers" includes hospital stays by people without insurance, some of who will pay all or only part of their hospital bill.

On average, Medicare was the largest payer for Bay Area hospitals, accounting for 40.3 percent of inpatient days in the market. Medicare is especially important to the CHW, Kaiser, and Daughters of Charity hospitals. Other third parties, including commercial managed care plans, covered an average of 32.2 percent of inpatient days. Inpatient days at the Kaiser Foundation hospitals in the Bay Area, on average, are evenly divided

between the HMO's commercial and Medicare patients.

Medi-Cal covered about 688,000 inpatient days in 2004, up from 657,000 in 2003, or an average of 21.7 percent of hospital days in the area. Alameda County Medical Center provided the most inpatient days to Medi-Cal patients, followed by Santa Clara Valley and San Mateo Medical Center. Of the private systems, Sutter Health, especially the Alta Bates campus in Berkeley, provides the most days of care for Medi-Cal recipients. The four Daughters of Charity provided 62,000 Medi-Cal days in 2004, up about 10,000 from 2003.

Physician Organizations

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 3,400 Permanente Medical Group physicians in the area; that number has grown by almost 10 percent in the past two years. About 35 percent of Permanente physicians are in primary care. Data on the finances of the Permanente physicians is not included here because it is not reported to the Department of Managed Health Care.

In some ways, the IPA is the predominant form of physician organization in the Bay Area. For example, the Brown & Toland Medical Group reports more than 189,000 capitated patients, though fewer than in previous years. One of the most successful IPAs is Hill Physicians, based in San Ramon, with about 165,000 capitated patients in these counties. It is profitable, invests in information systems, and is highly ranked in health plan report cards and surveys. It does well under the Pay for Performance programs. Still, it faces the same challenge as other physician organizations that see an erosion of their capitated HMO business.

As was noted earlier, many medical groups have seen a steady decline in the number of patients appearing through capitation contracts. Still, some of the largest medical groups continue to expand their facilities and geographic reach. For example, the Palo Alto Medical Foundation and its affiliate, the Camino Medical Group, have about 135,000 capitated patients, fewer than two years ago. These two medical groups are affiliated with the Sutter Hospitals. Together they are developing a small new hospital in the area and plan a major health center in Mountain View. The Sutter system also provides management services to IPAs in the area. In Contra Costa County, the John Muir/Mt. Diablo Health Network is organized as a medical foundation and reports 75,700 capitated patients, up from 70,900 two years ago.

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

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

Health Plans

Exhibit 33 shows the estimated market share of the largest health plans in the Bay Area at the end of 2005. (This analysis follows the method used to prepare *Exhibit 14.*) By this analysis, Kaiser Permanente has more than half of the HMO enrollment in the region. It is especially strong in the East Bay counties, where it has just under 900,000 enrollees. Blue Shield and Health Net are second and third in HMO enrollment, respectively. Blue Shield had grown to second place in 2003 as it added thousands of CalPERS members, but then lost some of those members because of reductions in its hospital network.

While still high compared to most other metropolitan areas in the country, HMO enrollment and penetration in the Bay Area have declined in the past three years. As shown in *Exhibit 14,* in 2005 about 3.5 million people in the Bay Area — down from 3.8 million in 2002 — were enrolled in an HMO. In the two East Bay counties HMO penetration was 63.9 percent in 2005; on the San Francisco side, it was 55.7 percent.

The decline has come in enrollment in commercial plans. 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

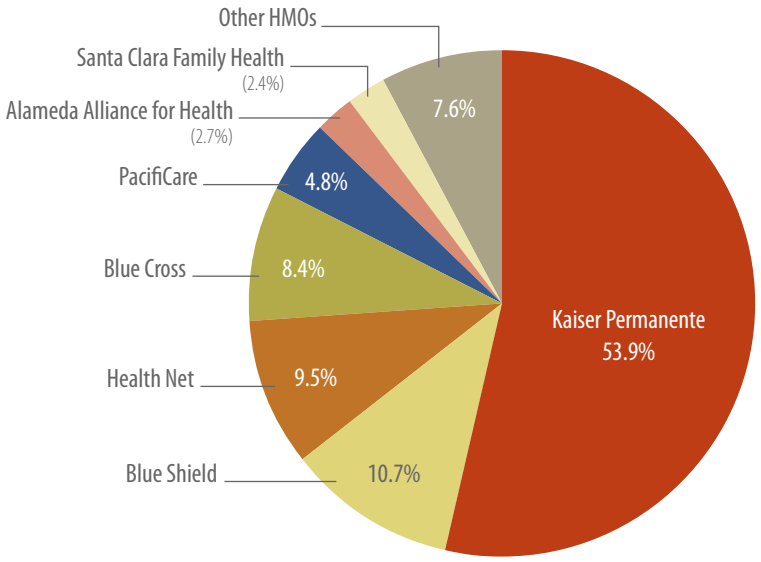
EXHIBIT 32. Physician Organizations in Bay Area, 2006 (includes Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara, and Sonoma counties)

Physician Organization / Notes	Estimated Enrollment	Number of PCPs	Number of Specialists	Number of Clinic Sites	DMHC Calculated Relative Working Capital	DMHC Calculated Relative TNE	Management Entity
Group Practice							
Bay Valley Medical Group	20,200	90	350	4	1.1	1.27	Bay Valley Management Group (includes IPA-type panel)
Camino Medical Group	63,000	83	159	15	NR	NR	Palo Alto Medical Foundation (Sutter Health); MSO of Hospital System
Children First Medical Group	35,400	186	172	0	NR	NR	
Palo Alto Medical Foundation	72,500	267	360	7	1.81	3.92	Palo Alto Medical Foundation (Sutter Health)
Note: Became group practice contractor with Palo Alto Medical Foundation May 1, 2000; Sutter Health is the sole corporate member.							
Permanente Medical Group	1,911,800	1,193	2,225	101	NR	NR	The Permanente Medical Group, Inc.
San Jose Medical Group	33,700	72	29	3	0.97	1.4	San Jose Medical Management, Inc.
Note: Includes old Good Samaritan Medical Group (absorbed into San Jose Medical Group) and IPA-type panel.							
IPA							
Affinity Medical Group	53,000	132	671	0	1.2	1.25	Pacific Partners Management Services, Inc. / Health Access Solutions
Note: Umbrella corporation for Alameda IPA, Contra Costa IPA, Eden IPA and San Leandro IPA, formerly panels of Alta Bates Medical Group.							
Alta Bates Medical Group	70,700	221	293	0	0.5	0.5	Sutter Connect
Brown & Toland Medical Group	189,500	332	1,267	0	NR	NR	Brown & Toland Physician Services Organization, Inc.
Children First Medical Group	35,400	186	172	0	3.92	4.34	Children First Healthcare Network, Inc.
Chinese Community Health Care Association	24,400	77	111	1	2.57	2.57	Chinese Community Health Plan
Community Health Center Network	32,300	133	450	28	1.57	2.05	Community Health Center Network, Inc. (IPA of group practices/clinics)
Note: Uses Alta Bates, Pacific Health Care specialists' panels, and Children's First specialists.							
Community Health Network of San Francisco	10,300	110	225	14	NR	NR	San Francisco City and County Government (IPA of group practices/clinics)
Hill Physicians Medical Group	165,300	412	654	0	1.5	1.52	PriMed Management Consulting Services, Inc.
Note: Catholic Healthcare West is an investor (27 percent) in PriMed.							
Marin IPA Medical Corp	31,600	94	215	0	1.09	1.14	Marin PHO
Mills-Peninsula Medical Group	59,700	124	232	0	1.09	1.13	Mills-Peninsula Medical Group, Inc.
Physicians Medical Group of San Jose	62,100	126	174	0	1.37	1.51	Excell MSO, LLC
Note: Physicians Medical Group of San Jose, Inc. purchased Regional Medical Management in 2001 and changed to Excel MSO LLC.							
Santa Clara County IPA	99,900	350	650	0	0.28	0.23	Pacific Partners Management Services, Inc. / Health Access Solutions
Medical Foundation							
John Muir/Mt. Diablo Health Network	75,700	241	549	15	1.59	2.27	John Muir / Mt. Diablo Health Network (includes medical group and IPA)
Palo Alto Medical Foundation	72,500	267	360	7	1.81	3.92	Palo Alto Medical Foundation (includes medical group)
Note: Sutter Health is the sole corporate member of the foundation.							
Stanford Health Services	9,150	54	1,000	7	NR	NR	Stanford Hospitals and Clinics (includes medical group)
Note: Began separate operations from Brown & Toland January 1, 2000.							
Sutter Medical Group of The Redwoods	20,150	84	235	4	NR	NR	Sutter Connect (includes medical group and IPA)
State/County Faculty/Staff							
Contra Costa Health Services	40,200	130	220	9	NR	NR	Contra Costa County Dept. of Health Services
Santa Clara Valley Health and Hospital System	55,500	143	284	11	NR	NR	Santa Clara Valley Health and Hospital System

NR: Not reported.

Source: Adopted from Cattaneo & Stroud's medical group inventory, April 2006.

EXHIBIT 33. Estimated Market Share for Bay Area HMOs, 2005 — Total Enrollment: 3,495,073



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

had senior plans in San Francisco. The reports posted on the CMS Web site were used to calculate penetration of HMO Medicare plans. In 2000, 41.2 percent of seniors in Alameda County and 26.4 percent of seniors in San Francisco were in a Medicare+Choice plan. At the end of 2005, about 63,000 (37 percent) of seniors in Alameda County were in an HMO while 28.8 percent of seniors in San Francisco were in an HMO plan. Those percentages have stayed even for the past few years and may show some gain in 2006. Kaiser and some other HMOs offer more than one Medicare plan, with different benefit designs and premium options. And seniors now have new choices for Part D prescription drug plans.

In 2006, three HMOs will offer senior plans in Alameda County and four will have full plans in San Francisco: Health Net, Kaiser Permanente, and PacifiCare Secure Horizons. Chinese Community Health Plan will also offer its senior plan in San Francisco.

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

Even with the expansions of Medi-Cal, Healthy Families, and some niche programs, a significant segment of the population in the Bay Area has no health insurance. According to one estimate from 2005, about 9 percent of the Bay Area's population under age 65 are uninsured. That represents about 469,000 uninsured persons, of which 52,000 are children under 18. There have been several initiatives in the area to try to improve access to health coverage by offering subsidized health plans through small employers. Foundations have provided funding to launch pilot projects to increase the number of small businesses that are able to offer health insurance and to improve the take-up rate of employees who are able to combine their own funds with a contribution from the employer and the participating foundations.

4.3 Sacramento

The economy of the Sacramento area has grown steadily, avoiding the boom and bust cycles of the Bay Area. By 2005, the population of the eight counties in and around Sacramento had grown to an estimated 2.3 million, up from 2 million in 2000. Driven by the combined engines of state government (state agencies, lobbying, and associations), a major University of California campus and strong high-tech industries, the region continues to grow.

Managed care and integrated delivery systems have grown up together in Sacramento. As in other state capitals, the early acceptance of managed care by public employers and the introduction of HMOs for persons on public assistance greatly encouraged the growth of managed care.

Overview of Hospitals

Four nonprofit hospital systems have emerged in the Sacramento area. They are Sutter Health, Catholic Healthcare West (including the Mercy hospitals), the University of California–Davis Medical Center, and the Kaiser Foundation hospitals. The five Sutter hospitals in the area make up the largest system in the region based on inpatient days and net patient revenues in 2004. They had nearly $1 billion in net patient revenues and provided 288,000 inpatient days of care. The six Catholic Healthcare West hospitals comprise the second largest system.

Sutter Medical Center in Sacramento is Sutter's flagship hospital in the area, with 673 staffed acute care beds and $598.2 million in net patient revenues in 2004. Sutter has two hospitals in Sacramento, and one apiece in Auburn, Davis, and Roseville. For-profit hospitals have not entered this part of the state, except for the period in which Tenet owned Redding Medical Center, about 165 miles north of Sacramento.

Catholic Healthcare West (CHW) has six hospitals and is virtually tied with Sutter Health for inpatient days. However, CHW is smaller when measured by patient revenues. CHW is made up of three Mercy hospitals — the largest of which is Mercy General in Sacramento — and three other nonprofit hospitals that affiliated with Mercy in 1993 and 1996. CHW used to operate those six hospitals as a separate Sacramento region. It has largely dismantled that regional structure and now runs the hospitals as a statewide organization based in San Francisco.

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

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

Financial Results

Sacramento-area hospitals generally had strong net income in 2004, but less than in 2001 or 2003. As shown in *Exhibit 34,* the 20 hospitals in this region had net income of $162.8 million in 2004, or 5.2 percent of total revenues of $3.1 billion. That is less than their combined net income of $210.1 million in 2003, which was 7.1 percent of total revenues.

Financial results for the two Kaiser hospitals in Sacramento are not included in this table but are rolled into the results shown in *Exhibit 30* for the northern California region of Kaiser.

The Sutter Health hospitals were the most profitable in the region in 2004 and 2003. They had net income of $107.3 million in 2004, down from $133.3 million in 2003. Two Sutter hospitals account for most of the profit. Sutter Medical Center in Sacramento alone had $59.8 million in net income and the Sutter hospital in Roseville facility had net income of $42.9 million. The Catholic Healthcare West hospitals in this area had net income of $46.1 million in 2004, up from $40.4 million in 2003. CHW's Mercy General hospital had net income of $20.9 million, but its Methodist Hospital lost $10.4 million.

Using the OSHPD reports, the University of California–Davis Medical Center reported a net loss of $13.3 million in 2004, after posting net income of $12.4 million in 2003. Its audited financial statements for 2004 show net income of $33 million. Most of the difference is due to IGT payments of $37.9 million. UC–Davis 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. When some California HMOs began to group their hospitals in tiers, UC–Davis along with some other academic health centers often ended up in the non-preferred tier. For the most part, those network and benefit designs were not well received by either employers or providers in the market.

Inpatient Occupancy

Average rates of inpatient occupancy declined in the Sacramento area in 2004, although it would be early to proclaim a trend in that direction. *Exhibit 35* compares the Sacramento hospital systems on their inpatient occupancy rates and payer mix for 2004. On average, Sacramento area hospitals had inpatient occupancy of 65.9 percent in 2004, down from 68.0 percent in 2003. Total inpatient days were virtually the same in 2004 as in 2003, but there was an increase in available capacity. Occupancy was highest at the Sutter Medical Center in Sacramento, at 77.4 percent. The five

EXHIBIT 34. Revenues and Net Income for Sacramento Hospitals, 2004

System / Hospital	City	Total Charges	Net Patient Revenue	Total Revenue	Operating Expenses	Net from Operations	Net Income (Loss)	% of Total Revenue
Catholic Healthcare West		**$2,924,842,500**	**$809,249,194**	**$843,668,472**	**$783,418,403**	**$41,444,626**	**$46,100,986**	**5.5%**
Mercy General Hospital	Sacramento	1,151,537,067	275,308,441	287,430,339	260,154,149	24,423,464	20,908,674	7.6%
Mercy Hospital	Folsom	173,388,174	57,340,330	58,272,303	53,237,634	4,558,768	5,034,669	8.8%
Mercy San Juan Hospital	Carmichael	860,983,940	240,124,100	247,528,133	223,843,806	18,819,862	20,402,935	8.5%
Methodist Hospital	Sacramento	326,700,395	93,935,588	95,879,801	105,969,775	(10,866,615)	(10,407,026)	– 11.1%
Sierra Nevada Memorial Hospital	Grass Valley	228,561,254	81,965,604	86,715,442	80,494,860	2,603,205	6,027,200	7.4%
Woodland Memorial Hospital	Woodland	183,671,670	60,575,131	67,842,454	59,718,179	1,905,942	4,134,534	6.8%
Kaiser Foundation*								
Sutter Health		**$3,500,946,769**	**$982,669,587**	**$1,031,778,333**	**$917,171,410**	**$88,282,464**	**$107,343,729**	**10.4%**
Sutter Auburn Faith Hospital	Auburn	238,912,126	70,208,524	73,278,796	71,430,887	(65,109)	1,461,787	2.1%
Sutter Center for Psychiatry	Sacramento	39,107,482	18,249,431	19,454,960	18,572,919	746,705	882,041	3.4%
Sutter Davis Hospital	Davis	175,129,280	59,500,519	61,868,884	57,813,334	3,557,219	2,323,189	3.9%
Sutter Medical Center	Sacramento	2,309,121,972	598,184,430	630,328,767	566,888,088	46,175,026	59,780,687	10.0%
Sutter Roseville Medical Center	Roseville	738,675,909	236,526,683	246,846,926	202,466,182	37,868,623	42,896,025	– 3.9%
UC – Davis Medical Center†	Sacramento	2,810,741,067	786,528,641	832,269,383	843,938,324	19,447,681	(13,291,760)	– 1.7%
Others		**$790,325,415**	**$339,963,864**	**$401,844,298**	**$363,789,901**	**$15,286,443**	**$22,605,190**	**6.6%**
Barton Memorial Hospital	South Lake Tahoe	155,524,353	77,454,243	94,882,841	73,570,132	4,205,236	7,239,331	9.3%
Marshall Medical Center.	Placerville	268,280,022	100,330,389	103,450,368	98,680,651	3,161,483	4,085,003	4.1%
Rideout Memorial Hospital	Marysville	342,669,738	148,726,010	153,691,041	137,924,156	11,729,046	15,085,800	10.1%
Shriners Hospital	Sacramento	0	0	36,319,118	41,080,856	(4,761,738)	(4,761,738)	NA
Sierra Vista Hospital	Sacramento	23,851,302	13,453,222	13,500,930	12,534,106	952,416	956,794	7.1%
Tahoe Forest Hospital	Truckee	74,157,222	47,897,473	56,982,369	46,959,871	1,640,652	4,707,299	9.8%
	TOTAL	**$10,026,855,751**	**$2,918,411,286**	**$3,109,560,486**	**$2,908,318,038**	**$164,461,214**	**$162,758,145**	**5.2%**

*Financial results for Kaiser Foundation hospitals are consolidated with the northern California results shown in Exhibit 30.

†UC – Davis Medical Center reported a 2004 net loss of $13.3 million in its OSHPD report but net income of $33 million in its audited financial statements. The difference of $46.3 million is the result of a $37.9 million intergovernmental transfer to the University of California as a contribution to Medi-Cal funds that are matched by federal dollars and some portion of $53.2 million in other intergovernmental transfers that are reported as an Other Deduction from Equity in the OSHPD report.

Source: Author's analysis of data for fiscal years ending in 2004 from Office of Statewide Health Planning and Development.

Sutter Health hospitals had an occupancy rate of nearly 73 percent. The two Kaiser hospitals had average occupancy rates of 67.4 percent, down from 70 percent in 2003.

Payer Mix

As *Exhibit 35* shows, Medicare is the largest single payer to hospitals in the area. It covered an average of 37.6 percent of inpatient hospital days in Sacramento-area hospitals while Medi-Cal covered 26 percent. Medicare covered a higher than average percentage of inpatient days at the two Kaiser hospitals and at some of the rural hospitals in the area. In past years, the Sutter Health hospitals had been above average in their Medicare days, but were only slightly above average in 2004. Commercial plans including managed care covered 31.2 percent of inpatient days for Sacramento-area hospitals.

The number of inpatient days covered by Medi-Cal increased from 220,000 in 2001 to 256,000 in 2003 and 268,000 in 2004. There are no county general hospitals in the region, so responsibility for serving Medi-Cal patients is shared broadly in the area. The Sutter Medical Center in Sacramento provided the most days of care to Medi-Cal patients: 68,000. The University of California – Davis Medical Center was second, with about 51,000 inpatient days in 2004, down from 54,000 inpatient days in 2003. County indigent care funds were applied to the care provided for 8.8 percent of inpatient days at the UC – Davis Medical Center.

EXHIBIT 35. Inpatient Occupancy Rates and Payer Mix for Sacramento Hospitals, 2004

System / Hospital	Staffed Beds	Inpatient Days	Occupancy	PAYER DISTRIBUTION				
				Medicare	Other Third Parties	Medi-Cal	County Indigent	Other Payers
Catholic Healthcare West	**1299**	**284,662**	**59.9%**	**38.2%**	**29.9%**	**29.9%**	**1.8%**	**0.2%**
Mercy General Hospital	391	78,553	54.9%	43.1%	37.0%	18.4%	1.4%	0.2%
Mercy Hospital, Folsom	85	13,297	42.7%	40.0%	51.1%	6.6%	1.9%	0.3%
Mercy San Juan Hospital	254	73,530	79.1%	39.5%	32.2%	25.6%	2.6%	0.1%
Methodist Hospital of Sacramento	333	78,726	64.6%	18.9%	21.0%	59.0%	1.0%	0.1%
Sierra Nevada Memorial Hospital	121	27,278	61.6%	68.7%	20.8%	6.4%	3.0%	1.0%
Woodland Memorial Hospital	115	13,278	31.5%	52.1%	25.4%	20.6%	1.5%	0.3%
Kaiser Foundation	**564**	**162,955**	**67.4%**	**45.6%**	**49.6%**	**3.2%**	**0.0%**	**1.6%**
Sacramento	411	118,466	67.4%	45.6%	49.6%	3.2%	0.0%	1.6%
South Sacramento	153	44,489	64.9%	45.9%	49.7%	2.8%	0.0%	1.5%
Sutter Health	**1,075**	**288,343**	**72.9%**	**38.0%**	**30.7%**	**27.8%**	**1.7%**	**1.8%**
Sutter Auburn Faith Hospital	97	18,808	53.0%	62.2%	23.6%	10.7%	2.3%	1.2%
Sutter Center For Psychiatry	69	18,297	72.5%	25.0%	63.6%	10.6%	0.0%	0.8%
Sutter Davis Hospital	48	8,361	47.6%	38.3%	30.1%	24.4%	4.7%	2.5%
Sutter Medical Center, Sacramento	673	192,322	77.4%	35.1%	26.4%	35.4%	1.5%	1.6%
Sutter Roseville Medical Center	188	50,555	73.5%	44.6%	37.7%	12.4%	2.4%	2.9%
University of California–Davis Medical Center	526	146,013	75.8%	24.6%	29.0%	34.9%	8.8%	2.7%
Others	**551**	**150,513**	**57.8%**	**40.0%**	**16.5%**	**30.9%**	**3.4%**	**9.2%**
Barton Memorial Hospital	121	29,571	66.8%	19.7%	14.0%	56.3%	1.6%	8.4%
Marshall Medical Center	105	26,156	68.1%	67.2%	18.0%	11.9%	1.8%	1.1%
Sierra Vista Hospital	72	20,375	77.3%	39.0%	43.4%	8.8%	8.1%	0.7%
Rideout Memorial Hospital	213	48,021	46.7%	55.2%	10.0%	28.4%	5.2%	1.2%
Tahoe Forest Hospital	66	18,012	68.4%	12.9%	12.7%	63.1%	0.1%	11.3%
TOTAL	3,451	1,032,486	65.9%	37.6%	31.2%	26.0%	2.7%	2.5%

Source: Author's analysis of data for fiscal years ending in 2004 from Office of Statewide Health Planning and Development.

The CHW hospitals provided 85,000 inpatient days to Medi-Cal recipients and the Sutter Health systems served 80,000 inpatient days at their Sacramento-area hospitals. Kaiser hospitals in this area provided about 5,000 inpatient days to Medi-Cal recipients.

Physician Organizations

Exhibit 36 lists the largest physician organizations in Sacramento County in 2005. Most of the large practices are closely tied to one of the hospital systems. By far the largest group practice was the Permanente Medical Group, with 785 primary care physicians and specialists in the area. Many of the other large medical groups are tied to the hospital systems. For example, Sutter Health provides administrative services to Sutter Independent Physicians, an IPA, and the Sutter Medical Foundation through an entity called Sutter Connect. Sutter Health is also a part owner of PriMed, the management company that administers Hill Physicians, the largest IPA in the area. Hill Physicians has about 450 primary care physicians and specialists in Sacramento. The faculty group at the University of California–Davis Medical Center grew from about 324 primary care and specialty physicians in 2001 to 468 physicians at 10 clinic sites in 2005.

Health Plans

Based on *Exhibit 14*, 1.5 million people, or 64.7 percent of the residents, in the Sacramento area were enrolled in an HMO in 2005. Six statewide HMOs plus Western Health Advantage, based in Sacramento, compete for commercial business in the area. Kaiser Permanente has more than 625,000 Sacramento-area enrollees, accounting for about 47 percent of HMO enrollment in the region. Health

EXHIBIT 36. Physician Organizations in Sacramento County, 2006

Physician Organization / Notes	Estimated Enrollment	Number of PCPs	Number of Specialists	Number of Clinic Sites	DMHC Calculated Relative Working Capital	DMHC Calculated Relative TNE	Management Entity
Group Practice							
Molina Healthcare, Inc	10,400	7	0	5	NR	NR	Molina Healthcare of California, Inc.
Permanente Medical Group	365,500	305	480	12	NR	NR	The Permanente Medical Group, Inc.
Sacramento Family Medical Clinics	24,800	15	0	6	NR	NR	
IPA							
Golden State Physicians Medical Group	10,850	145	212	0	1.27	1.29	Medical Benefits Administration, Inc.
Hill Physicians Medical Group	129,800	157	294	0	1.5	1.52	PriMed Management Consulting, Inc.
Note: Catholic Healthcare West is an investor (27 percent) in PriMed.							
River City Medical Group	35,500	102	425	0	1.44	1.47	River City Medical Group, Inc.
Sutter Independent Physicians	27,000	91	420	0	1.47	1.48	Sutter Connect
Medical Foundation							
Mercy Medical Group	55,600	43	78	7	NR	NR	Catholic Healthcare West Medical Foundation
Sutter Medical Foundation	73,000	62	213	10	1.61	1.92	Sutter Connect
Note: Includes medical group.							
State/County Faculty/Staff							
UC – Davis Medical Group	86,800	135	333	10	NR	NR	UC – Davis Medical Center

NR: Not reported.

Source: Adopted from Cattaneo & Stroud's medical group inventory, April 2006.

Net is second largest, with about 177,000 enrollees, including about 30,000 Medi-Cal lives. Now one of only three HMOs serving state employees covered through CalPERS, Blue Shield is the third largest HMO in the area with almost 20 percent of HMO enrollees.

Sacramento was one of two counties that implemented a multi-HMO competitive model for Medi-Cal. That plan will now expand to other nearby counties as part of the state's Medi-Cal managed care expansions. Six HMOs now compete for Medi-Cal enrollees in a geographic managed care arrangement in Sacramento: Blue Cross, Care 1st, Health Net, Kaiser Permanente, Molina Health, and Western Health Advantage. Blue Cross is the largest Medi-Cal contractor in Sacramento County with almost half of the 164,000 total enrollees. Health Net is the second largest Medi-Cal plan in the region with about 30,000 enrollees.

As shown in *Exhibit 9,* four HMOs are offering Medicare Advantage plans in Sacramento in 2006, enrolling almost 40 percent of the 172,000 seniors in the county. The basic federal payment rates are lower here than in the Bay Area counties. The Average Area Per Capita Cost rate for Sacramento County in 2006 is $696, compared to $802 in Alameda County and $759 in San Francisco.

4.4 Central Valley

The following analysis of the Central Valley is based on the counties included in health planning regions 6 (North San Joaquin) and 9 (Central). An extensive range of food products are grown or processed here and exported across the country and the world. A high percentage of the agricultural workforce has no health insurance, which puts an enormous strain on the health care providers who provide free care or collect fees on a sliding scale. 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 the cultural competency of health service providers is an important issue.

Overview of Hospitals

There are five hospital systems in the area from San Joaquin to Bakersfield, one of which is only in the Fresno area: Adventist, Catholic Healthcare West (CHW), Community Health System of Fresno, Sutter Health, and Tenet Health. In addition, Kaiser operates a Fresno hospital, bought a CHW hospital in Manteca, and is constructing a Modesto hospital. The Central Valley is also the location of relatively new cardiac hospitals in Bakersfield and Fresno,

and surgical hospitals in Fresno and Modesto. Fresno Surgery Center was sold in 2006 to Cirrus Health, a Texas-based developer and operator of ambulatory care facilities and hospitals. MedCath, a national operator of cardiac hospitals and laboratories, owns the Bakersfield Heart Hospital.

There are several district and county hospitals in the area. The Porterville hospital district is developing plans for a new hospital. Stanislaus County used to run a county hospital but closed it and contracted with a Tenet hospital (Doctors of Modesto) to provide some of those services. Doctors Hospital of Modesto serves a high percentage of Medi-Cal patients. Stanislaus County still runs an inpatient psychiatric hospital and has been in discussions with other hospitals to take over its operation.

Based upon inpatient days in 2004, Catholic Healthcare West is the largest system in the region. It has eight member hospitals from Stockton to Bakersfield, one of which is a mental health facility. Its two largest facilities in the area are both in Bakersfield. In 2004, CHW closed Mercy Westside Hospital in Taft (near Bakersfield) and sold St. Dominic's Hospital in Manteca to Kaiser.

Sutter Health has hospitals in Jackson and Tracy. It also has affiliation arrangements with the Memorial Hospitals in Los Banos and Modesto. Memorial Hospital in Modesto is the largest in that city, with 91,000 inpatient days in 2004. The Stanislaus Surgical Hospital in Modesto is a new specialty hospital. The Adventist Health system has five hospitals in the Central Valley.

As in northern California, almost all hospitals in the Central Valley are nonprofit. Tenet, which has two hospitals in the Modesto area, is currently the only for-profit hospital company in the area. Two of the largest hospitals in the Central Valley, Community Medical Center and St. Agnes, are historic competitors in Fresno. Community Medical Center is part of the Community Health System, which absorbed University Medical Center, Fresno's county hospital. A new medical center for Community Health will soon open in downtown Fresno. The Fresno Medical Education program of the UC–San Francisco is located on that downtown campus and hosts residencies for newly graduated doctors. Community Health was listed as the fourth largest employer in Fresno.

Along with a group of doctors, Community Health System developed Fresno Heart Hospital, which opened in October 2003. Fresno Heart has struggled since its opening but has shown recent signs of beginning to reach its goals. Community Health has recapitalized Fresno Heart Hospital, buying out the physician investors at a deeply discounted return of their original investment. St. Agnes responded to the new competition for cardiac surgery by announcing a new affiliation with Stanford University for cardiac surgery services.

St. Agnes is part of the Trinity Health System, a Catholic hospital system based in Novi, Michigan, which formed about four years ago by combining two large Catholic systems. In the past, each of the Fresno hospitals had close ties to HMOs, but those relationships changed over time. In 2005, St. Agnes Medical Center completed its new North Wing with 100 private rooms, a cardiac center and expanded emergency department.

Kaiser started with one hospital in the region but has recently acquired a second and is building a third. Kaiser's Fresno hospital has 108 beds. In Stockton, Kaiser uses Dameron Hospital, and in Modesto and Turlock, Kaiser uses Emanuel Medical Center and many non-Kaiser doctors. However, Kaiser's use of outside providers is now changing. Kaiser acquired a hospital in Manteca and is building a medical office building there. In addition, Kaiser is constructing a 225-bed hospital and medical office building in Modesto, which is expected to cost $500 million and is scheduled to open in 2007.

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

Financial Results

In *Exhibit 37,* Central Valley hospitals are compared on their revenues and net income. The hospitals included in this analysis reported net income of $203.5 million or 4.5 percent of total revenues. That was less than in 2003, when those hospitals had net income of $314 million, or 7.7 percent of total revenues. In 2004, area hospitals had net income on patient operations of $157 million plus additional revenues from philanthropy, investments, and government grants.

The four Sutter hospitals reported net income of $74.3 million, down from $103.8 million in 2003. As in past years, Memorial Hospital in Modesto accounted for most of that net income. The Catholic Healthcare West hospitals in the Central Valley lost $10.9 million in 2004, which is an improvement—in 2003 the CHW hospitals in the region lost $12 million. In 2004 and 2003, Bakersfield Memorial had a small amount of net income but Mercy Hospital in Bakersfield reported a loss for the year.

EXHIBIT 37. Revenues and Net Income for Central Valley Hospitals, 2004

System / Hospital	City	Total Charges	Net Patient Revenue	Total Revenue	Operating Expenses	Net from Operations	Total Margin	% of Total Revenue
Adventist		**$1,093,159,371**	**$28,456,924**	**$250,362,889**	**$32,813,034**	**($3,952,384)**	**$5,097,599**	**2.0%**
Central Valley General Hospital	Hanford	133,536,288	44,536,613	44,943,024	39,821,447	4,968,154	5,121,577	11.4%
Hanford Community Hospital	Hanford	296,833,043	65,014,110	67,359,485	65,472,237	20,276	241,969	0.4%
San Joaquin Community Hospital	Bakersfield	529,507,892	104,545,671	108,969,894	105,513,293	721,282	3,456,601	3.2%
Selma Community Hospital	Selma	133,282,148	28,456,924	29,090,486	32,813,034	(3,952,384)	(3,722,548)	– 12.8%
Catholic Healthcare West		**$2,799,172,292**	**$715,306,243**	**$739,070,513**	**$743,098,183**	**($15,718,325)**	**($10,936,853)**	**– 1.5%**
Bakersfield Memorial Hospital	Bakersfield	600,739,401	152,827,401	155,153,357	149,591,634	4,154,503	5,561,723	3.6%
Mark Twain St. Joseph's Hospital	San Andreas	72,773,791	32,207,118	32,701,928	32,071,620	614,455	553,178	1.7%
Mercy Hospital, Bakersfield	Bakersfield	470,345,055	122,401,773	126,003,496	134,507,577	(10,901,290)	(9,771,948)	– 7.8%
Mercy Medical, Community	Merced	342,331,625	79,879,012	80,658,911	80,808,317	(259,273)	(149,457)	– 0.2%
Mercy Medical, Dominican	Merced	99,114,723	28,483,557	33,624,831	38,967,873	(8,815,737)	(8,889,608)	– 26.4%
Mercy Westside Hospital	Taft	7,308,005	4,260,783	4,321,896	7,328,962	(3,059,642)	(3,007,066)	– 69.6%
Oak Valley District Hospital	Oakdale	104,400,412	39,050,220	40,358,234	37,626,955	2,463,254	2,369,155	5.9%
St. Dominic's Hospital	Manteca	148,914,206	30,180,935	30,592,625	34,717,879	(4,406,580)	(5,573,633)	– 18.2%
St. Joseph's Behavioral Health	Stockton	22,467,531	7,901,971	7,915,930	7,297,815	609,569	618,115	7.8%
St. Joseph's Medical Center	Stockton	930,777,543	218,113,473	227,739,305	220,179,551	3,882,416	6,990,564	3.1%
Community Health System		**$1,344,382,733**	**$512,376,054**	**$540,973,958**	**$535,756,452**	**($5,011,614)**	**$5,066,092**	**0.9%**
Community Medical Center	Clovis	244,808,710	97,063,091	98,186,721	88,773,473	8,970,427	9,395,443	9.6%
Community Medical Center	Fresno	1,099,574,023	415,312,963	442,787,237	446,982,979	(13,982,041)	(4,329,351)	– 1.0%
Kaiser Foundation, Fresno*								
St. Agnes Medical Center	Fresno	**$935,273,376**	**$309,302,295**	**$327,189,184**	**$299,647,549**	**$15,707,957**	**$27,060,613**	**8.3%**
Sutter Health		**$1,856,390,984**	**$494,875,432**	**$509,893,277**	**$433,297,395**	**$65,754,266**	**$74,304,843**	**14.6%**
Memorial Hospital Los Banos	Los Banos	108,401,524	29,928,967	30,593,285	29,355,044	648,919	1,044,959	3.4%
Memorial Hospital Modesto	Modesto	1,428,231,273	350,913,757	362,821,321	300,857,651	53,311,279	60,712,084	16.7%
Sutter Amador Hospital	Jackson	108,861,751	43,258,418	43,258,418	42,809,537	448,881	448,881	1.0%
Sutter Tracy Community Hospital	Tracy	210,896,436	70,774,290	73,220,253	60,275,163	11,345,187	12,098,919	16.5%
Tenet Health		**$3,375,285,016**	**$361,260,774**	**$364,000,007**	**$314,114,193**	**$49,506,091**	**$49,481,822**	**13.6%**
Doctors Hospital of Manteca	Manteca	482,191,802	53,457,875	53,896,633	47,667,681	5,984,068	5,969,248	11.1%
Doctors Medical Center	Modesto	2,893,093,214	307,802,899	310,103,374	266,446,512	43,522,023	43,512,574	14.0%
Others		**$4,840,034,359**	**$1,602,588,411**	**$1,747,915,009**	**$1,600,523,038**	**$51,053,645**	**$53,456,859**	**3.1%**
Bakersfield Heart Hospital	Bakersfield	152,510,219	52,276,873	52,761,462	52,590,265	164,780	(329,640)	– 0.6%
Children's Hospital, Central CA	Madera	508,611,210	236,597,653	258,276,329	242,143,303	2,472,824	8,827,217	3.4%
Dameron Hospital	Stockton	564,468,987	120,978,752	127,676,653	120,192,518	2,250,604	4,719,278	3.7%
Delano Regional Medical Center	Delano	121,918,972	49,776,575	51,519,232	46,623,109	3,499,341	4,894,455	9.5%
Emanuel Medical Center	Turlock	411,622,728	92,357,321	102,530,430	94,330,730	(265,867)	7,570,605	7.4%
Fresno Surgery Center	Fresno	88,589,650	26,409,923	26,826,347	29,765,789	(2,972,970)	(2,901,527)	– 10.8%
John C. Fremont Healthcare District	Mariposa	16,665,991	10,729,661	12,431,043	11,997,956	(921,122)	433,087	3.5%
Kaweah Delta District Hospital	Visalia	942,552,117	249,209,455	275,703,853	269,531,572	2,368,458	4,994,460	1.8%

EXHIBIT 37. Revenues and Net Income for Central Valley Hospitals, 2004, cont.

System / Hospital	City	Total Charges	Net Patient Revenue	Total Revenue	Operating Expenses	Net from Operations	Total Margin	% of Total Revenue
Others, cont.		$4,840,034,359	$1,602,588,411	$1,747,915,009	$1,600,523,038	$51,053,645	$53,456,859	3.1%
Kern Medical Center	Bakersfield	323,724,506	183,341,022	220,092,337	176,173,231	8,374,985	(6,749,751)	– 3.1%
Kern Valley Healthcare District	Lake Isabella	45,299,253	19,685,598	20,336,104	19,577,618	293,456	645,390	3.2%
Kingsburg Medical Hospital	Kingsburg	13,504,359	6,486,512	7,194,713	6,692,991	(188,036)	22,168	0.3%
Lodi Memorial Hospital	Lodi	529,393,630	94,881,030	97,572,221	87,603,213	8,018,720	9,577,304	9.8%
Madera Community Hospital	Madera	117,516,319	51,774,260	53,006,914	51,626,132	953,573	1,380,782	2.6%
Ridgecrest Regional Hospital	Ridgecrest	70,154,778	33,987,505	34,634,879	32,981,273	1,157,739	1,500,325	4.3%
San Joaquin General Hospital	French Camp	260,661,253	165,679,857	186,968,954	155,811,894	17,025,255	1,574,119	0.8%
San Joaquin Valley Rehab Hospital	Fresno	26,893,952	17,082,040	17,113,944	18,263,577	(1,149,633)	(1,149,633)	– 6.7%
Sierra View District Hospital	Porterville	300,365,733	86,912,129	88,901,893	78,039,601	9,778,674	10,746,993	12.1%
Stanislaus Surgical Hospital	Modesto	148,724,738	25,101,347	25,346,066	21,187,150	4,143,566	4,088,752	16.1%
Tehachapi Hospital	Tehachapi	18,230,826	8,838,201	9,738,947	9,016,722	(153,211)	722,225	7.4%
Tulare District Hospital	Tulare	106,067,351	47,297,219	51,801,772	49,852,475	(761,828)	1,931,253	3.7%
Tuolumne General Hospital	Sonora	72,557,787	23,185,478	27,480,916	26,521,919	(3,035,663)	958,997	3.5%
	TOTAL	$16,243,698,131	$4,024,166,133	$4,479,404,837	$3,959,249,844	$157,339,636	$203,530,975	4.5%

*Financial results for Kaiser Foundation hospitals are consolidated with the northern California results shown in Exhibit 30.

Source: Author's analysis of data for fiscal years ending in 2004 from Office of Statewide Health Planning and Development.

Despite some of the challenges faced by Tenet Health, Doctors Medical Center (the Tenet hospital in Modesto) reported $43.5 million in net income, among the highest in the region. That is modest in comparison to its 2003 net income of $160.0 million, or 39.2 percent of total revenues. The large Community Medical Center in Fresno lost money in 2004 but the smaller hospital in Clovis had net income of $9.4 million. Also in Fresno, St. Agnes Medical Center doubled its net income, going from $13.3 million in 2003 to $27.1 million in 2004.

Most of the independent hospitals reported positive net income. The district hospital in Porterville had net income of $10.7 million. However, Kern Medical Center had a loss of $6.7 million in 2004, less than its loss of $9.2 million in 2003.

Occupancy

Average rates of inpatient occupancy have increased in the Central Valley as available capacity and total inpatient days have both increased. As shown in *Exhibit 38,* inpatient occupancy in Central Valley hospitals averaged 70.8 percent in 2004, higher than 69.8 percent in 2003 and 64.7 percent in 2001. The Sutter hospitals in the area had average occupancy rates of 70.5 percent, while the CHW hospitals had average occupancy of 67.4 percent. Occupancy rates at the Community Health System hospitals averaged 69.1 percent. Inpatient occupancy at St. Agnes was 85.4 percent and 57.2 percent at Kaiser's hospital in Fresno. Kaiser completed a 24-bed addition to its Fresno hospital in 2004. The Tenet hospital in Modesto had an inpatient occupancy rate of 70.9 percent, which is higher than most Tenet hospitals in the state. As mentioned earlier, Doctors Medical Center of Modesto took over some of the responsibilities of a county general hospital several years ago.

Payer Mix

Medicare is the most significant payer for hospitals in the Central Valley and has become increasingly important. As shown in *Exhibit 38,* on average Medicare covered 38.7 percent of inpatient days in Central Valley hospitals in 2004, up from 37.3 percent in 2003. In particular, Medicare was a very significant payer for St. Agnes and Kaiser in Fresno. In addition, Medicare covered an above-average proportion of days at the Sutter and Adventist hospitals in the area. On the other hand, Medicare covered only 30.8 percent of inpatient days at Community Medical Center in Fresno.

Medi-Cal covered 33.7 percent of inpatient days in the area. Out of 608,000 Medi-Cal inpatient days (up from 603,000 in 2003), Community Medical Center – Fresno provided about 77,500 inpatient days and was the largest single provider for Medi-Cal patients. Children's Hospital Central California

EXHIBIT 38. Inpatient Occupancy Rates and Payer Mix for Central Valley Hospitals, 2004

System / Hospital	Staffed Beds	Inpatient Days	Occupancy	PAYER DISTRIBUTION				
				Medicare	Other Third Parties	Medi-Cal	County Indigent	Other Payers
Adventist	**273**	**85,753**	**71.0%**	**48.7%**	**16.1%**	**30.7%**	**1.5%**	**2.9%**
Central Valley General Hospital	26	9,205	55.9%	26.0%	26.5%	40.9%	4.6%	2.0%
Hanford Community Hospital	50	17,654	77.8%	57.3%	20.9%	14.8%	5.1%	1.8%
San Joaquin Community Hospital	166	50,924	83.8%	49.8%	13.1%	33.6%	0.0%	3.5%
Selma Community Hospital	31	7,970	38.2%	48.6%	12.5%	36.2%	0.0%	2.7%
Catholic Healthcare West	**1,469**	**381,835**	**67.4%**	**43.9%**	**23.2%**	**29.6%**	**0.4%**	**2.8%**
Bakersfield Memorial Hospital	349	83,482	65.4%	47.2%	29.6%	21.7%	0.0%	1.6%
Mark Twain St. Joseph's Hospital	26	6,865	39.1%	64.9%	18.1%	11.8%	2.5%	2.7%
Mercy Hospital, Bakersfield	261	68,560	71.8%	51.8%	40.2%	6.3%	0.0%	1.7%
Mercy Medical Center, Community Campus	104	35,881	63.7%	51.4%	16.0%	28.1%	3.0%	1.4%
Mercy Medical Center, Dominican Campus	89	9,668	29.7%	70.1%	15.5%	13.1%	0.0%	1.3%
Mercy Westside Hospital	84	16,606	49.9%	2.8%	0.1%	96.9%	0.0%	0.3%
Oak Valley District Hospital	150	46,694	85.1%	18.2%	3.9%	65.2%	0.1%	12.7%
St. Dominic's Hospital	77	19,907	70.6%	17.5%	11.9%	65.3%	0.0%	5.2%
St. Joseph's Behavioral Health Center	35	11,852	92.5%	59.2%	40.7%	0.0%	0.0%	0.1%
St. Joseph's Medical Center of Stockton	294	82,320	76.5%	53.1%	22.9%	22.9%	0.5%	0.6%
Community Health System	**793**	**200,630**	**69.1%**	**31.4%**	**22.5%**	**40.4%**	**4.1%**	**1.6%**
Community Medical Center, Clovis	109	28,696	71.9%	34.7%	51.9%	12.4%	0.1%	0.9%
Community Medical Center, Fresno	684	171,934	68.7%	30.8%	17.6%	45.1%	4.8%	1.7%
Kaiser Foundation, Fresno	**108**	**34,548**	**57.2%**	**58.5%**	**40.0%**	**0.4%**	**0.0%**	**1.1%**
St. Agnes Medical Center	**330**	**103,130**	**85.4%**	**61.7%**	**26.2%**	**10.8%**	**0.0%**	**1.3%**
Sutter Health	**441**	**130,131**	**70.5%**	**52.5%**	**27.8%**	**16.0%**	**0.3%**	**3.3%**
Memorial Hospital Los Banos	48	8,357	47.6%	55.4%	15.4%	24.9%	0.0%	4.3%
Memorial Hospital Modesto	248	90,691	79.7%	52.5%	29.1%	15.2%	0.1%	3.1%
Sutter Amador Hospital	66	15,458	64.0%	57.7%	19.3%	17.9%	2.3%	2.8%
Sutter Tracy Community Hospital	79	15,625	54.0%	46.2%	35.3%	14.1%	0.0%	4.5%
Tenet Health	**349**	**115,822**	**68.5%**	**32.8%**	**26.7%**	**35.3%**	**2.4%**	**2.8%**
Doctors Hospital of Manteca	73	14,846	55.6%	40.6%	47.4%	10.2%	0.0%	1.8%
Doctors Medical Center, Modesto	276	100,976	70.9%	31.7%	23.7%	39.0%	2.7%	2.9%
Others	**2,620**	**752,555**	**72.7%**	**31.3%**	**17.3%**	**41.9%**	**4.1%**	**5.4%**
Bakersfield Heart Hospital	47	15,557	90.4%	76.5%	16.7%	4.8%	0.0%	2.0%
Children's Hospital, Central California	255	69,553	74.5%	0.2%	28.1%	71.3%	0.0%	0.3%
Dameron Hospital	188	54,400	79.1%	46.7%	37.3%	14.2%	0.0%	1.8%
Delano Regional Medical Center	98	35,363	61.9%	23.1%	17.3%	57.3%	1.4%	0.9%
Emanuel Medical Center	330	97,180	80.2%	28.3%	10.7%	37.9%	0.0%	23.1%
Fresno Surgery Center	20	3,622	49.5%	29.7%	69.4%	0.0%	0.0%	0.9%
John C. Fremont Healthcare District	34	9,760	78.4%	8.8%	1.2%	85.5%	0.2%	4.3%
Kaweah Delta District Hospital	411	138,670	79.9%	44.6%	18.6%	29.3%	5.9%	1.5%
Kern Medical Center	179	55,896	78.3%	12.5%	11.8%	57.1%	18.6%	0.0%
Kern Valley Healthcare District	101	29,404	79.5%	10.2%	3.7%	83.6%	0.4%	2.1%

EXHIBIT 38. Inpatient Occupancy Rates and Payer Mix for Central Valley Hospitals, 2004, cont.

System / Hospital	Staffed Beds	Inpatient Days	Occupancy	PAYER DISTRIBUTION Medicare	Other Third Parties	Medi-Cal	County Indigent	Other Payers
Others, cont.	2,620	752,555	72.7%	31.3%	17.3%	41.9%	4.1%	5.4%
Kingsburg Medical Hospital	35	8,915	69.6%	29.9%	7.8%	58.9%	0.4%	3.0%
Lodi Memorial Hospital	172	43,300	68.8%	45.7%	17.7%	33.7%	0.0%	2.9%
Madera Community Hospital	103	24,557	65.1%	44.6%	20.8%	25.5%	6.4%	2.6%
Ridgecrest Regional Hospital	74	9,718	36.0%	47.5%	34.4%	16.6%	0.0%	1.4%
San Joaquin General Hospital	138	47,688	66.5%	20.4%	7.1%	44.5%	15.6%	12.5%
San Joaquin Valley Rehab Hospital	62	13,926	61.4%	79.3%	18.4%	2.3%	0.0%	0.0%
Sierra View District Hospital	147	39,260	73.0%	37.8%	11.8%	45.4%	1.9%	3.0%
Stanislaus Surgical Hospital	9	3,133	37.2%	16.5%	73.9%	0.0%	0.0%	9.7%
Tehachapi Hospital	25	7,147	78.1%	7.2%	7.5%	78.3%	0.0%	7.0%
Tulare District Hospital	112	21,522	52.5%	47.8%	17.3%	26.3%	4.6%	4.0%
Tuolumne General Hospital	80	23,984	81.9%	14.6%	5.9%	68.7%	2.9%	7.9%
TOTAL	6,383	1,804,404	70.8%	38.7%	21.4%	33.7%	2.5%	3.7%

Source: Author's analysis of data for fiscal years ending in 2004 from Office of Statewide Health Planning and Development.

(Valley Children's Hospital) in Madera was the second largest provider of Medi-Cal inpatient days in the Central Valley, followed by Doctor's Hospital in Modesto.

Other commercial payers including managed care covered 21.4 percent of inpatient days in 2004 and 21.9 percent in 2003. The Kaiser HMO covered two of every five hospital days for Kaiser Foundation in Fresno. The Sutter Health hospitals had a high proportion of commercial and managed care payers, covering 27.8 percent of all its inpatient days. Commercial business was less important for the Adventist Hospitals in the area, accounting for only 16.1 percent of total pays.

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 Central Valley. The Permanente Medical Group (northern California) is the largest group practice in the region, with centers in Fresno, Modesto, and other locations. It has about 353,000 patients and 614 physicians practicing in 42 locations. In the Bakersfield area, the Southern California Permanente Medical Group has 169 primary care and specialty physicians with about 88,000 patients.

The largest IPA in the area is Sante Community Physicians, which is affiliated with St. Agnes in Fresno. It has 1,045 primary care and specialty physicians and about 118,000 capitated patients, down about 10,000 patients in the past two years. St. Agnes is directly affiliated with four clinics in Fresno and Clovis.

Health Plans

Based on the analysis in *Exhibit 14,* about 44 percent of the population of the two regions that comprise the Central Valley is enrolled in an HMO. Kaiser Permanente is now the largest HMO in the area. It has about 479,000 enrollees in the two regions and has grown in recent years. In 2003, it opened new health centers in Clovis and Selma, both in the northern end of the valley. New health centers and hospitals are under construction in other parts of the region, which will likely stimulate additional enrollment growth.

Blue Cross is the second largest health plan with about 454,000 enrollees in the region. Blue Shield added public employees in 2003 and was at about 234,000 Central Valley HMO enrollees in 2005. PacifiCare used to have a larger presence in the area, including a large Secure Horizon plan for seniors that was closely tied to some of the provider systems. Health Net has about 167,000 enrollees in the region.

In 2006 three HMOs in Fresno County will offer Medicare Advantage plans: Aetna Health will join Kaiser and PacifiCare. Aetna's Medicare HMO, which has recently been available only in southern California, will also be available in Kern County. A Blue Cross company will offer a regional PPO plan in Fresno and some nearby counties. The recent

EXHIBIT 39. Physician Organizations in Central Valley, 2006 (includes Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, Tulare, and Tuolumne counties)

Physician Organization / Notes	Estimated Enrollment	Number of PCPs	Number of Specialists	Number of Clinic Sites	DMHC Calculated Relative Working Capital	DMHC Calculated Relative TNE	Management Entity
Group Practice							
Clinica Sierra Vista	19,900	29	9	12	NR	NR	Clinica Sierra Vista (self managed)
Permanente Medical Group	353,300	239	375	42	NR	NR	The Permanente Medical Group, Inc.
Southern California Permanente Medical Group	87,700	51	118	7	NR	NR	Southern California Permanente Medical Group
IPA							
Allcare IPA	45,000	142	170	0	1.05	1.07	Independent Physicians Associates Medical Group, Inc.
Central Valley Medical Group	7,000	80	73	0	1	1	North American Medical Management California, Inc.
ChildNet Medical Associates	800	57	142	0	NR	NR	Children's Hospital Central California
Delano Regional Medical Group, Inc.	4,100	20	125	0	2.26	2.26	Managed Care Systems, LP
Family Health Care Network	28,800	81	3	9	NR	NR	
Gemcare Medical Group	52,200	88	180	0	1.3	1.3	Managed Care Systems, LP
Key Medical Group	15,350	106	175	0	0.18	0.18	Foundation for Medical Care of Tulare and Kings Counties
Heritage Provider Network, Inc.	34,400	91	93	6	NR	NR	
Hill Physicians Medical Group	68,300	114	370	0	NR	NR	PriMed Management Consulting, Inc.
Independence Medical Group	24,500	100	200	0	NR	NR	
Medcore Medical Group	14,000	125	223	0	4.42	2.51	Medcore HP
Sante Community Physicians IPA	117,600	335	710	0	1.08	1.08	Sante Health System, Inc.
Medical Foundation							
Sutter Gould Medical Foundation	95,800	143	210	16	0.87*	1.69	Sutter Connect
Note: Sutter Health is the sole corporate member of Gould Medical Foundation. Includes medical group and IPA. *RBO reported they met criteria.							
State/County Faculty/Staff							
Central California Faculty Medical Group	5,800	29	69	6	NR	NR	Central California Faculty Medical Group, Inc.
San Joaquin Faculty Medical Group	8,000	35	72	6	NR	NR	San Joaquin County Health Care Services

NR: Not reported.

Source: Adopted from Cattaneo & Stroud's medical group inventory, April 2006.

increase in federal payment rates has stimulated HMO interest in the seniors of the region. Kaiser had about 16,509 seniors in Fresno County in 2005, and PacifiCare Secure Horizons had fewer than 4,000.

Several of the counties in the Central Valley have two-plan arrangements for Medi-Cal managed care. However, some of the counties started local initiative plans and then exited that business so there is no local initiative plan. In Fresno, Stanislaus, and Tulare, two commercial HMOs, Blue Cross and Health Net, compete. In San Joaquin and Kern Counties, Blue Cross is the commercial plan that competes against the local initiative plan.

4.5 Los Angeles/Orange Counties

The organization and delivery of health care and health benefits 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 is growing and was estimated at about 13.2 million in 2005. Recent surveys have found that 2.7 million people in Los Angeles County (28 percent of the population) have no health insurance, limiting their access to care providers.

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

More than in other parts of the state, governments in Los Angeles have responded to health care demands by heavy investment in bricks-and-mortar facilities and systems to deliver and administer care to underserved populations. About 300,000 uninsured or low-income persons receive health care through the clinics and hospitals operated by the Los Angeles County Department of Health Services (Los Angeles County DHS). Maintaining this system and the infrastructure of county hospitals demands an ongoing commitment of a huge amount of resources. Twice in the last 15 years Los Angeles County has turned to the federal government for a bailout of its public health system. A federal extension of relief in the 1990s was conditioned on the expansion of local clinic services and a reduction in hospital services. While the Los Angeles County DHS did expand clinical services, it remained heavily committed to maintaining its system of hospitals. In recent years, county leaders have proposed to cover health budget shortfalls by closing some of the county's facilities, but those efforts have been entangled in litigation.

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

The sprawling landscape of the area also presents a challenge to the delivery of health care. Development of new residential areas continues in different parts of the region, such as the valleys to the north. In such a spread-out area, geographic access to hospitals and physicians is an important issue. Some successful medical groups are watching this development and trying to be the first to build clinics to serve the new communities. Of course, that requires the capital to invest both in clinic buildings and in the doctors and nurses to staff new clinics. Extending the geographic reach of their clinics provides an advantage to medical groups 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, to reach patients the health plans need those medical groups who have been able to extend their geographical reach to new population centers.

Overview of Hospitals

There are about 15 hospital systems in the Los Angeles area, though that depends partly on how one counts. Some systems are relatively small and in some cases, were formed by hospitals that were split off from larger systems. HCA has largely exited the region and now has only one hospital in the area.

For-profit hospitals are much more common in this part of the state than in northern California. Tenet Health is the largest hospital system in the area, but in 2004 it had already reduced its network to 25 hospitals with about 4,400 inpatient beds. Only a few years ago it was making acquisitions at a brisk pace in California and other parts of the country. It has since sold the two Daniel Freeman hospitals and Centinela, also in West Los Angeles. In 2004 Tenet also sold four hospitals in eastern Los Angeles County: Garfield Medical Center, Monterey Park Hospital, Greater El Monte Community Hospital, and Whittier Hospital Medical Center. The buyer was AHMC Inc., a privately owned California company that operates Alhambra Hospital Medical Center and Doctors' Hospital Medical Center of Montclair. Toward the end

of 2004, Tenet finalized the sale of Hollywood Presbyterian Medical Center in Los Angeles to the CHA Medical Group.

Alta Healthcare and Pacific Health Corporation are relatively new for-profit companies in the area. The Los Angeles hospitals owned by Paracelsus Health Care Corporation (a Houston-based company that emerged from bankruptcy reorganization under the name Clarent Health) changed ownership to Alta Health Corporation. In turn, some of those hospitals were sold to other investor-owned companies.

The Kaiser Foundation hospitals in the area are the largest nonprofit system, with 1,378 inpatient beds in 2004, which is less than in 2003. Los Angeles County had 1,700 beds in its six hospitals in 2004, also less than in 2003. Catholic Healthcare West had almost 1,500 beds in its six hospitals.

The University of California–Irvine Medical Center is in the midst of constructing a new hospital building to comply with seismic safety requirements and has raised $30 million of the cost from donors. It will include 191 patient rooms and is scheduled to open in 2009. Also in Orange County, the Orange Coast Memorial Medical Center in Fountain Valley plans to build a new hospital. That hospital is one of the few nonprofits in Orange County.

The two exhibits that follow provide data on the finances, utilization, and payment rates of the hospital systems in the area and about 33 hospitals that are not part of those systems. A few of the independent hospitals, like Cedars-Sinai, are bigger than some systems in the area. Still, of the 23,000 inpatient hospital beds in the area, all but about 6,000 are in one of those systems.

There are two Adventist hospitals in Los Angeles County and one in Orange County. White Memorial Medical Center in East Los Angeles is in the process of building a new patient care tower that will meet seismic standards and replace the old hospital. Construction of the new specialty care tower was complete in 2006, but the new campus will not be finished until 2008. The hospital is getting financial help from the Federal Emergency Management Agency. Glendale Adventist has begun construction on a new patient care tower as part of the first phase of an expansion plan to increase inpatient capacity. Hospital leaders expect the growth and aging of the local population to increase the need for hospital care.

Financial Results

Exhibit 40 compares Los Angeles/Orange County hospitals and systems on their revenues and net income in 2004. The hospitals had net income of $781.4 million, or 3.9 percent of total revenues of $19.9 billion. That compares to 2003 net income of $976.9 million. However, about 45 hospitals, including most of the Tenet hospitals, reported losses for their 2004 operations.

The Kaiser hospitals for southern California, including San Diego and Riverside and San Bernardino Counties, had net income of $557.5 million in 2004, or 15.6 percent of total revenues. Kaiser has shown steady improvement in its financial results. It had net income of $389.1 million in 2003 and $229.2 million in 2001. In turn, 2001 was a major improvement over 2000 when the Kaiser hospitals had total losses of $104.8 million. Another nonprofit system, St. Joseph Health had the next best results, with net income of $120.6 million or 12.5 percent of total revenues—almost three times as much as its net income for 2003. St. Joseph has used its strong position in Orange County to negotiate more favorable payments and other terms from health plans.

Tenet Health suffered through a disappointing year in 2004. In some of its other key states like Florida, 2004 was also a bad year financially. In 2004, Tenet Health lost $130.9 million in its Los Angeles and Orange County hospitals, or 6.1 percent of total revenues. That was a sharp reversal from its very strong results in 2003: net income of $309.5 million, or 11.1 percent of total revenues. In some cases, the losses are not cash or operating losses. Instead, Tenet may have written down the value of assets. Still, the losses are a concern to doctors that practice in Tenet hospitals, who may worry about whether Tenet will make investments in money-losing hospitals and wonder if this is a good time to increase their admissions to other hospitals outside of Tenet.

UCLA Medical Center operates its main hospital in Westwood plus a smaller facility in Santa Monica and both are in the middle of major construction projects. In 2004, those two hospitals reported combined losses of $94 million in their OSHPD reports. Although the UCLA Medical Center does not make intergovernmental transfer (IGT) payments, it does make other payments to the UC system that are recorded in its financial statements as reductions in net assets and in the OSHPD reports as expenses reducing net income.

Disputes between hospitals and insurers have become very heated and public in the past two years. In 2006, the UCLA Medical Center was involved in a very public dispute with Blue Shield. It has become a familiar scenario: the academic health center seeks higher

EXHIBIT 40. Revenues and Net Income for Los Angeles/Orange County Hospitals, 2004

System / Hospital	City	Total Charges	Net Patient Revenue	Total Revenue	Operating Expenses	Net from Operations	Total Margin	% of Total Revenue
Adventist		**$1,942,854,601**	**$448,416,566**	**$490,025,805**	**$470,382,812**	**($8,629,857)**	**$14,861,978**	**3.0%**
Glendale Adventist Medical	Glendale	966,745,985	205,660,849	221,466,261	211,976,372	(3,159,675)	6,557,802	3.0%
South Coast Medical Center	South Laguna	240,039,294	63,208,919	67,170,851	65,070,275	2,100,576	2,100,576	3.1%
White Memorial Medical	Los Angeles	736,069,322	179,546,798	201,388,693	193,336,165	(7,570,758)	6,203,600	3.1%
Alta Healthcare		**$261,933,140**	**$61,585,982**	**$61,837,339**	**$58,217,866**	**$3,619,473**	**$2,666,435**	**4.3%**
Hollywood Community	Hollywood	105,708,165	24,993,694	24,993,694	23,512,582	1,481,112	1,481,112	5.9%
Los Angeles Community	Los Angeles	156,224,975	36,592,288	36,843,645	34,705,284	2,138,361	1,185,323	3.2%
Catholic Healthcare West		**$3,759,444,280**	**$834,871,532**	**$878,338,636**	**$881,818,335**	**($28,674,193)**	**($12,321,892)**	**– 1.4%**
California Hospital Medical	Los Angeles	582,838,902	135,523,684	144,506,699	165,208,957	(20,659,380)	(20,702,778)	– 14.3%
Glendale Memorial	Glendale	753,540,901	163,426,064	168,859,007	161,121,456	3,967,162	6,818,795	4.0%
Northridge Hospital Medical	Northridge	917,359,218	210,854,583	225,444,649	206,384,782	7,667,754	16,267,882	7.2%
Northridge Hospital Medical	Van Nuys	294,294,789	61,753,801	72,082,734	72,503,903	(9,411,232)	(4,726,569)	– 6.6%
St. Mary Medical Center	Long Beach	698,861,541	160,332,843	163,890,995	165,567,678	(2,683,879)	(2,168,950)	– 1.3%
San Gabriel Valley Medical	San Gabriel	512,548,929	102,980,557	103,554,552	111,031,559	(7,554,618)	(7,810,272)	– 7.5%
Cedars-Sinai Medical Center		**$4,035,020,320**	**$1,072,019,334**	**$1,215,219,430**	**$1,183,104,391**	**$3,123,048**	**$24,748,406**	**2.0%**
County of Los Angeles		**$4,682,113,251**	**$2,236,345,903**	**$2,817,425,515**	**$1,898,112,034**	**$376,170,549**	**$48,732,309**	**1.7%**
Martin Luther King Jr. / Drew	Los Angeles	823,536,370	389,884,556	511,519,858	339,010,705	55,883,764	20,288,793	4.0%
Rancho Los Amigos Rehab	Downey	294,569,602	190,999,757	244,432,029	146,749,556	46,316,357	24,902,893	10.2%
UCLA Medical Center, Harbor	Torrance	1,105,479,555	441,637,812	507,892,902	365,110,897	82,047,623	(10,049,485)	– 2.0%
UCLA Med Center, Olive View	Sylmar	482,654,661	299,418,926	381,561,860	233,844,440	71,579,962	26,244,368	6.9%
USC Medical Center	Los Angeles	1,975,873,063	914,404,852	1,172,018,866	813,396,436	120,342,843	(12,654,260)	– 1.1%
Daughters of Charity		**$1,519,009,298**	**$416,673,606**	**$439,808,896**	**$463,761,215**	**($38,916,830)**	**($65,030,186)**	**– 14.8%**
Robert F. Kennedy Medical	Hawthorne	207,889,800	53,614,472	54,279,817	84,263,464	(30,042,049)	(65,549,964)	–120.8%
St. Francis Medical Center	Lynwood	715,995,147	200,320,073	211,812,071	198,872,838	6,493,719	12,391,584	5.9%
St. Vincent Medical Center	Los Angeles	595,124,351	162,739,061	173,717,008	180,624,913	(15,368,500)	(11,871,806)	– 6.8%
Hoag Memorial Hospital Presbyterian		**$1,006,900,170**	**$436,469,720**	**$531,036,520**	**$436,168,401**	**$24,339,162**	**$85,989,548**	**16.2%**
Kaiser Foundation, Southern Region*		**$3,517,312,150**	**$3,517,312,150**	**$3,564,272,274**	**$3,006,805,921**	**$510,506,229**	**$557,466,353**	**15.6%**
Memorial Health Services		**$2,478,323,980**	**$757,162,991**	**$830,535,383**	**$790,889,411**	**$25,350,946**	**$25,635,793**	**3.1%**
Anaheim Memorial	Anaheim	635,328,664	151,912,176	155,748,330	156,259,288	(3,122,207)	(2,614,174)	– 1.7%
Earl and Lorraine Miller Children's	Long Beach	445,927,939	161,653,982	182,348,798	208,165,268	(27,603,479)	(29,627,226)	– 16.2%
Long Beach Memorial	Long Beach	1,056,505,402	344,988,735	390,840,943	327,924,755	55,376,542	55,898,856	14.3%
Orange Coast Memorial	Fountain Valley	340,561,975	98,608,098	101,597,312	98,540,100	700,090	1,978,337	1.9%
Pacific Health Corporation		**$611,753,705**	**$225,271,238**	**$229,655,385**	**$243,111,079**	**($15,524,251)**	**($14,671,314)**	**– 6.4%**
Anaheim General Hospital	Anaheim	142,462,564	30,391,149	32,574,071	35,443,664	(4,970,490)	(3,972,564)	– 12.2%
Bellflower Medical Center	Bellflower	178,325,057	39,462,538	39,559,467	38,929,742	629,725	352,648	0.9%
LA Metropolitan Medical	Los Angeles	175,722,738	62,246,962	62,390,042	51,114,493	11,275,549	6,314,316	10.1%
Tustin Hospital Medical	Tustin	115,243,346	25,853,043	26,169,667	24,414,624	1,755,043	1,418,904	5.4%
Providence Healthcare Systems		**$1,154,751,859**	**$301,421,901**	**$309,936,229**	**$302,486,986**	**$4,171,458**	**$7,449,243**	**2.4%**
Little Company of Mary	Torrance	756,565,050	193,289,365	199,366,784	198,914,739	(1,323,982)	452,045	0.2%
Little Company of Mary	San Pedro	398,186,809	108,132,536	110,569,445	103,572,247	5,495,440	6,997,198	6.3%
Sisters of Providence		**$2,025,771,260**	**$423,309,970**	**$432,014,249**	**$423,577,135**	**$5,909,213**	**$7,572,085**	**1.8%**
Providence Holy Cross	Mission Hills	875,132,093	163,905,635	166,923,602	163,734,386	2,847,571	3,011,700	1.8%
Providence Saint Joseph	Burbank	1,150,639,167	259,404,335	265,090,647	259,842,749	3,061,642	4,560,385	1.7%

EXHIBIT 40. Revenues and Net Income for Los Angeles/Orange County Hospitals, 2004, cont.

System / Hospital	City	Total Charges	Net Patient Revenue	Total Revenue	Operating Expenses	Net from Operations	Total Margin	% of Total Revenue
St. Joseph		**$2,754,503,720**	**$854,835,557**	**$962,783,547**	**$817,994,353**	**$112,409,081**	**$120,601,880**	**12.5%**
Mission Hospital Regional	Mission Viejo	771,676,048	234,461,905	256,496,512	218,137,636	23,807,010	25,087,491	9.8%
St. Joseph Hospital	Orange	1,120,553,529	349,179,678	416,881,739	360,785,266	42,179,715	45,180,544	10.8%
St. Jude Medical Center	Fullerton	862,274,143	271,193,974	289,405,296	239,071,451	46,422,356	50,333,845	17.4%
Tenet Health		**$13,482,187,073**	**$ 2,118,978,934**	**$2,156,491,083**	**2,256,627,228**	**($119,084,988)**	**($130,895,170)**	**– 6.1%**
Chapman Medical Center	Orange	195,053,389	37,493,020	38,243,675	43,337,748	(5,532,736)	(5,688,854)	– 14.9%
Coastal Communities	Santa Ana	298,167,831	52,831,030	53,928,704	58,181,520	(5,132,382)	(5,093,855)	– 9.4%
Community and Mission	Huntington Park	223,410,011	37,984,726	38,198,370	44,400,558	(6,376,263)	(6,292,435)	– 16.5%
Daniel Freeman Marina	Marina Del Rey	171,969,944	32,141,498	34,486,359	36,776,410	(3,138,043)	(2,631,975)	– 7.6%
Daniel Freeman Memorial	Inglewood	642,063,933	88,541,588	89,339,279	113,772,047	(24,583,230)	(24,628,926)	– 27.6%
Encino Tarzana Regional	Encino	411,321,817	51,659,881	52,032,887	59,959,557	(8,028,645)	(8,150,644)	– 15.7%
Encino Tarzana Regional	Tarzana	1,096,733,704	150,267,056	155,983,447	151,078,969	777,015	(7,405,233)	– 4.7%
Fountain Valley Regional	Fountain Valley	1,117,104,265	218,796,312	219,977,552	214,250,132	5,569,140	3,627,420	1.6%
Garden Grove Hospital	Garden Grove	357,239,724	65,589,222	66,903,691	69,738,775	(3,880,550)	(3,507,304)	– 5.2%
Garfield Medical Center	Monterey Park	830,734,308	103,957,672	105,926,066	101,415,693	3,007,559	2,313,343	2.2%
Greater El Monte Community	South El Monte	208,435,256	29,392,772	29,868,562	34,846,141	(5,398,238)	(5,028,760)	– 16.8%
Irvine Medical Center	Irvine	545,003,638	89,555,792	90,066,965	92,195,336	(2,129,395)	(2,239,600)	– 2.5%
Lakewood Regional Medical	Lakewood	603,161,580	93,623,031	95,713,268	92,767,797	1,177,790	(575,284)	– 0.6%
Los Alamitos Medical Center	Los Alamitos	680,228,460	104,799,211	106,679,842	96,757,164	8,525,422	7,896,829	7.4%
Midway Hospital Medical	Los Angeles	687,651,892	72,619,333	74,397,461	76,352,365	(3,529,201)	(4,346,731)	– 5.8%
Monterey Park Hospital	Monterey Park	281,429,957	33,796,576	34,480,183	37,529,581	(3,588,047)	(3,147,765)	– 9.1%
Placentia-Linda Community	Placentia	217,869,028	41,580,339	42,133,060	41,324,566	438,086	365,484	0.9%
Queen of Angels / Hollywood Presbyterian	Los Angeles	895,830,101	142,167,568	146,652,562	147,998,956	(1,741,141)	(2,052,789)	– 1.4%
San Dimas Community	San Dimas	362,661,295	44,543,674	45,435,587	47,250,975	(2,490,682)	(2,271,380)	– 5.0%
Suburban Medical Center	Paramount	275,469,628	37,964,543	38,522,404	45,956,167	(7,760,737)	(7,887,361)	– 20.5%
USC Kenneth Norris Jr. Cancer	Los Angeles	290,311,465	86,879,533	89,424,437	104,103,247	(15,221,322)	(14,819,156)	– 16.6%
USC University Hospital	Los Angeles	1,478,945,165	246,692,892	249,824,725	257,086,817	(8,057,695)	(7,511,976)	– 3.0%
Western Medical Center	Anaheim	323,831,806	60,452,213	60,999,912	69,232,855	(8,233,305)	(8,380,755)	– 13.7%
Western Medical Center	Santa Ana	852,024,688	145,702,287	146,924,008	155,258,275	(8,707,597)	(8,483,494)	– 5.8%
Whittier Hospital Medical	Whittier	435,534,188	49,947,165	50,348,077	65,055,577	(15,050,791)	(14,953,969)	– 29.7%
University of California†		**$3,770,928,023**	**$1,322,170,329**	**$1,403,879,591**	**$1,429,179,938**	**($28,679,070)**	**($95,807,878)**	**– 6.8%**
UC – Irvine Medical Center	Orange	1,309,623,323	454,498,011	482,911,162	414,064,164	67,440,101	(1,660,533)	– 0.3%
UCLA Neuropsychiatric	Los Angeles	50,526,435	31,322,038	32,544,784	32,576,468	(1,254,430)	(31,684)	– 0.1%
UCLA Medical Center	Los Angeles	2,038,378,917	732,912,518	780,527,451	853,089,803	(72,562,352)	(72,562,352)	– 9.3%
West Hills Hospital & Medical Center (HCA)		**$463,352,916**	**$108,951,525**	**$111,541,601**	**$113,819,983**	**($3,129,513)**	**($2,632,564)**	**– 2.4%**
Others		**$11,027,630,978**	**$3,143,755,577**	**$3,533,757,234**	**$3,324,554,186**	**$5,333,933**	**$189,119,342**	**5.4%**
Alhambra Hospital	Alhambra	126,331,968	52,363,200	53,206,395	50,444,188	2,546,856	2,622,016	4.9%
American Recovery Center	Pomona	6,237,551	6,199,903	6,220,873	6,264,268	(43,395)	(43,395)	– 0.7%
Antelope Valley Hospital	Lancaster	701,721,131	188,722,347	196,793,762	207,038,051	(12,824,534)	(23,896,394)	– 12.1%
Children's Hospital	Los Angeles	711,195,236	275,534,808	435,345,052	410,802,361	(23,114,753)	14,298,295	3.3%
Children's Hospital	Orange	572,292,959	226,996,016	259,181,071	252,569,399	5,963,271	6,421,539	2.5%
City of Angels Medical	Los Angeles	131,223,403	51,431,332	53,548,300	46,985,446	6,562,854	6,562,854	12.3%

EXHIBIT 40. Revenues and Net Income for Los Angeles/Orange County Hospitals, 2004, cont.

System / Hospital	City	Total Charges	Net Patient Revenue	Total Revenue	Operating Expenses	Net from Operations	Total Margin	% of Total Revenue
College Hospital Costa Mesa	Costa Mesa	75,202,976	22,218,706	27,068,191	29,439,601	(2,371,410)	(2,371,410)	– 8.8%
Community Hospital	Gardena	44,600,181	15,095,905	15,126,972	14,974,384	152,588	152,588	1.0%
Community Hospital	Long Beach	123,013,195	33,020,852	34,796,369	33,036,517	453,701	1,185,175	3.4%
Del Amo Hospital	Torrance	58,724,886	18,978,843	19,048,803	16,958,004	2,047,681	2,068,348	10.9%
Downey Regional Medical	Downey	460,204,892	106,401,310	116,861,692	120,339,464	(13,623,018)	(3,715,288)	– 3.2%
Foothill Presbyterian	Glendora	206,482,228	46,711,639	47,256,530	46,195,923	984,208	1,060,607	2.2%
Good Samaritan Hospital	Los Angeles	744,936,566	187,064,943	204,210,924	210,426,037	(21,772,510)	(6,781,990)	– 3.3%
Healthbridge Children's	Orange	35,664,528	7,410,254	7,419,952	6,416,178	1,003,774	598,291	8.1%
Henry Mayo Newhall Memorial	Valencia	521,250,051	115,034,414	118,681,874	110,703,757	4,405,880	7,973,824	6.7%
Huntington Beach Hospital	Huntington Beach	182,290,678	44,276,045	44,613,708	47,650,796	(3,037,088)	(3,040,042)	– 6.8%
Huntington Memorial	Pasadena	1,119,758,038	335,267,724	363,377,633	325,954,480	18,995,396	35,935,772	9.9%
Kedren Community Mental Health Center	Los Angeles	18,669,420	18,669,420	18,693,320	20,511,981	(1,818,661)	(1,818,661)	– 9.7%
Kindred Hospital Brea	Brea	57,442,285	20,268,812	20,322,164	18,651,205	1,670,959	1,670,959	8.2%
La Palma Intercommunity	La Palma	135,493,633	37,389,707	37,746,718	37,910,451	(163,733)	(3,290,796)	– 8.7%
Lancaster Community	Lancaster	288,698,916	63,160,344	63,829,165	66,691,459	(3,511,401)	(3,108,770)	– 4.9%
Methodist Hospital	Arcadia	559,977,748	164,621,674	172,302,067	158,500,380	8,279,862	13,722,365	8.0%
Mission Community Hospital	Panorama City	111,860,709	41,639,672	42,178,686	43,303,294	(1,510,156)	(1,695,836)	– 4.0%
Newport Bay Hospital	Newport Beach	11,926,383	8,729,699	8,730,341	8,943,198	(212,857)	(212,857)	– 2.4%
Orthopaedic Hospital	Los Angeles	69,486,501	21,022,234	54,060,878	42,546,519	(16,280,358)	10,748,453	19.9%
Pacific Alliance Medical	Los Angeles	80,900,891	48,589,478	65,200,383	53,820,953	(5,021,561)	8,964,405	13.7%
Pacifica Hospital of the Valley	Sun Valley	161,346,956	59,312,817	60,143,102	61,658,145	(1,515,043)	31,445,154	52.3%
Pomona Valley Hospital	Pomona	1,120,290,937	249,723,727	263,779,549	248,538,158	5,501,157	7,897,005	3.0%
Presbyterian Intercommunity	Whittier	911,203,517	230,250,239	248,853,665	196,002,048	35,988,988	52,851,617	21.2%
San Vicente Hospital	Los Angeles	5,877,210	3,813,505	4,497,583	3,604,362	209,143	888,521	19.8%
Sherman Oaks Hospital	Sherman Oaks	257,680,888	67,169,847	67,831,009	67,895,313	(198,945)	(64,304)	– 0.1%
Temple Community Hospital	Los Angeles	102,264,867	38,622,444	38,654,269	36,668,620	1,964,165	1,953,649	5.1%
Torrance Memorial	Torrance	1,046,438,284	266,700,037	291,851,820	260,306,673	6,393,364	20,615,807	7.1%
West Anaheim Medical	Anaheim	266,941,366	71,343,680	72,324,414	62,802,573	9,229,509	9,521,841	13.2%
	TOTAL	$58,493,790,724	$18,212,235,269	$19,899,596,579	$18,007,402,718	$852,508,468	$781,409,605	3.9%

*Includes all southern California hospitals for Kaiser Foundation.
†UCLA Medical Center, including UCLA – Santa Monica and the UCLA Neuropsychiatric hospital, reported a 2004 net loss of $94.1 million in its combined OSHPD reports but net income of $11.7 million in its audited financial statements. The difference of $105.8 million is due to a higher amount reported as operating expenses in the OSHPD reports that are classified as reductions to equity in UCLA Medical Center's audited financial statements.
Source: Author's analysis of data for fiscal years ending in 2004 from Office of Statewide Health Planning and Development.

payment for its services from a major insurer that balks, saying that the requested payment is far above the going rate in the market and would cause the insurer to lose employer accounts. In most cases the parties compromise and the contracts are renewed. But sometimes the hospital or the insurer refuses to budge and the insurer's members are directed to other hospitals. In the case of Blue Shield and UCLA, the medical center terminated the contract in July 2006, but the parties reached an agreement four months later.

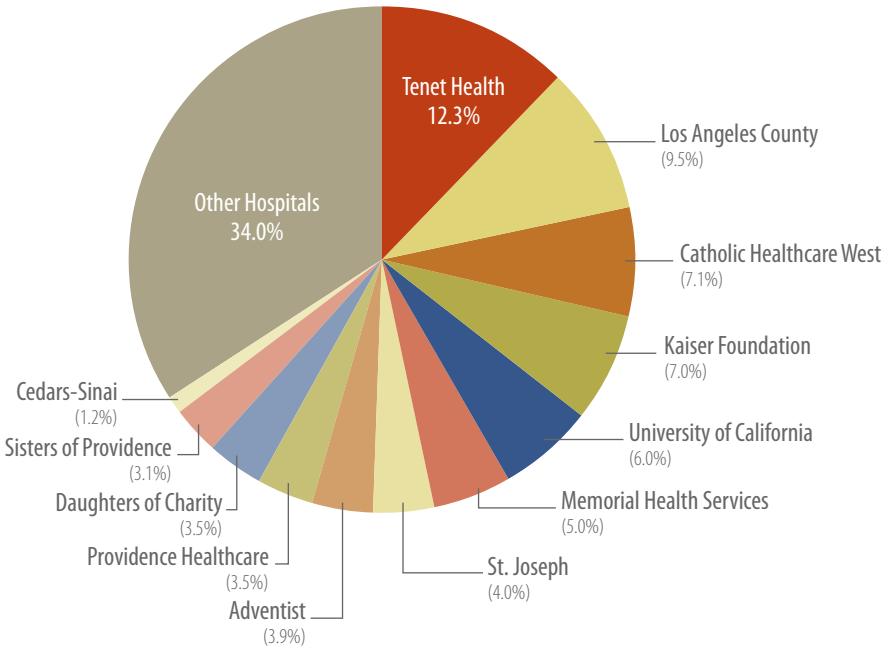
Some of the religious systems in the area did not fare well in 2004. The six CHW hospitals lost $12.3 million and the Daughters of Charity hospitals lost $65 million. The Adventist hospitals had combined net income of $14.9 million in 2004. Among the independent hospitals, Cedar-Sinai had net income of $24.7 million.

Market Share and Occupancy

Exhibit 41 looks at hospital market share across the Los Angeles/Orange Counties area. The hospital market is less concentrated here than in the Bay Area; the four largest systems have about 36 percent of the market for inpatient care. In the Bay Area, the four largest systems have almost 50 percent of the inpatient care days. The pie chart shows that Tenet Health had 12.3 percent of the Lost Angeles/Orange Counties market. While still the largest in the area for market share, Tenet's share has declined in the past three years because it sold off several hospitals. The Los Angeles County hospitals accounted for 9.5 percent of inpatient hospital days in the two counties for 2004, and its market share for inpatient services has also declined. Catholic Healthcare West and the Kaiser hospitals each had about 7 percent of inpatient care market share in the area in 2004.

Hospital capacity is a major issue in the Los Angeles/Orange County region. Major new construction or reconstruction projects are now underway or in the planning stages. Besides fundamental capacity needs, the driving forces behind these projects also include the need to meet seismic safety standards, modernize outmoded facilities, and stay competitive with the most cutting-edge technology and equipment. During the first years of this decade when hospital finances were weaker, they could not afford the cost of new construction and their balance sheets were not strong enough to bond for the debt. As hospital finances improved, it became possible for them to begin investing in new projects. Some systems in the state received upgraded bond ratings, easing their access to debt markets.

EXHIBIT 41. Market Share for Los Angeles/Orange County Hospital Systems, 2004



Source: Author's analysis of annual hospital report data for year-end 2004 from the Office of Statewide Health Planning and Development.

Most of the hospital construction projects in Los Angeles and Orange Counties are tied to the need to bring hospitals up to the state's new standards for seismic safety. Children's Hospital in Los Angeles will construct a new patient care tower designed to meet the new standards. Reconstruction of the UCLA Medical Center, heavily earthquake-damaged, is almost complete. Kaiser has announced plans to replace six of its hospitals in southern California over the next 10 years, largely to comply with the state's standards for seismic safety in hospital construction. When combined with the expansions described in earlier sections, Kaiser has an enormous construction program planned for California in the next 15 years.

Health care and real estate development can be closely linked. Some older hospitals find themselves on land that has become more valuable for residential or commercial development. In 2006, the Orthopaedic Hospital in downtown Los Angeles will sell a tract of land to developers building high-end condominiums. Public authorities are also considering pursuing new medical facility construction on publicly owned property that is currently underused. For example, a new Shriners hospital may be built on county land near the construction site of a new LA County/USC hospital.

Average inpatient occupancy rates in the area have increased since 2000, although they are lower than in some other regions of the state. *Exhibit 42* compares Los Angeles and Orange County hospitals and systems on their inpatient occupancy rates and payer mix in 2004. Hospitals in the area had, on average, 64.7 percent inpatient occupancy. That is higher than in 2003, when the average was 63.8 percent, and 2001 when the average was 62.9 percent.

EXHIBIT 42. Inpatient Occupancy Rates and Payer Mix for Los Angeles/Orange County Hospitals, 2004

System / Hospital	Staffed Beds	Inpatient Days	Occupancy	PAYER DISTRIBUTION				
				Medicare	Other Third Parties	Medi-Cal	County Indigent	Other Payers
Adventist	**758**	**233,971**	**66.7%**	**43.5%**	**18.7%**	**34.8%**	**0.0%**	**2.9%**
Glendale Adventist Medical Center	396	107,289	74.0%	52.7%	17.2%	28.8%	0.0%	1.4%
South Coast Medical Center	84	29,759	42.1%	36.7%	39.0%	18.1%	0.2%	6.0%
White Memorial Medical Center	278	96,923	71.8%	35.5%	14.1%	46.7%	0.0%	3.7%
Alta Healthcare	**337**	**63,761**	**50.2%**	**33.4%**	**2.5%**	**60.9%**	**0.0%**	**3.2%**
Hollywood Community Hospital	160	26,346	45.0%	57.3%	0.5%	41.9%	0.0%	0.3%
Los Angeles Community Hospital	177	37,415	54.7%	16.6%	3.9%	74.3%	0.0%	5.3%
Catholic Healthcare West	**1,478**	**420,767**	**58.7%**	**44.6%**	**17.2%**	**35.2%**	**0.0%**	**3.0%**
California Hospital Medical Center	275	69,549	69.1%	26.4%	6.1%	65.3%	0.0%	2.2%
Glendale Memorial Hospital	334	75,715	61.9%	50.8%	14.9%	26.8%	0.0%	7.4%
Northridge Hospital Medical Center	250	89,177	58.7%	37.2%	36.7%	24.0%	0.0%	2.0%
Northridge Hospital Medical Center, Sherman	122	43,061	60.3%	36.4%	16.2%	45.9%	0.0%	1.5%
St. Mary Medical Center	223	79,268	46.6%	49.2%	10.3%	37.2%	0.0%	3.3%
San Gabriel Valley Medical Center	274	63,997	63.8%	66.8%	14.1%	18.2%	0.0%	0.9%
Cedars-Sinai Medical Center	**875**	**284,959**	**89.0%**	**41.3%**	**25.7%**	**15.5%**	**0.1%**	**17.3%**
County of Los Angeles	**1,699**	**564,355**	**68.2%**	**7.8%**	**5.2%**	**49.5%**	**36.8%**	**0.7%**
Martin Luther King Jr./Drew Medical Center	212	74,269	65.7%	8.8%	2.3%	35.3%	53.1%	0.5%
Rancho Los Amigos National Rehabilitation	191	55,660	52.8%	9.9%	4.2%	62.5%	22.0%	1.5%
UCLA Medical Center, Harbor	321	117,487	73.6%	10.5%	4.0%	56.1%	28.9%	0.5%
UCLA Medical Center, Olive View	238	60,858	69.9%	5.7%	2.8%	51.7%	39.1%	0.7%
USC Medical Center	737	256,081	70.7%	6.2%	7.4%	47.3%	38.4%	0.7%
Daughters of Charity	**733**	**206,609**	**60.7%**	**44.6%**	**11.4%**	**38.0%**	**1.5%**	**4.5%**
Robert F. Kennedy Medical Center	229	43,970	52.5%	47.8%	6.8%	41.3%	0.0%	4.0%
St. Francis Medical Center	323	98,411	70.2%	31.7%	8.4%	50.2%	3.1%	6.6%
St. Vincent Medical Center	181	64,228	55.2%	62.2%	19.1%	17.1%	0.0%	1.5%
Hoag Memorial Hospital Presbyterian	**354**	**105,057**	**81.1%**	**45.2%**	**47.5%**	**2.5%**	**0.9%**	**4.0%**
Kaiser Foundation Hospitals	**1,378**	**466,990**	**58.2%**	**42.4%**	**52.0%**	**3.2%**	**0.0%**	**2.4%**
Anaheim	132	47,550	90.2%	36.0%	58.7%	3.3%	0.0%	2.0%
Baldwin Park	140	42,509	56.1%	37.9%	58.5%	1.9%	0.0%	1.7%
Bellflower	214	67,716	55.4%	35.3%	57.5%	4.8%	0.0%	2.3%
Harbor City	176	48,603	52.1%	45.6%	48.9%	3.6%	0.0%	1.9%
Panorama City	126	41,057	42.8%	48.4%	44.3%	2.8%	0.0%	4.6%
Sunset	308	125,304	67.5%	40.5%	53.9%	3.0%	0.1%	2.5%
West Los Angeles	143	45,186	46.6%	50.4%	43.2%	4.1%	0.0%	2.3%
Woodland Hills	139	49,065	61.5%	51.6%	44.7%	1.3%	0.0%	2.3%
Memorial Health Services	**953**	**299,363**	**70.3%**	**39.0%**	**31.8%**	**25.8%**	**0.7%**	**2.7%**
Anaheim Memorial Medical Center	162	57,899	73.2%	50.4%	30.0%	12.9%	1.7%	4.9%
Earl and Lorraine Miller Children's Hospital	225	76,475	74.4%	1.6%	39.4%	58.3%	0.0%	0.7%
Long Beach Memorial Medical Center	458	128,751	76.8%	53.8%	23.7%	18.8%	0.8%	2.9%
Orange Coast Memorial Medical Center	108	36,238	47.4%	46.9%	47.3%	2.5%	0.6%	2.6%

EXHIBIT 42. Inpatient Occupancy Rates and Payer Mix for Los Angeles/Orange County Hospitals, 2004, cont.

System / Hospital	Staffed Beds	Inpatient Days	Occupancy	PAYER DISTRIBUTION				
				Medicare	Other Third Parties	Medi-Cal	County Indigent	Other Payers
Pacific Health Corporation	**665**	**103,366**	**42.5%**	**43.5%**	**6.0%**	**47.1%**	**0.4%**	**3.0%**
Anaheim General Hospital	143	22,552	43.1%	50.1%	4.6%	39.7%	1.0%	4.5%
Bellflower Medical Center	144	27,998	53.1%	45.3%	4.9%	45.8%	0.0%	4.0%
Los Angeles Metropolitan Medical Center	201	39,125	53.2%	48.4%	5.7%	44.8%	0.0%	1.1%
Tustin Hospital Medical Center	177	13,691	21.1%	14.9%	11.7%	68.8%	1.2%	3.5%
Providence Healthcare Systems	**828**	**210,479**	**61.2%**	**41.0%**	**23.4%**	**31.7%**	**0.0%**	**3.9%**
Little Company of Mary Hospital	410	92,255	60.6%	55.6%	29.6%	12.2%	0.0%	2.6%
Little Company of Mary Hospital, San Pedro	418	118,224	61.8%	29.6%	18.5%	46.9%	0.0%	4.9%
Sisters of Providence	**678**	**186,982**	**75.4%**	**51.0%**	**24.3%**	**21.1%**	**0.0%**	**3.6%**
Providence Holy Cross Medical Center	251	81,218	88.4%	43.1%	22.9%	28.5%	0.0%	5.6%
Providence Saint Joseph Medical Center	427	105,764	67.7%	57.1%	25.4%	15.5%	0.0%	2.1%
St. Joseph	**961**	**235,541**	**64.0%**	**47.2%**	**40.5%**	**8.7%**	**1.4%**	**2.2%**
Mission Hospital Regional Medical Center	294	72,771	58.8%	48.1%	37.0%	10.3%	2.2%	2.3%
St. Joseph Hospital, Orange	366	86,766	64.8%	39.0%	47.9%	10.8%	0.9%	1.3%
St. Jude Medical Center	301	76,004	69.0%	55.8%	35.4%	4.7%	1.1%	3.0%
Tenet Health	**4,377**	**1,010,447**	**65.3%**	**42.4%**	**20.0%**	**34.5%**	**0.8%**	**2.3%**
Chapman Medical Center	110	25,827	64.2%	26.7%	35.9%	33.5%	0.7%	3.2%
Coastal Communities Hospital	178	40,923	62.8%	30.8%	5.3%	59.2%	2.1%	2.6%
Community and Mission Hospitals, Huntington Park	157	22,512	39.2%	20.5%	5.0%	71.5%	0.0%	3.0%
Daniel Freeman Marina Hospital	90	12,072	41.5%	64.5%	20.0%	7.4%	0.0%	8.1%
Daniel Freeman Memorial Hospital	339	56,971	52.0%	44.4%	14.5%	37.0%	0.0%	4.1%
Encino Tarzana Regional, Encino	151	35,627	64.5%	58.5%	9.3%	30.6%	0.0%	1.6%
Encino Tarzana Regional, Tarzana	245	67,263	75.0%	44.6%	33.6%	20.3%	0.0%	1.4%
Fountain Valley Regional, Euclid	400	89,723	61.3%	38.5%	29.4%	27.7%	3.1%	1.4%
Garden Grove Hospital and Medical Center	74	26,871	44.0%	34.2%	14.5%	41.2%	3.0%	7.1%
Garfield Medical Center	208	58,960	92.9%	49.8%	12.0%	36.7%	0.0%	1.5%
Greater El Monte Community Hospital	117	22,106	61.9%	29.2%	4.2%	62.8%	0.0%	3.8%
Irvine Medical Center	176	29,854	46.3%	41.0%	53.8%	3.4%	0.7%	1.1%
Lakewood Regional Medical Center	143	37,221	71.1%	68.5%	15.7%	13.3%	0.0%	2.6%
Los Alamitos Medical Center	167	43,780	71.6%	69.3%	19.8%	8.3%	1.1%	1.4%
Midway Hospital Medical Center	117	39,204	75.0%	73.3%	10.1%	14.8%	0.0%	1.8%
Monterey Park Hospital	101	20,385	66.2%	44.0%	7.2%	47.6%	0.0%	1.2%
Placentia-Linda Community Hospital	114	12,143	29.1%	44.9%	41.0%	9.0%	3.1%	2.1%
Queen of Angels/Hollywood Presbyterian	410	99,951	66.6%	33.7%	4.4%	58.8%	0.0%	3.0%
San Dimas Community Hospital	93	26,517	77.9%	35.0%	17.8%	46.0%	0.0%	1.1%
Suburban Medical Center	182	27,401	49.4%	16.2%	5.5%	76.6%	0.0%	1.7%
USC Kenneth Norris Jr. Cancer Hospital	51	16,797	75.8%	42.2%	52.3%	2.5%	0.0%	2.9%
USC University Hospital	182	66,438	68.0%	46.3%	38.1%	15.3%	0.0%	0.3%
Western Medical Center, Anaheim	188	42,324	61.5%	31.9%	22.9%	42.3%	1.0%	1.9%
Western Medical Center, Santa Ana	282	58,494	56.7%	35.6%	22.5%	35.2%	2.8%	3.9%
Whittier Hospital Medical Center	102	31,083	56.3%	33.5%	18.3%	46.0%	0.0%	2.2%

EXHIBIT 42. Inpatient Occupancy Rates and Payer Mix for Los Angeles/Orange County Hospitals, 2004, cont.

System / Hospital	Staffed Beds	Inpatient Days	Occupancy	PAYER DISTRIBUTION				
				Medicare	Other Third Parties	Medi-Cal	County Indigent	Other Payers
University of California	**1,414**	**354,537**	**66.5%**	**31.8%**	**39.0%**	**21.7%**	**2.2%**	**5.3%**
UCLA Medical Center	670	172,387	70.3%	30.8%	47.1%	17.0%	0.4%	4.7%
UCLA Medical Center, Santa Monica	291	51,246	48.1%	50.3%	37.3%	8.2%	0.0%	4.2%
UCLA Neuropsychiatric Hospital	70	26,051	63.0%	27.9%	52.2%	11.2%	0.0%	8.7%
University of California – Irvine Medical Center	383	104,853	74.8%	25.2%	23.3%	38.7%	6.8%	6.0%
West Hills Hospital and Medical Center (HCA)	**116**	**41,405**	**47.9%**	**58.9%**	**35.3%**	**4.0%**	**0.0%**	**1.9%**
Others	**5,482**	**1,496,408**	**64.8%**	**42.0%**	**24.4%**	**27.6%**	**2.8%**	**3.2%**
Alhambra Hospital, Alhambra	144	40,664	77.2%	53.3%	4.2%	40.5%	0.0%	2.0%
American Recovery Center	156	38,876	68.1%	0.0%	0.0%	0.0%	99.6%	0.4%
Antelope Valley Hospital	329	93,595	75.0%	34.9%	28.7%	29.0%	0.0%	7.3%
Children's Hospital of Los Angeles	279	84,154	82.4%	0.3%	26.8%	69.7%	0.0%	3.2%
Children's Hospital of Orange County	202	49,613	67.1%	0.1%	44.0%	54.6%	0.0%	1.3%
City of Angels Medical Center	180	44,748	67.9%	32.1%	1.6%	55.6%	0.0%	10.7%
College Hospital Costa Mesa	83	30,199	69.9%	14.7%	22.8%	60.7%	1.0%	0.8%
Community Hospital of Gardena	31	6,526	36.4%	86.1%	8.9%	3.6%	0.0%	1.4%
Community Hospital of Long Beach	81	17,611	32.7%	67.8%	12.0%	13.5%	0.0%	6.8%
Del Amo Hospital	111	34,386	56.6%	52.1%	32.7%	12.2%	0.0%	3.0%
Downey Regional Medical Center	193	45,961	65.1%	53.7%	22.1%	19.6%	0.0%	4.6%
Foothill Presbyterian Hospital	106	21,444	55.3%	56.8%	30.2%	11.0%	0.0%	2.0%
Good Samaritan Hospital, Los Angeles	361	90,092	68.2%	51.1%	29.7%	15.9%	0.0%	3.2%
Healthbridge Children's Hospital, Orange	24	8,510	96.9%	0.0%	32.4%	67.6%	0.0%	0.0%
Henry Mayo Newhall Memorial Hospital	217	54,290	68.4%	47.5%	34.3%	10.3%	1.1%	6.7%
Huntington Beach Hospital	71	25,256	52.7%	47.5%	13.2%	35.1%	2.8%	1.4%
Huntington Memorial Hospital	496	138,019	72.2%	50.1%	31.1%	15.0%	0.3%	3.4%
Kedren Community Mental Health Center	48	12,758	72.6%	0.0%	100.0%	0.0%	0.0%	0.0%
Kindred Hospital Brea	48	14,096	80.2%	85.7%	10.9%	3.4%	0.0%	0.0%
La Palma Intercommunity Hospital	141	23,002	44.6%	34.8%	50.8%	12.5%	0.0%	1.9%
Lancaster Community Hospital	75	26,482	61.8%	67.3%	22.3%	7.6%	0.0%	2.9%
Methodist Hospital of Southern California	253	79,995	76.7%	62.7%	24.0%	10.4%	0.0%	3.0%
Mission Community Hospital, Panorama	145	36,342	68.5%	41.2%	7.5%	47.8%	0.0%	3.5%
Newport Bay Hospital	34	9,349	75.1%	97.9%	2.1%	0.0%	0.0%	0.0%
Orthopaedic Hospital	73	4,749	11.6%	16.9%	28.2%	38.8%	0.0%	16.1%
Pacific Alliance Medical Center	77	27,845	55.1%	53.2%	2.6%	43.2%	0.0%	1.1%
Pacifica Hospital of the Valley	169	59,740	71.9%	23.7%	5.2%	68.4%	0.0%	2.6%
Pomona Valley Hospital Medical Center	429	102,525	65.3%	36.1%	18.8%	42.0%	0.0%	3.1%
Presbyterian Intercommunity Hospital	243	81,000	65.3%	45.9%	31.7%	20.2%	0.0%	2.2%
San Vicente Hospital	17	220	3.5%	4.1%	0.0%	0.0%	0.0%	95.9%
Sherman Oaks Hospital and Health Center	153	29,497	52.8%	70.9%	17.2%	9.3%	0.0%	2.6%
Temple Community Hospital	130	25,867	41.6%	53.7%	4.6%	41.3%	0.0%	0.4%
Torrance Memorial Medical Center	269	98,404	75.7%	49.5%	42.3%	6.8%	0.0%	1.4%
West Anaheim Medical Center	114	40,593	50.6%	73.5%	18.2%	4.0%	3.6%	0.7%
TOTAL	**23,086**	**6,284,997**	**64.7%**	**39.1%**	**24.6%**	**28.3%**	**4.4%**	**3.5%**

At the largest systems, occupancy rates ranged from 68.2 percent at the Los Angeles County hospitals to 58.2 percent at the Kaiser hospitals in Los Angeles. Cedars-Sinai, which usually reports high occupancy rates, was up to 89.0 percent in 2004, up from 87.1 percent in 2003. Total inpatient days at the Los Angeles County hospitals decreased from 622,000 in 2001 to 613,000 in 2003 and 564,000 in 2004. Inpatient days declined at the St. Joseph hospitals from 249,000 to 231,000 in 2003, but then increased to 236,000 in 2004.

Payer Mix

Medicare (including senior HMO plans) covered 39.1 percent of inpatient days for hospitals in the Los Angeles/Orange County region in 2004, slightly more than in 2003. Medicare was an especially key payer for the CHW, Daughters of Charity and Sisters of Providence hospitals, and it covered 42.4 percent of inpatient days at the Tenet hospitals in the area. The Los Angeles County hospitals see a relatively small number of Medicare patients. Proposed changes in Medicare funding of hospitals, such as the ones proposed by federal authorities in 2006, can reduce funding for some hospitals while improving payments to others. From time to time, the Medicare program will identify certain procedures and determine that it pays hospitals too much for them and will seek to reduce payments. Sometimes, the opposite occurs and it decides to increase payments for other services.

Medi-Cal paid for 28.3 percent of inpatient days in the area in 2004. On average, Medi-Cal is an especially important payer in the area (as are county indigent care funds), in particular, to some of the Tenet hospitals. According to the OSHPD data there were almost 1.8 million inpatient days covered by Medi-Cal for these hospitals in 2004, down from 2003. Tenet hospitals had almost 350,000 Medi-Cal days in 2004, down from 372,000 inpatient days in 2003. That is more than the Los Angeles County hospitals, which had almost 280,000 Medi-Cal days. The CHW hospitals had just over 148,000 Medi-Cal days.

Commercial insurers and managed care plans covered 24.6 percent of inpatient days in 2004. Some hospitals and systems see a higher proportion of managed care patients, including St. Joseph in Orange County and Memorial Health Services hospitals. 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.

Physician Organizations

Integrated medical groups are the most prominent form of physician organization in southern California. As was discussed earlier in the report, they face significant challenges. For example, many are seeing their capitated HMO enrollment decline at the rate of 2 to 3 percent each year. The successful groups have replaced that lost revenue by increasing their fee-for-service visits and by changing their processes and incentives so that they are fairly compensated for those visits. Groups have found that they need to pay more attention to coding for claims: if physicians appropriately spent extra time with the patients, they should make sure to bill for that extra effort.

A small but increasing amount of physician groups' compensation is tied to performance measures. For the medical groups interviewed for this year's report, this was especially true for their Blue Cross patients. As noted earlier, Blue Cross has a system of incentive payments that includes some of the same measures used by the statewide Pay for Performance initiative, but with special emphasis on formulary compliance and generic prescribing. Medical groups have found that improvements in recordkeeping, including the expanded use of patient registries and introduction of electronic medical records, are key to maximizing incentive payments. Immunization compliance rates have improved in recent years, for example, but part of that is just better documentation.

Exhibit 43 provides an overview of the larger Los Angeles and Orange County medical groups in 2006. Some have grown in the past two years by internal expansion and by absorbing other medical groups. By far the largest medical group in the area is the Southern California Permanente Medical Group. In 2006 it reported 1,756,000 patients in the two counties, slightly more than in 2004. HealthCare Partners is a large medical group with 31 clinic locations around Los Angeles County. Its patient base has declined to 425,000 capitated patients in the past two years, reflecting the decision of employers to leave HMOs for PPOs. While in compliance with state requirements, HealthCare Partners generally did not score as high as other large group practices on its financial solvency measures.

Other large medical groups include LaVida Medical Group, Facey Medical Foundation in the northern valleys, and Bristol Park Medical Group in Orange County. Large medical foundations include St. Joseph Heritage Healthcare, Monarch Healthcare, and Greater Newport Physicians Medical Group. The largest IPA in the area is Physician Associates of the Greater San Gabriel Valley. It has its own management

EXHIBIT 43. Physician Organizations in Los Angeles/Orange County, 2006

Physician Organization / Notes	Estimated Enrollment	Number of PCPs	Number of Specialists	Number of Clinic Sites	DMHC Calculated Relative Working Capital	DMHC Calculated Relative TNE	Management Entity
Group Practice							
Bright Medical Associates	49,200	67	250	6	1.11	1.34	Integrated Medical Management, Inc. (Bright Medical Associates) (includes IPA-type panel)
Bristol Park Medical Group	109,000	90	550	11	1.62	1.88	Bristol Park Medical Group, Inc. (self managed)
Community Medical Group of the West Valley, Inc.	41,750	37	121	2	1.75	1.77	Progressive Healthcare Systems, LLC (Community Medical Group) (includes IPA-type panel)
Facey Medical Foundation	121,000	95	107	11	2.39	2.26	Facey Medical Foundation (MSO of hospital system)
Gateway Medical Group	32,900	168	413	0	NR	NR	Pinnacle Health Resources (MSO of sponsoring group)
HealthCare Partners Medical Group	425,400	648	878	31	1.02	1.01	HealthCare Partners Management Company, Inc.
Hispanic Physicians IPA	12,600	43	171	0	4.2	4.24	Physicians Care Management Company, Inc. (includes IPA-type panel)
La Vida Medical Group	167,800	450	2,550	10	1.71	1.28	La Vida Medical Group, Inc. (includes IPA-type panel)
Lakeside Medical Group	88,500	210	762	5	1.41	1.31	Lakeside Healthcare, Inc.
Pacific Alliance Medical Group	7,400	54	198	5	NR	NR	SynerMed
Southern California Permanente Medical Group	1,756,000	1,053	1,537	70	NR	NR	Southern California Permanente Medical Group (includes IPA-type panel)
Talbert Medical Group, Inc.	74,400	85	282	9	1.08	1.15	Talbert Medical Management Corporation
IPA							
Accountable Health Care IPA	29,850	161	290	0	1.5	1.37	Accountable Healthcare MSO
Affiliated Doctors of Orange County	61,200	301	665	0	1.22	1.33	Affiliated Management Services, a partnership (MSO of own medical group)
Allied Physicians of California	57,800	311	272	0	1.01	1.13	Network Medical Management, Inc.
Arta Health Network	14,100	266	490	0	1.06	1.06	Western Medical Management, LLC
Arta Western Medical Group	40,000	330	469	0	2.01	2.01	Western Medical Management, LLC
Bay Area Community Medical Group	42,700	70	250	0	1.13	1.13	Santa Monica Bay Physicians Health Services, Inc. (MSO of own medical group)
Capnet IPA	1,100	70	80	0	NR	NR	Meridian Holdings, Inc.
CareMore Medical Group	74,000	220	560	0	1.47	1.11	CareMore Medical Management Company, a California Limited Partnership
Exceptional Care Medical Group	26,900	143	196	0	1.04	1.04	CAP Management Systems (CMS-Tenet)
Global Care Medical Group	52,200	360	458	0	1.01	0.83	MedPoint Management, Inc.
Good Samaritan Medical Practice Association	29,200	122	351	0	1.13	1.13	Advanced Medical Management, Inc.
Greater Covina Medical Group	18,500	98	197	0	1	1.48	Heritage Provider Network, Inc.
Lakewood Health Plan	57,600	150	195	0	1.51	1.5	Lakewood Health Plan, Inc, a Medical Group
Memorial Healthcare IPA	67,200	236	264	1	0.47	1.03	Independent Physician Management, LLC
New Horizon Medical Group IPA	11,300	48	111	0	1.21	1.21	MV Medical Management
Noble Community Medical Associates	38,300	145	232	0	NR	NR	Quality Medical Management, Inc. (Cap Management Systems)
Northridge Medical Group IPA	33,500	100	385	0	1.83	1.83	Meridian Health Care Management

EXHIBIT 43. Physician Organizations in Los Angeles/Orange County, 2006, cont.

Physician Organization / Notes	Estimated Enrollment	Number of PCPs	Number of Specialists	Number of Clinic Sites	DMHC Calculated Relative Working Capital	DMHC Calculated Relative TNE	Management Entity
IPA, cont.							
Omnicare Health Systems Medical Group	50,900	172	239	0	1.17	1.05	Advanced Medical Management, Inc.
Pacific Independent Physicians Association	56,600	200	290	0	1.18	1.35	California Management Service Enterprise, a California Limited Partnership
Physician Associates of the Greater San Gabriel Valley	133,000	325	610	0	1.53	1.62	Physician Associates of the Greater San Gabriel Valley, a Medical Group, Inc.
Physicians' Healthways	60,700	386	185	0	NR	NR	HealthCare Partners, Ltd.
Preferred IPA of California	78,000	370	580	0	NR	NR	Thrifty Management Services, Inc.
Pro Med Health Network of Pomona Valley	66,100	109	170	0	3.03	3.2	Pro Med Healthcare Administrators
Prospect Health Source Medical Group	22,050	92	99	0	NR	NR	Prospect Medical Systems, Inc.
Prospect Medical Group	32,300	353	535	0	1.57	1.23	Prospect Medical Systems, Inc.
Prospect NWOC Medical Group	12,500	140	249	0	NR	NR	Prospect Medical Systems, Inc.
Prospect Professional Care Medical Group	33,300	188	378	0	NR	NR	Prospect Medical Systems, Inc.
Universal Care Medical Group	65,300	50	500	12	NR	NR	Universal Care (HMO) (self managed)
West Covina Medical Group	23,800	23	100	3	NR	NR	Combined Management Services, Inc.
Medical Foundation							
CHOC Physicians Network	75,000	252	436	2	NR	NR	
Cedars-Sinai Medical Care Foundation	62,200	98	332	6	1.15	1.51	Cedars-Sinai Medical Care Foundation (MSO of hospital system)
Greater Newport Physicians Medical Group	115,300	143	323	0	NR	NR	Greater Newport Physicians Medical Group, Inc. (self managed)
Health Care LA IPA	80,200	63	158	38	NR	NR	
Heritage Provider Network	146,400	589	1802	2	NR	NR	
Monarch Healthcare	158,400	500	1,300	0	1.12	1.14	Physician Weblink of California (MSO of sponsoring group)
Presbyterian Health Physicians	37,700	140	160	3	4.63*	1.31*	HealthMed Services, Inc. (Presbyterian Intercommunity Hospital) (includes medical group)
*Includes approved sponsoring organization guarantee.							
St. Joseph Heritage Healthcare	191,100	350	675	15	0.78	1.25	St. Jude Hospital Yorba Linda (MSO of hospital system)
Torrance Hospital IPA Medical Group	52,900	145	200	0	NR	NR	
State/County Faculty/Staff							
Los Angeles County Dept. of Health Services	92,000	402	3,598	27	NR	NR	County of Los Angeles Department of Health Services
UCLA Medical Group	65,700	130	1,200	28	NR	NR	UCLA Medical Center
Includes 100-physician Internal Medicine Faculty Group. Includes old Santa Monica Medical Center Medical Group and United Physicians Association of Santa Monica; both merged into UCLA July 1, 2001.							

NR: Not reported.

Source: Adopted from Cattaneo & Stroud's medical group inventory, April 2006.

services corporation. CareMore Medical Group, an IPA with about 74,000 lives, recently entered the Medical Advantage HMO business in southern California. Two Orange County groups are the largest medical foundations in the area: St. Joseph Heritage Healthcare and Monarch Healthcare. Both had limited Knox-Keene licenses at one time. Many of the physicians at Children's Hospital Orange County (CHOC) also practice in a medical foundation.

Many of the area's medical groups are trying to reposition themselves in order to gain PPO patients to replace the capitated HMO lives they have lost. However, their administrative systems and medical practice protocols are very focused on capitated HMO lives. To successfully attract PPO patients, they will need to address the trend of patients wanting to get away from "managed care medicine." Still, the physician groups in Los Angeles and Orange Counties are bullish on the capitated model and think that Medicare HMO plans will gain enrollees again.

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

As more commercial enrollment moves away from the capitated model to PPO arrangements with higher cost sharing, medical groups are concerned that their size is not adequate to support the kind of investment in administrative systems that they need, or to give them the geographic coverage that some health plans demand. There have been some tentative efforts to bring smaller medical groups (50,000 to 100,000 patients) together for both purposes—broader geographic coverage and a bigger base of patients to cover investment in systems—but these have not succeeded. There have also been discussions between Kaiser Permanente and some medical groups in southern California about entering the Kaiser system. Kaiser generally adds capacity internally, but it has recently shown more interest in acquisition. As noted earlier, Kaiser is acquiring a major physician group in Ventura County.

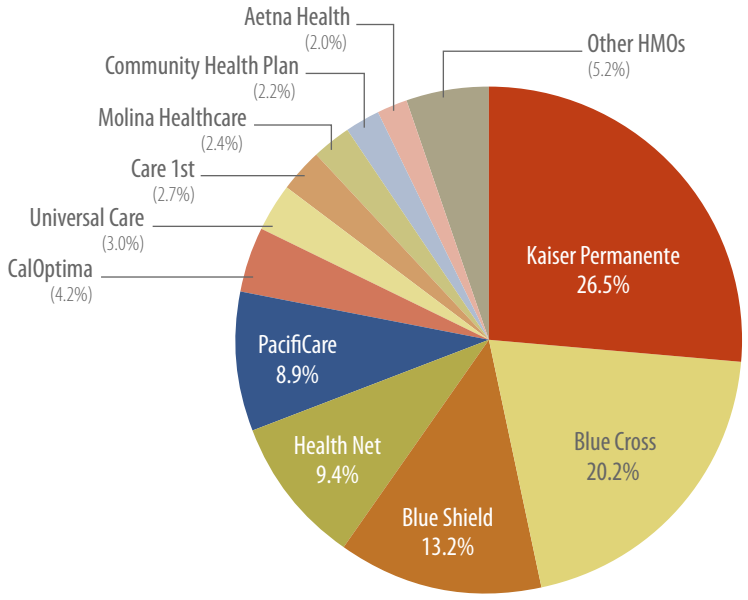
Health Plans

Exhibit 44 shows an estimate of market share of the largest health plans in Los Angeles and Orange Counties combined. Kaiser Permanente is the largest, followed by Blue Cross. Together they have almost half of the market share in the region. Three HMOs that are primarily contracting with the state for Medi-Cal managed care—CalOptima, Universal Care, and Care 1st—collectively have almost 10 percent of the region's market share.

According to the estimates made in constructing *Exhibit 14,* 7.1 million people in Los Angeles/Orange County area were enrolled in HMOs in 2005. That is down from 7.6 million people in 2003. About 52.9 percent of Los Angeles County residents and 58.2 percent of Orange County residents were enrolled in an HMO in 2005.

In 2005 about 3.1 million people in Los Angeles were enrolled in a commercial HMO plan, which is fewer than in previous years and is expected to decline further in the next few years. Just over 1 million are in commercial HMO plans in Orange County. As commercial HMO enrollment declines, it is difficult

EXHIBIT 44. Estimated Market Share for Los Angeles/Orange County HMOs, 2005



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

to track 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 higher co-payments and deductibles. Most of those plans, whether they are coupled with a spending account, high deductible, or other kinds of features, are being offered outside of HMOs.

The number of Los Angeles/Orange County seniors in Medicare+Choice HMOs peaked at about 508,000 in 2000 but then declined to 446,000 in 2002. Based on data from the Centers for Medicare and Medicaid Services, that trend changed and the number of seniors in Medicare HMO plans in the two counties increased to 483,000 at the end of 2003, which is where it stayed through 2005, as shown in *Exhibit 9.* The number of HMOs offering senior plans in the Los Angeles area has increased to 13 in 2006. Seniors in this region have more options than in other parts of the state, and are showing some new interest in joining (in some case re-joining) Medicare HMOs. As was noted earlier, some medical groups are helping with the marketing effort. For now, the infusion of new federal dollars (to the point where the federal government is paying more for HMOs than for traditional plans) has enabled HMOs to expand benefits and reduce enrollee co-premiums and co-payments.

Los Angeles County has a two-plan model for Medi-Cal managed care, with L.A. Care and Health Net being the official competitors. Both have subcontracting relationships for some (Health Net) or all (L.A. Care) of their Medi-Cal enrollment. In Los Angeles, Medi-Cal HMO enrollment has dropped in the past two years and was under 1.2 million at the end of 2005.

Orange County's county-operated health system, known as CalOptima, did not experience the same kind of membership decrease as L.A. Care did in 2004. CalOptima lost $24.4 million in 2005 and $19.3 million in 2004.

4.6 Inland Empire

The rapidly growing counties of Riverside and San Bernardino are referred to as California's Inland Empire. The region's population has grown from 3 million in the 2000 census to 3.9 million according to the state's 2005 estimate. A recent report projected that there would be about $2.4 billion in health facility construction in these two counties in the next 10 years, and that $1 billion of that would be within the Kaiser system. Also under construction is a new heart-surgical hospital in Loma Linda. Southwest Healthcare System is proposing a new hospital and medical campus at Temecula.

About 56 percent of the region's population (2.2 million out of 3.5 million) is enrolled in one of 15 HMOs. That is down from a peak of about 64 percent just a few years ago.

Overview of Hospitals

Though some of the major hospital systems in the state are represented here, most of the 5,500 inpatient beds in the area are not in systems. With 753 acute care beds, the largest hospital in the area is Loma Linda University Medical Center, which is affiliated with the Seventh Day Adventist church (though separate from the Adventist Health system). A group of doctors and investors is building a new $40 million surgical hospital in Loma Linda, which would specialize in cardiovascular and orthopedic surgeries. Loma Linda University Medical Center (and some other providers) opposed the new hospital, scheduled to open in early 2007, saying that it would divert lucrative surgeries that Loma Linda needs to subsidize necessary services likes its emergency department.

There are four hospital systems in the area. Catholic Healthcare West was the largest in 2004, as measured by inpatient days of care. It has two of the major hospitals in San Bernardino County. Next is Kaiser, which has two acute care hospitals in the area, in Fontana and Riverside. It also operates an inpatient facility for chemical dependency. Both San Bernardino and Riverside Counties own their own county hospitals and there is a district hospital at San Gorgonio. There are 10 district hospitals in the region. Three of them — Hemet Valley, Menifee Valley, and Moreno Valley — are in a system called Valley Health, which was originally formed in 1948. Valley Health also has a skilled nursing facility and the system is looking at developing a cardiac hospital at the Hemet Valley campus.

For-profit systems that have a presence here include Tenet, Universal Health Systems, and HCA, which owns Riverside Community Hospital (not to be confused with Riverside County). Tenet has Desert Regional in Palm Springs and John F. Kennedy Memorial in Indio.

Financial Results

As shown in *Exhibit 45,* hospitals in the area posted net income of $111.1 million in 2004, or 3.0 percent of total revenues. That is down from 2003 when the region's hospitals had stronger net income of $188.0 million or 6.0 percent of total revenues. Loma Linda University Medical Center had the best financial results in 2004, with net income of $47.3

EXHIBIT 45. Revenues and Net Income for Inland Empire Hospitals, 2004

System / Hospital	City	Total Charges	Net Patient Revenue	Total Revenue	Operating Expenses	Net from Operations	Total Margin	% of Total Revenue
Catholic Healthcare West		**$1,219,200,809**	**$284,835,461**	**$291,474,320**	**$307,730,094**	**($19,497,702)**	**($31,184,027)**	**– 10.7%**
Community Hospital	San Bernardino	497,825,987	108,482,735	111,584,393	124,890,095	(14,215,942)	(26,976,915)	– 24.2%
St. Bernardine Medical Center	San Bernardino	721,374,822	176,352,726	179,889,927	182,839,999	(5,281,760)	(4,207,112)	– 2.3%
Kaiser Foundation*								
Tenet Health		**$2,039,416,271**	**$320,546,625**	**$325,194,147**	**$315,540,286**	**$6,614,942**	**$6,906,964**	**2.1%**
Desert Regional Medical Center	Palm Springs	1,598,857,958	259,112,030	263,079,857	243,481,067	17,162,528	17,238,064	6.6%
John F. Kennedy Memorial	Indio	440,558,313	61,434,595	62,114,290	72,059,219	(10,547,586)	(10,331,100)	– 16.6%
Valley Health		**$719,019,401**	**$174,039,903**	**$180,036,009**	**$178,885,157**	**($3,706,894)**	**$1,129,803**	
Hemet Valley Medical Center	Hemet	410,482,807	101,243,362	104,889,143	103,715,512	(1,565,964)	1,161,424	1.1%
Menifee Valley Medical Center	Sun City	158,317,859	35,455,391	36,549,064	34,476,872	1,135,203	2,068,160	5.7%
Moreno Valley Community	Moreno Valley	150,218,735	37,341,150	38,597,802	40,692,773	(3,276,133)	(2,099,781)	– 5.4%
Others		**$8,072,597,423**	**$2,602,192,387**	**$2,853,775,782**	**$2,535,110,106**	**$144,655,017**	**$134,286,286**	**4.7%**
Arrowhead Regional Medical	Colton	806,908,614	339,323,801	401,845,376	324,271,790	16,650,663	(4,159,672)	– 1.0%
Barstow Community Hospital	Barstow	142,785,614	32,370,328	32,437,152	25,559,146	6,878,006	5,586,981	17.2%
Bear Valley Community Hospital	Big Bear Lake	16,278,562	10,573,414	11,060,356	11,541,792	(914,233)	(481,436)	– 4.4%
Canyon Ridge Hospital	Chino	17,761,435	8,684,815	8,708,418	9,120,883	(434,316)	(412,465)	– 4.7%
Chino Valley Medical Center	Chino	170,132,911	45,239,409	46,539,370	47,219,632	(1,605,550)	(916,194)	– 2.0%
Colorado River Medical Center	Needles	64,911,701	26,315,760	26,640,071	20,546,345	5,820,535	6,050,213	22.7%
Corona Regional Medical Center	Corona	317,343,506	88,248,165	90,270,999	82,863,047	7,047,282	6,211,081	6.9%
Desert Valley Hospital	Victorville	233,639,270	60,845,835	62,159,357	52,112,693	8,904,110	6,346,480	10.2%
Doctors' Hospital Medical Center	Montclair	144,703,763	45,567,222	46,099,788	43,122,022	2,690,538	2,354,321	5.1%
Eisenhower Medical Center	Rancho Mirage	1,144,431,689	241,692,162	275,491,756	254,450,307	(6,842,893)	14,805,819	5.4%
Hi-Desert Medical Center	Joshua Tree	79,923,374	40,332,354	42,270,748	43,139,503	(2,517,708)	(1,921,248)	– 4.5%
Loma Linda University Medical	Loma Linda	2,097,103,424	652,621,174	721,089,280	672,792,588	34,972,761	47,258,131	6.6%
Mammoth Hospital	Mammoth Lakes	37,657,302	28,765,274	31,096,643	28,571,462	327,268	2,462,800	7.9%
Northern Inyo Hospital	Bishop	49,530,250	29,708,281	31,159,992	29,686,655	196,377	1,473,337	4.7%
Redlands Community Hospital	Redlands	365,057,402	140,380,866	142,664,495	135,149,430	6,014,586	7,515,065	5.3%
Riverside Community Hospital	Riverside	704,624,830	209,930,397	214,485,361	190,632,102	21,638,070	23,853,259	11.1%
Riverside County Regional	Moreno Valley	559,168,121	266,534,565	328,274,506	247,908,598	24,317,483	(5,911,502)	– 1.8%
St. Mary Regional Medical Center	Apple Valley	408,327,318	122,137,108	125,614,107	119,302,799	4,247,942	5,719,081	4.6%
San Gorgonio Memorial Hospital	Banning	62,771,038	22,234,243	22,403,129	23,220,260	(854,321)	(817,131)	– 3.6%
Southern Inyo Hospital	Lone Pine	7,519,230	4,491,275	5,034,151	5,128,665	(492,324)	(94,514)	– 1.9%
Southwest Healthcare System	Murrieta	518,786,299	147,682,308	148,934,376	126,938,933	21,632,043	21,833,055	14.7%
Victor Valley Community Hospital	Victorville	123,231,770	38,513,631	39,496,351	41,831,454	(3,021,302)	(2,469,175)	– 6.3%
	TOTAL	**$12,050,233,904**	**$3,381,614,376**	**$3,650,480,258**	**$3,337,265,643**	**$128,065,363**	**$111,139,026**	**3.0%**

*Financial results for Kaiser Foundation hospitals are consolidated with the southern California results shown in Exhibit 40.

Source: Author's analysis of data for fiscal years ending in 2004 from Office of Statewide Health Planning and Development.

million — more than double its net income of $19.2 million in 2003. It had operating net income of $35 million plus other revenues. Riverside Community Hospital, owned by HCA, had the next best financial results, with net income of $23.9 million. The Southwest Healthcare System – Murrieta and Eisenhower Medical Center in Rancho Mirage also had strong net income, $21.8 million and $14.8 million, respectively. While one Tenet Health hospital – Desert Regional Medical Center in Palm Springs — did well financially, John F. Kennedy had $10.3 million in losses in 2004.

The two CHW hospitals in the area lost $31.2 million in 2004, much more than their losses of $12.6 million in 2003. Valley Health, a local three-hospital system, posted a small gain in 2004 of $1.1 million after reporting a small loss in 2003.

Occupancy

Exhibit 46 compares the hospitals on their inpatient occupancy and payer mix in 2004. On average, the hospitals in the region averaged 67.9 percent, down a little from 68.4 percent in 2003. The largest hospital in the area, Loma Linda University Medical Center, had occupancy of 67.4 percent. The Tenet hospitals had average occupancy of 67.2 percent, the Kaiser hospitals averaged 61.4 percent, and the Catholic Healthcare West hospitals averaged 67.7 percent. Arrowhead Regional hospital had occupancy of 80.3 percent, higher than in 2003.

Payer Mix

Exhibit 46 shows that Medicare covered an average of 40.4 percent of inpatient days in 2004, while Medi-Cal covered 30.2 percent. This is the only major region of the state where Medi-Cal covers more than 30 percent of inpatient days. Commercial payers including managed care covered 23.9 percent of inpatient days.

Medicare was an especially important payer to the Valley Health system, where Medicare covered 65.6 percent of inpatient days. Medicare is less significant to Loma Linda University Medical Center, accounting for only 22.2 percent of inpatient days there. Most of Loma Linda's patients are covered by Medi-Cal and commercial payers.

Hospitals in this region provided 458,000 inpatient days of care to Medi-Cal recipients in 2004, down slightly from 2003. Loma Linda University was the biggest provider, with almost 84,000 Medi-Cal days. The two CHW hospitals provided 72,000 Medi-Cal days (up 10 percent from 2003) while Arrowhead Regional provided 55,000 Medi-Cal days.

Physician Organizations

Exhibit 47 shows that the Permanente Medical Group clinics in this region now have more than 1,200 doctors serving about 616,000 patients, an increase of about 10 percent over 2004. The Loma Linda University Health Care group is the only foundation model group in the area. It has about 470 physicians, most of them specialists. The Beaver Medical Group now numbers about 135 physicians at nine clinical sites, with 95,400 capitated lives. Epic Management, Beaver Medical's management company, also provides services to Physicians Health Network Medical Corp.

Two of the medical groups that still operate Knox-Keene limited license plans are in the Inland Empire. One is PrimeCare Medical Network, which includes 941 doctors in the area in medical groups and IPA arrangements. North American Medical Management, one of the few physician management companies left over from the 1990s, provides management services to PrimeCare. In addition, Heritage Provider Network still operates a Knox-Keene limited license plan. However, some of its participating clinics are losing a major health plan contract. Kaiser is dropping Heritage as a provider because Kaiser opened additional clinics in Palm Springs, Palm Desert, and Indio in July 2006. Kaiser Permanente enrollees seeing Heritage doctors will be required to switch to the new Kaiser clinics. According to the Department of Managed Health Care, about 20,000 San Bernardino County enrollees will be affected by the change.

A management company called Primary Provider provides administrative services to three IPAs in the area: Vantage Medical Group, Empire Physicians Medical Group, and Alpha Care Medical Group.

Health Plans

About 64 percent of the population of the Inland Empire is enrolled in an HMO. By the estimates in this analysis, more than 2.3 million people belong to HMOs in this region. Kaiser Permanente is the largest HMO in the area with about 670,000 lives. Blue Cross has about 277,000 HMO members here, and Blue Shield has about 283,000 lives.

These counties are a popular retirement destination, and Medicare managed care is still competitive in the area with eight HMOs selling senior plans in Riverside County and ten in San Bernardino. CMS data show that in 2005 about 43 percent of seniors were enrolled in an HMO, a percentage that has grown in the past few years. About 57,000 of Kaiser's enrollees are in its Medicare HMO plan. PacifiCare has about 50,000

EXHIBIT 46. Inpatient Occupancy Rates and Payer Mix for Inland Empire Hospitals, 2004

System / Hospital	Staffed Beds	Inpatient Days	Occupancy	PAYER DISTRIBUTION				
				Medicare	Other Third Parties	Medi-Cal	County Indigent	Other Payers
Catholic Healthcare West	**601**	**151,704**	**67.7%**	**33.5%**	**12.6%**	**47.4%**	**0.4%**	**6.1%**
Community Hospital of San Bernardino	316	77,293	64.6%	25.7%	4.9%	67.5%	0.0%	1.9%
St. Bernardine Medical Center	285	74,411	71.3%	41.6%	20.6%	26.5%	0.8%	10.5%
Kaiser Foundation	**452**	**147,314**	**61.4%**	**43.4%**	**51.6%**	**2.7%**	**0.5%**	**1.9%**
Kaiser Foundation, Fontana	307	96,378	59.8%	42.8%	51.9%	3.0%	0.3%	1.9%
Kaiser Foundation, Riverside	145	50,936	64.7%	44.5%	50.9%	2.1%	0.7%	1.9%
Tenet Health	**411**	**128,631**	**67.2%**	**45.0%**	**22.1%**	**30.3%**	**0.2%**	**2.4%**
Desert Regional Medical Center	275	100,770	76.3%	47.1%	23.9%	26.7%	0.2%	2.0%
John F. Kennedy Memorial Hospital	136	27,861	47.0%	37.5%	15.5%	43.3%	0.0%	3.7%
Valley Health	**555**	**138,522**	**68.2%**	**65.6%**	**11.3%**	**19.2%**	**0.2%**	**3.8%**
Hemet Valley Medical Center	370	95,829	70.8%	66.1%	10.2%	19.3%	0.2%	4.2%
Menifee Valley Medical Center	84	21,910	71.3%	81.0%	11.1%	4.7%	0.2%	3.0%
Moreno Valley Community Hospital	101	20,783	56.2%	46.6%	16.9%	33.6%	0.3%	2.6%
Others	**3,470**	**951,042**	**68.9%**	**34.1%**	**23.8%**	**33.4%**	**6.3%**	**2.5%**
Arrowhead Regional Medical Center	353	109,596	80.3%	12.8%	10.5%	50.4%	26.4%	0.0%
Barstow Community Hospital	24	8,439	54.9%	48.5%	24.9%	24.1%	0.0%	2.5%
Bear Valley Community Hospital	24	7,794	88.7%	6.7%	3.3%	86.5%	0.0%	3.4%
Canyon Ridge Hospital	59	15,939	73.8%	26.3%	41.3%	23.8%	6.2%	2.4%
Chino Valley Medical Center	52	19,080	41.4%	33.2%	25.1%	35.4%	0.0%	6.3%
Colorado River Medical Center	49	8,471	47.2%	58.4%	23.7%	16.2%	0.6%	1.1%
Corona Regional Medical Center, Main	216	47,711	60.4%	49.0%	19.6%	29.4%	0.9%	1.0%
Desert Valley Hospital	83	19,953	65.7%	63.2%	17.7%	14.9%	0.8%	3.5%
Doctors' Hosp Medical Center of Montclair	60	21,748	58.3%	39.4%	21.3%	31.0%	1.3%	7.1%
Eisenhower Medical Center	241	72,398	78.2%	73.4%	19.7%	4.4%	0.3%	2.3%
Hi-Desert Medical Center	159	50,671	77.3%	19.7%	7.4%	69.6%	0.5%	2.8%
Loma Linda University Medical Center	753	189,544	67.4%	22.2%	31.3%	44.1%	0.5%	1.8%
Mammoth Hospital	15	1,747	31.8%	16.3%	55.1%	15.0%	1.5%	12.0%
Northern Inyo Hospital	32	3,280	28.0%	53.7%	22.1%	16.7%	5.4%	2.2%
Redlands Community Hospital	172	53,108	84.4%	49.0%	30.9%	18.8%	0.2%	1.1%
Riverside Community Hospital	345	82,252	65.1%	42.7%	30.1%	22.6%	0.7%	3.9%
Riverside County Regional	359	86,001	65.5%	11.4%	27.6%	31.1%	29.9%	0.0%
St. Mary Regional Medical Center	186	50,573	74.3%	52.2%	24.4%	21.4%	0.5%	1.5%
San Gorgonio Memorial Hospital	49	17,188	67.1%	56.1%	25.6%	15.7%	0.4%	2.3%
Southern Inyo Hospital	37	12,019	88.8%	5.4%	0.1%	92.3%	0.0%	2.2%
Southwest Healthcare System, Murrieta	139	50,396	78.2%	47.6%	32.5%	11.7%	0.7%	7.5%
Victor Valley Community Hospital	63	23,134	59.6%	28.2%	19.3%	38.7%	0.9%	13.0%
TOTAL	5,489	1,517,213	67.8%	38.7%	24.1%	30.2%	4.0%	2.9%

Source: Author's analysis of data for fiscal years ending in 2004 from Office of Statewide Health Planning and Development.

EXHIBIT 47. Physician Organizations in Inland Empire Area, 2006 (includes Imperial, Riverside, and San Bernardino counties)

Physician Organization / Notes	Estimated Enrollment	Number of PCPs	Number of Specialists	Number of Clinic Sites	DMHC Calculated Relative Working Capital	DMHC Calculated Relative TNE	Management Entity
Group Practice							
Beaver Medical Group	95,400	73	62	9	1.14	1.8	Epic Management LP (Beaver Medical Group) (includes IPA-type panel)
Chino Medical Group	26,800	13	27	2	NR	NR	
Desert Family Practice Associates	9,500	12	40	0	NR	NR	Primary Provider Management Company, Inc. (includes IPA-type panel)
Desert Valley Medical Group	13,800	16	109	6	1.19	1.31	Desert Valley Medical Group, Inc. (self managed)
Family Practice Medical Group of San Bernardino	9,000	11	95	0	NR	NR	Family Practice Medical Group of San Bernardino, Inc. (includes IPA-type panel)
High Desert Primary Care Medical Group	17,100	17	68	2	1.63	1.63	High Desert Primary Care Medical Group, a California General Partnership
Inland Faculty Medical Group	22,750	72	220	8	1.01	1.18	Arrowhead Medical Management Services, Inc. (Inland Faculty)
Inland Healthcare Group, a Medical Corp	26,100	26	167	0	1.26	1.35	Inland Health Organization of Southern California (includes IPA-type panel)
LaSalle Medical Associates	34,500	38	0	4	1.08	1.2	MV Medical Management (independent MSO)
Molina Healthcare of California	10,800	8	0	4	NR	NR	Molina Healthcare of California
PrimeCare Medical Network	232,000	291	650	11	NR	NR	North American Medical Management California (includes IPA-type panel)
Riverside Medical Clinic	69,200	54	51	7	1.22	1.05	Riverside Medical Clinic, Inc.
San Bernardino Medical Group	16,000	18	173	1	1.79	1.55	San Bernardino Medical Group, Inc.
Southern California Permanente Medical Group	615,600	561	649	24	NR	NR	Southern California Permanente Medical Group
United Family Care Medical Corp.	17,600	14	169	3	0.61	0.82	United Family Care, Inc, a Medical Corp.
IPA							
Alpha Care Medical Group	12,800	47	196	0	1.23	1.23	Primary Provider Management Company
Empire Physicians Medical Group	10,100	46	187	0	NR	NR	Primary Provider Management Company, Inc.
Hemet Community Medical Group	71,000	142	194	0	1.83	1.86	KM Strategic Management, LLC
Family/Seniors Medical Group	4,400	11	300	0	1.91	1.91	Meridian Health Care Management
Heritage Provider Network, Inc.	67,000	177	148	4	NR	NR	Heritage Provider Network, Inc.
McKinley Medical Group	25,000	23	94	0	NR	NR	
Mission Medical Group	29,600	70	109	0	NR	NR	Primary Provider Management Company
Physicians Health Network Medical Corp	17,600	55	147	0	1.57	1.93	Epic Management LP (Beaver Medical Group)
Pro Med Health Network of Pomona Valley	8,900	79	50	0	3.03	3.2	Pro Med Healthcare Administrators
Riverside Family Health Medical Group	8,800	17	170	0	NR	NR	MedPoint Management, Inc.
Riverside Physician Network / Riverside Community Health Agency	55,100	62	103	0	0.89	0.9	Riverside Community Healthplan Medical Group, Inc.
St. Mary Choice Medical Group, a Medical Corp.	27,300	44	143	0	1.75	1.75	Desert Physicians Management, LLC
Old Corwin IPA and merger of St. Mary Medical Group and Choice Medical Group IPAs. Effective September 1, 2001 became self-administered.							
Vantage Medical Group	96,300	166	490	0	1.04	1.05	Primary Provider Management Company, Inc.
Medical Foundation							
Loma Linda University Health Care	35,400	65	407	8	1.28	1.35	Adventist Health Managed Care (includes medical group)

NR: Not reported.

Source: Adopted from Cattaneo & Stroud's medical group inventory, April 2006.

seniors in its Secure Horizons plan. Another Medicare HMO is Long Beach-based SCAN Health Plan, which was created as an experimental Social HMO, combining Medicare benefits and other services to seniors. It has about 20,000 seniors in Riverside and San Bernardino, up from 13,000 a few years ago.

Riverside and San Bernardino counties collaborate for Medi-Cal managed care in a two-plan model, and have a strong local initiative plan that works closely with the two county hospitals. The county plan, Inland Empire Health Plan, has more than 245,000 Medi-Cal members. Its provider network includes the two county hospitals, public health agencies, community health centers, and some of the large group practices in the area. Molina Medical Centers, a Medi-Cal HMO, is the "commercial" plan that competes with Inland Empire Health Plan. In 2005, Molina had about 90,000 Medi-Cal enrollees in those two counties. In 2005, the state decided to transfer the contract from Molina to Blue Cross, citing required information that was missing from Molina's proposal. Molina appealed that decision and eventually prevailed, and now has a new contract for Medi-Cal in those counties.

4.7 San Diego/Imperial Counties

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

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

The region's hospital systems, to differing degrees, provide significant amounts of care to people without insurance. There is an active community health foundation that promotes community-based approaches to addressing health care issues, through grantmaking and by convening employers, providers, consumers, and government agencies to become part of the solution. San Diego is one of only two parts of the state that has a competitive model for Medi-Cal managed care in which multiple HMOs compete to enroll Medi-Cal recipients. While there are noted health services researchers throughout the state, it seems that those working at the local universities are more closely connected to the issues facing the community. All of these factors contribute to an optimistic sense that a community can be innovative and have a real impact on problems of health care access, cost, and quality.

Overview of Hospitals

Exhibit 48 shows the relative market share of the major hospital systems in the San Diego area based on 2004 inpatient hospital days. With 30.1 percent of the inpatient hospital days in the county, Sharp has the largest share, followed by the Scripps Health hospitals (21.1 percent), and the two Palomar Pomerado hospitals in the northern part of San Diego county (12.1 percent). Sharp is the larger system but, as *Exhibit 48* shows, Sharp and Scripps combined control half of the inpatient care market in the San Diego area.

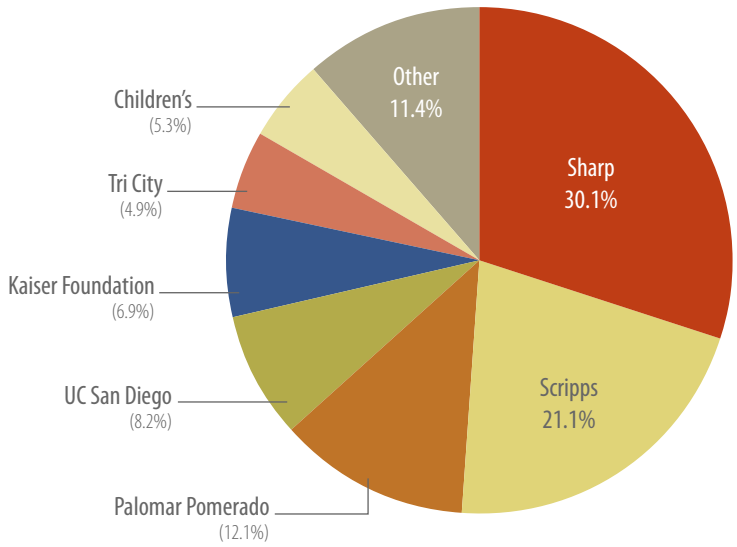
Kaiser's single hospital in the area is also a major provider of care with 6.9 percent of the inpatient days. Earlier, Kaiser had explored constructing its own hospital in the northern part of the county. For now it has chosen to continue its working relationship with the Palomar Pomerado district hospitals.

Both Sharp and Scripps Health are closely tied to medical groups. (Those ties have not always been so close or cordial, particularly in the case of Scripps.) For example, Scripps Clinic has about 315 physicians in two medical foundations and Scripps Health also provides management services to a 480-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 in this region. Tenet owns the Alvarado Hospital Medical

EXHIBIT 48. Market Share for San Diego Area Hospital Systems, 2004



Source: Author's analysis of annual hospital report data for year-end 2004 from the Office of Statewide Health Planning and Development.

Center in San Diego, which is currently for sale following a settlement of federal investigations over certain payment practices. HCA/Columbia does not have a presence in the region.

As in other parts of the state, hospital construction is moving ahead at a fast pace here. Sharp is building a new tower at its Memorial facility in San Diego. Sharp operates the Grossmont district hospital, where voters recently approved a $247 million bond issue to finance improvements to the hospitals and bring it into compliance with seismic construction standards. In a different election, voters in north San Diego County turned down a bond issue of almost $600 million to bring Oceanside Hospital into seismic compliance. Tri-City Healthcare Districts operates Oceanside. Ground will be broken next year for a new Palomar hospital.

Children's Hospital of San Diego will begin construction of a new pavilion expected to cost $350 million. It will include 84 new beds plus several specialty centers.

Financial Results

Exhibit 49 shows that hospitals in the area reported net income of $39.4 million in 2004 or 1.0 percent of total revenues of $3.8 billion. That is less than the $82.2 million they posted in 2003, which was 2.4 percent of total revenue. In 2001 the hospitals reported average margins of 2.7 percent. In general, hospitals in this area broke even on operations and benefited from other revenues, including investment income and philanthropy.

Scripps had the best results, with its hospitals posting net income of $37.7 million. It had its best results at Scripps Green hospital in La Jolla. According to its OSHPD reports, the University of California–San Diego Medical Center lost $13.2 million on total revenues of $576.0 million, which includes disproportionate share hospital funds and county indigent care funds. In its 2004 annual financial statements, the UC–San Diego Medical Center reported net income of $37.8 million. Most of the difference in the two financial reports is that the medical center made IGT payments of $59.7 million in 2004.

The Sharp hospitals had net income of $13.8 million, or 1.4 percent of total revenue. That was half of their net income in 2003. The two Palomar Pomerado hospitals reported net income of $5 million in 2004, down from $11 million in 2003.

Occupancy

Exhibit 50 compares the hospitals on their average inpatient occupancy rates in 2004. On average, San Diego area hospitals had inpatient occupancy of 68.5 percent, the same as in 2003 and higher than most other parts of the state. Occupancy rates are relatively higher at the Kaiser Foundation hospital (73.2 percent), the Palomar Pomerado hospitals (76.8 percent), and Sharp hospitals (72.9 percent). Inpatient use rates at the University of California–San Diego Medical Center are slightly below average at 68.8 percent.

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

EXHIBIT 49. Revenues and Net Income for San Diego Area Hospitals, 2004

System / Hospital	City	Total Charges	Net Patient Revenue	Total Revenue	Operating Expenses	Net from Operations	Total Margin	% of Total Revenue
Alvarado Hospital Medical Center	San Diego	$724,208,518	$122,039,565	$125,066,534	$128,566,489	($4,902,210)	($4,968,279)	– 4.0%
Kaiser Foundation*								
Palomar Pomerado		**$883,234,350**	**$300,535,911**	**$309,728,393**	**$304,737,622**	**$3,810,156**	**$4,990,771**	**1.6%**
Palomar Medical Center	Escondido	642,037,350	216,681,285	223,620,717	219,120,757	3,533,776	4,499,960	2.0%
Pomerado Hospital	Poway	241,197,000	83,854,626	86,107,676	85,616,865	276,380	490,811	0.6%
Scripps		**$2,979,163,762**	**$911,179,825**	**$940,119,485**	**$901,684,174**	**$34,146,425**	**$37,693,696**	**4.0%**
Scripps Green Hospital	La Jolla	537,133,986	178,253,921	186,258,874	159,922,205	26,336,669	26,336,669	14.1%
Scripps Memorial Hospital	Chula Vista	310,118,672	83,097,754	85,499,684	99,377,418	(13,877,734)	(13,877,734)	– 16.2%
Scripps Memorial Hospital	Encinitas	302,422,520	96,071,575	97,320,279	95,588,488	1,625,719	1,731,791	1.8%
Scripps Memorial Hospital	La Jolla	958,222,885	295,757,611	304,081,947	285,928,731	17,124,373	18,153,216	6.0%
Scripps Mercy Hospital	San Diego	871,265,699	257,998,964	266,958,701	260,867,332	2,937,398	5,349,754	2.0%
Sharp		**$3,577,352,319**	**$953,605,967**	**$975,262,824**	**$951,949,310**	**$8,219,839**	**$13,840,021**	**1.4%**
Cabrillo Hospital	San Diego	20,622,825	10,597,884	10,599,239	14,180,812	(3,581,573)	(3,687,794)	– 34.8%
Coronado Hospital	Coronado	119,370,200	41,644,539	43,991,487	42,319,781	(646,610)	(268,657)	– 0.6%
Chula Vista Medical Center	Chula Vista	663,513,226	147,342,204	150,767,772	156,511,470	(8,138,739)	(6,355,979)	– 4.2%
Grossmont Hospital	La Mesa	1,211,865,741	307,255,814	313,885,640	307,671,699	241,497	4,539,364	1.4%
Mary Birch Hospital For Women	San Diego	281,772,865	71,924,426	72,564,338	62,330,581	9,864,812	9,328,341	12.9%
Memorial Hospital	San Diego	1,276,166,812	373,194,190	381,807,354	367,348,716	10,419,709	10,243,365	2.7%
Vista Pacifica	San Diego	4,040,650	1,646,910	1,646,994	1,586,251	60,743	41,381	2.5%
University of California – San Diego Medical†		**$1,152,955,371**	**$534,591,314**	**$576,008,852**	**$529,185,589**	**$39,960,238**	**($13,237,922)**	**– 2.3%**
Others		**$2,258,366,612**	**$779,827,773**	**$852,232,241**	**$847,125,638**	**($36,896,666)**	**$1,095,523**	**0.1%**
Children's Hospital, San Diego	San Diego	657,676,197	280,522,698	325,035,611	324,092,145	(21,447,269)	(1,711,367)	– 0.5%
El Centro Regional Medical Center	El Centro	184,508,355	65,852,816	68,114,047	65,813,350	1,191,624	2,104,702	3.1%
Fallbrook Hospital District	Fallbrook	112,201,023	34,563,249	34,952,161	31,743,023	2,920,745	3,159,846	9.0%
Paradise Valley Hospital	National City	526,281,191	127,456,475	132,856,193	133,729,520	(3,420,436)	(1,901,722)	– 1.4%
Pioneers Memorial Hospital	Brawley	143,825,339	48,425,445	52,861,774	51,243,977	(1,988,378)	1,535,252	2.9%
Tri-City Medical Center	Oceanside	565,134,135	189,301,679	200,055,474	202,795,361	(10,752,682)	(2,739,907)	– 1.4%
University Community Medical	San Diego	68,740,372	33,705,411	38,356,981	37,708,262	(3,400,270)	648,719	1.7%
	TOTAL	$11,575,280,932	$3,601,780,355	$3,778,418,329	$3,663,248,822	$44,337,782	$39,413,810	1.0%

*Financial results for Kaiser Foundation hospitals are consolidated with the southern California results shown in Exhibit 40.
†The UC – San Diego Medical Center reported a 2004 net loss of $13.2 million in its OSHPD report but net income of $37.8 million in its audited financial statements. The difference of $51 million is the result of an intergovernmental transfer of $59.7 million to the University of California as a contribution to Medi-Cal funds that are matched by federal dollars. Also, UC – Irvine Medical Center had the benefit of $51 million in reduced pension obligations, which was recorded as an addition to equity in that year.

Source: Author's analysis of data for fiscal years ending in 2004 from Office of Statewide Health Planning and Development.

Payer Mix and Market Share

On average, Medicare covered 39.5 percent of inpatient days in 2004. Medicare is especially important to the Scripps hospitals, where it covers 45.7 percent of inpatient days. Medicare is also very important at the Kaiser hospital and at Alvarado Medical Center, a Tenet hospital.

Medi-Cal covers an average of 25.6 percent of inpatient days in the area and paid for about 405,000 inpatient days in 2004, about the same as in 2003. Major providers of care for Medi-Cal patients include the Sharp hospitals (126,200 days), Children's Hospital (42,400) and the University of California – San Diego (40,000 days).

EXHIBIT 50. Inpatient Occupancy Rates and Payer Mix for San Diego Area Hospitals, 2004

System / Hospital	Staffed Beds	Inpatient Days	Occupancy	PAYER DISTRIBUTION				
				Medicare	Other Third Parties	Medi-Cal	County Indigent	Other Payers
Alvarado Hospital Medical Center	**291**	**55,158**	**51.8%**	**64.2%**	**19.0%**	**11.9%**	**1.6%**	**3.3%**
Kaiser Foundation	**368**	**105,037**	**73.2%**	**47.7%**	**49.2%**	**1.9%**	**0.0%**	**1.1%**
Palomar Pomerado	**512**	**184,295**	**76.8%**	**39.2%**	**19.1%**	**34.5%**	**1.7%**	**5.6%**
Palomar Medical Center	317	114,308	74.4%	40.3%	21.2%	29.8%	2.6%	6.1%
Pomerado Hospital	195	69,987	81.0%	37.3%	15.6%	42.1%	0.3%	4.6%
Scripps	**894**	**320,477**	**69.5%**	**45.7%**	**30.2%**	**14.6%**	**2.9%**	**6.5%**
Scripps Green Hospital	105	36,204	57.2%	58.3%	38.6%	0.6%	0.0%	2.5%
Scripps Memorial Hospital, Chula Vista	122	44,650	80.8%	47.6%	9.1%	30.5%	4.3%	8.5%
Scripps Memorial Hospital, Encinitas	109	39,574	81.3%	54.9%	29.5%	10.0%	2.5%	3.1%
Scripps Memorial Hospital, La Jolla	282	99,349	76.2%	44.6%	41.4%	4.8%	1.4%	7.9%
Scripps Mercy Hospital	276	100,700	61.6%	37.9%	25.9%	24.1%	5.2%	7.0%
Sharp	**1,661**	**457,334**	**72.9%**	**39.4%**	**27.1%**	**27.6%**	**1.5%**	**4.5%**
Sharp Cabrillo Hospital	76	22,064	79.3%	54.1%	15.2%	26.8%	0.0%	3.9%
Sharp Chula Vista Medical Center	326	93,726	78.6%	43.2%	14.5%	35.6%	1.7%	5.1%
Sharp Coronado Hospital	175	49,377	66.1%	13.4%	8.8%	69.5%	0.4%	7.9%
Sharp Grossmont Hospital	439	111,733	69.5%	54.4%	20.3%	18.2%	2.7%	4.4%
Sharp Mary Birch Hospital For Women	166	44,872	73.9%	0.6%	61.9%	36.1%	0.0%	1.4%
Sharp Memorial Hospital	467	132,273	73.8%	45.3%	37.8%	12.2%	1.5%	3.3%
Sharp Vista Pacifica	12	3,289	74.9%	0.0%	63.9%	0.0%	0.0%	36.1%
University of California – San Diego Medical	**485**	**125,123**	**68.8%**	**26.7%**	**28.5%**	**32.0%**	**6.8%**	**6.0%**
Others	**1,164**	**335,699**	**61.0%**	**31.9%**	**24.1%**	**35.9%**	**1.2%**	**6.9%**
Children's Hospital, San Diego	301	79,958	72.6%	0.2%	45.6%	53.1%	0.0%	1.2%
El Centro Regional Medical Center	165	28,622	47.4%	52.5%	15.5%	21.2%	3.9%	6.9%
Fallbrook Hospital District	92	33,138	64.7%	17.7%	27.8%	49.9%	0.0%	4.6%
Paradise Valley Hospital	202	73,753	66.9%	43.4%	10.0%	37.9%	2.4%	6.3%
Pioneers Memorial Hospital	99	20,387	56.3%	39.2%	23.0%	32.2%	3.7%	1.9%
Tri-City Medical Center	205	73,768	50.8%	52.8%	24.9%	12.1%	0.0%	10.2%
University Community Medical Center	100	26,073	71.2%	27.8%	1.2%	46.1%	1.8%	23.1%
TOTAL	5,375	1,583,123	68.5%	39.5%	27.4%	25.6%	2.1%	5.4%

Source: Author's analysis of data for fiscal years ending in 2004 from Office of Statewide Health Planning and Development.

Physician Organizations

Besides the hospital construction taking place in the San Diego area, new ambulatory health centers are also springing up. For example, the expanded Scripps campus in Encinitas will include medical office buildings and other facilities, and will be brought up to seismic safety standards. Clinics are trying to keep up with new population growth in places like Rancho Bernardo on the Interstate Highway 15 corridor to the north.

Exhibit 51 provides information about 15 of the largest physician groups in San Diego. Scripps Clinic MD Group, a medical foundation, has about 295 doctors and 94,000 enrollees. A second foundation, Scripps Mercy Medical Group, is also affiliated with Scripps Health and has 21 physicians practicing at Scripps Mercy in downtown San Diego. 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 2005, the

EXHIBIT 51. Physician Organizations in San Diego Area, 2006 (includes San Diego and Imperial counties)

Physician Organization / Notes	Estimated Enrollment	Number of PCPs	Number of Specialists	Number of Clinic Sites	DMHC Calculated Relative Working Capital	DMHC Calculated Relative TNE	Management Entity
Group Practice							
Centre for Health Care Medical Associates	28,300	42	301	3	1.24	1.21	Centre Care Management Co, LLC (includes IPA-type panel)
Graybill Medical Group, Inc.	1,000	26	70	5	NR	NR	Graybill Medical Group, Inc.
Sharp Mission Park Medical Centers	52,000	52	405	9	NR	NR	Sharp Mission Park Medical Group, Inc. (includes IPA-type panel)
Sharp Rees-Stealy Medical Group, Inc.	145,300	97	221	15	NR	NR	Sharp Rees-Stealy Medical Group, Inc.
Southern California Permanente Medical Group	471,100	411	523	22	NR	NR	Southern California Permanente Medical Group
IPA							
Children's Physicians Medical Group	65,000	127	290	0	1.62	1.62	Children's Physicians Medical Group, Inc.
Greater Tri-Cities IPA Medical Group, Inc.	13,100	32	110	0	0.37	0.37	Physicians Data Trust, Inc.
Mercy Physicians Medical Group, Inc.	23,100	60	189	0	1	1	North American Medical Management California
Primary Care Associates Medical Group, Inc.	54,400	61	275	0	0.87*	1.04	Primary Care Associates Medical Group, Inc.
San Diego Physicians Medical Group, Inc.	36,400	112	369	0	1.28	1.33	Southern California Physicians Managed Care Services, Inc.
Sharp Community Medical Group, Inc.	171,000	243	550	0	0.47†	1.14	Sharp Community Medical Group, Inc.
Medical Foundation							
La Maestra Family Clinic	5,950	15	200	2	NR	NR	La Maestra Family Clinic
Scripps Clinic MD Group, Inc./Scripps Clinic/ Scripps Medical Foundation	93,500	82	213	13	NR	NR	Scripps Clinic Health Plan Services, Inc. (includes medical group)
Scripps Mercy Medical Group, Inc./ Scripps Medical Foundation	14,000	21	0	2	NR	NR	Scripps Clinic Health Plan Services, Inc. (includes medical group and IPA)
State/County Faculty/Staff							
UC – San Diego Healthcare Network	30,900	63	500	12	NR	NR	UCSD Healthcare Network

*RBO reported they met criteria.
†RBO reported they met criteria. RBO has long-term securities, which are highly liquid. The securities are converted to current assets when calculating the met/not met requirements. However, they are not used when calculating the "relative" requirements.

NR: Not reported.

Source: Adopted from Cattaneo & Stroud's medical group inventory, April 2006.

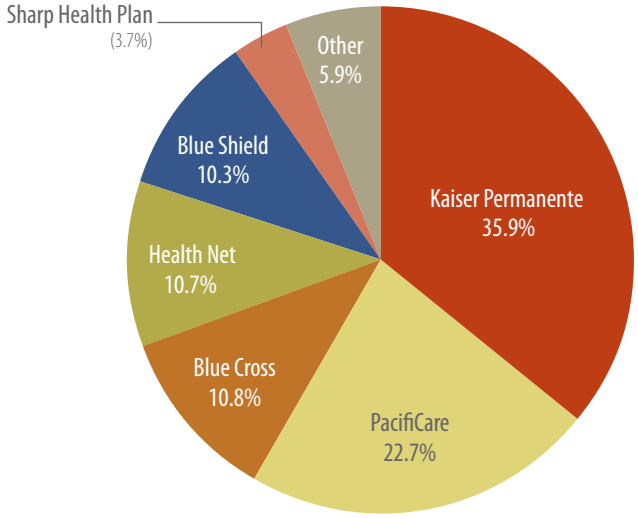
Knox-Keene company reported 38,000 enrollees — only about half of what it had in 2004 — with enrollees in both commercial and Medicare plans. (See *Exhibit 5.*) The Kaiser Permanente clinics in the area have about 930 doctors. Kaiser also uses outside doctors, particularly in the north county area and for certain specialties.

Health Plans

At the end of 2005, HMO penetration in San Diego was an estimated 43.7 percent, or 1.4 million members out of an estimated population of 3.2 million. (See the analysis for *Exhibit 14.*) That is lower than in the other major metropolitan areas of the state. The five largest health plans in San Diego County are statewide companies like Kaiser Permanente, PacifiCare, and Blue Cross. Local health plans — Sharp Health Plan and Community Health Group — have grown and play an important role in serving Medi-Cal enrollees, but have a smaller share of the market for employer health plans. The University of California–San Diego ran a Medi-Cal HMO plan until the end of 2003.

As shown in *Exhibit 52,* Kaiser continues to be the largest HMO in San Diego, with an estimated 35.9 percent of the market. About 1.1 million residents in the area are enrolled in HMO commercial plans, down about 10 percent from three years ago. Another 169,000 are in Medi-Cal managed care as of December 2005, split among six HMOs. Sharp Health Plan, one of the few remaining provider-sponsored HMOs in the state, had the second largest Medi-Cal enrollment in the

EXHIBIT 52. Estimated Market Share for San Diego Area HMOs, 2005 — Total Enrollment: 1,397,277



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

area. Only Community Health Group is larger. Both Sharp and Universal Care transitioned their Medi-Cal and Healthy Families members in the area to Molina Healthcare in 2005. Care 1st has entered the market here as it did in Sacramento, competing for Medi-Cal managed care enrollment. The geographic managed care arrangement will be extended into Imperial County.

The Sharp hospitals continue to contract with health plans on a capitated basis, which makes them exceptional today in California. For a hospital, sponsoring a health plan and accepting capitation risk are two sides of the same coin. A provider organization that has skilled management and systems in place can succeed with risk arrangements. That is especially true in an environment where premiums are increasing faster than medical costs, which has generally been the case for the past few years in California.

The different Sharp medical groups, including Sharp Rees-Steely and Sharp Community Medical Group, were invested in information systems and medical management practices designed for capitated payments. Sharp Health Plan has also been a key partner in an initiative to make employer-sponsored health coverage more accessible. This program, which leveraged grants to subsidize the premiums on a limited-benefit health plan, has had a positive impact, helping to raise awareness of health insurance and to get coverage for more employed households.

According to 2005 data from the Centers for Medicare and Medicaid Services, 38.7 percent (142,000) of San Diego seniors are enrolled in one of four Medicare+Choice HMOs. The four still participating are PacifiCare, Kaiser Permanente, Health Net, and Blue Cross. Health Net and Blue Cross are small in San Diego, with fewer than 10,000 seniors each. PacifiCare is the largest with 75,000 seniors; Kaiser had about 56,000 in its senior plan, up about 8 percent compared to 2004.

Subject Index

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