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Reality Used to Be a Friend of Mine

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Reality Used to Be a Friend of Mine

- Reality once was broad comprehensive HMO benefit packages, with simple (and low) co-pays
  - Supported less complex operational relationship with delegated medical groups
- Reality today is relentless cost pressures are driving the health benefits market place is moving toward lower price points with greater consumer financial participation
- More change is needed by all parties for the HMO to be competitive at lower price points.

Who are We?

- CAHP represents 35 California Health Plans:
  - Aetna
  - Alameda Alliance for Health
  - Blue Cross of California
  - Blue Shield of California
  - Care 1st Health Plan
  - Central Coast Alliance
  - Chinese Community Health Plan
  - CIGNA Healthcare of California
  - Community Health Group (SD)
  - Community Health Plan (LA)
  - Contra Costa Health Plan
  - Health Net
  - Health Plan of San Joaquin
  - Health Plan of San Mateo
  - Inland Empire Health Plan
  - Inter Valley Health Plan
  - Kaiser Foundation Health Plan
  - Kern Health Systems
  - LA Care Health Plan
  - Molina Healthcare of California
  - On Lok Senior Health
  - Great West Healthcare
  - PacifiCare
  - Partnership Health Plan
  - San Francisco Health Plan
  - Santa Barbara Regional Health Plan
  - Santa Clara Family Health Plan
  - SCAN Health Plan
  - Sharp Health Plan
  - SIMNSA Health Plan
  - UHP Healthcare
  - Universal Care
  - Valley Health Plan
  - Ventura County Health Plan
  - Western Health Advantage

Delegated Model
At Risk When Most Needed

- In the delegated model, consumers have three tiers of protection and support
  - RBO
  - Health Plan
  - DMHC
- Declines of 5% in the HMO population in California for four years running
- PPO growth up 5.6% in four years

HMO v PPO Growth

CA Statewide HMO and PPO Enrollment for Selected Health Plans for March 2001 - 2004

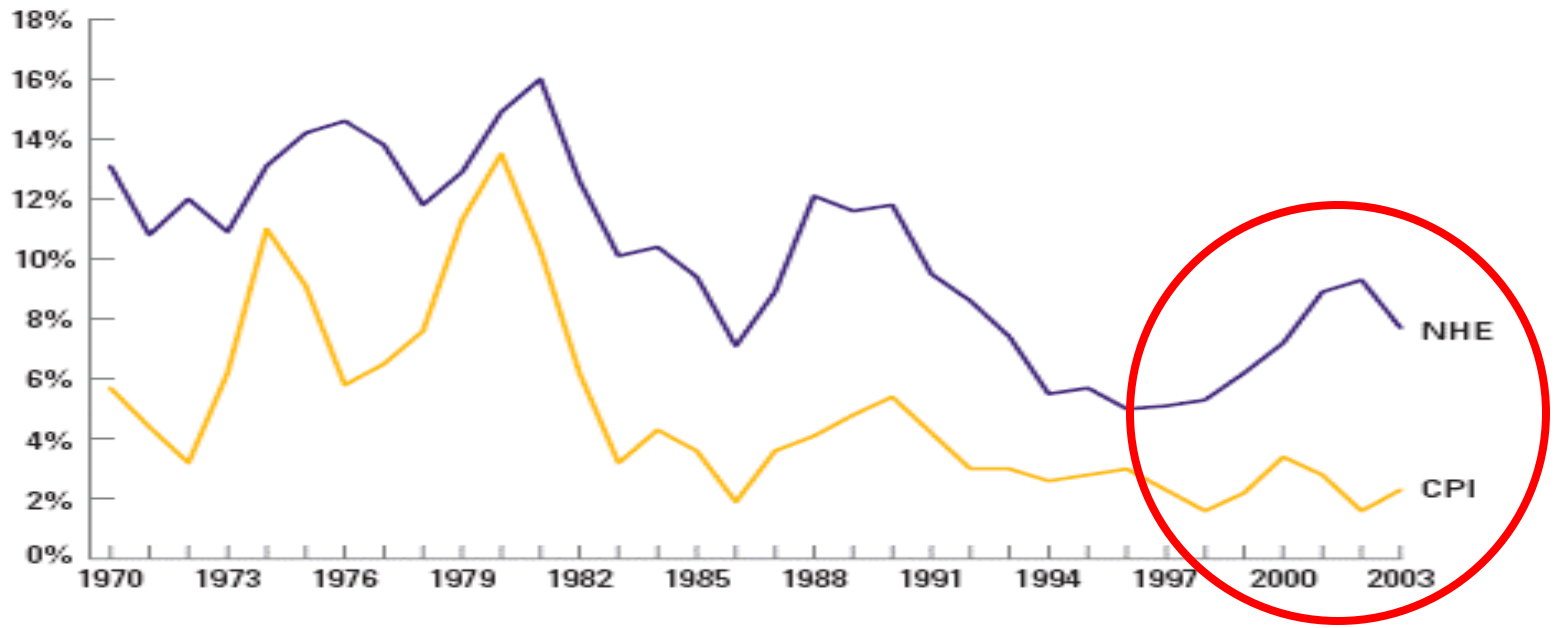
Plan	2001	2002	2003	2004	Growth '01 - '04
Blue Cross HMO	2,526,673	2,612,801	2,853,227	2,735,026	8.2%
Blue Cross PPO	3,353,263	3,828,667	3,938,548	4,234,234	26.3%
Blue Cross TOTAL	5,879,936	6,441,468	6,791,775	6,969,260	18.5%
Blue Shield HMO	1,044,174	1,038,275	1,345,924	1,315,479	26.0%
Blue Shield PPO	994,194	1,268,761	1,308,158	1,172,916	18.0%
Blue Shield TOTAL	2,038,368	2,307,036	2,654,082	2,488,395	22.1%
Cigna HMO	652,466	649,311	584,586	97,576	-85.0%
Cigna PPO	555,799	582,523	412,355	383,495	-31.0%
Cigna TOTAL	1,208,265	1,231,834	996,941	481,071	-60.2%
HealthNet HMO	2,068,944	1,981,396	1,934,398	2,116,341	2.3%
HealthNet PPO	57,262	64,112	174,382	224,461	292.0%
HealthNet TOTAL	2,126,206	2,045,508	2,108,780	2,340,802	10.1%
PacifiCare HMO	2,263,992	2,088,018	1,715,200	1,757,398	-22.4%
PacifiCare PPO	8,140	20,606	40,241	79,747	879.7%
PacifiCare TOTAL	2,272,132	2,108,624	1,755,441	1,837,145	-19.1%
United PPO	442,671	474,649	513,500	651,000	47.1%
(United sold it's HMO to Blue Shield in Dec 2000)					
TOTAL HMO	**8,556,249**	**8,369,801**	**8,433,335**	**8,021,820**	**-4.9%**
TOTAL PPO	**5,411,329**	**6,239,318**	**6,387,184**	**6,745,853**	**5.6%**
TOTAL ENROLLMENT	**13,967,578**	**14,609,119**	**14,820,519**	**14,767,673**	**-0.4%**

Source: Cattaneo & Stroud, Inc. at www.cattaneostroud.com

Sustained Cost Increases Far Greater Than Inflation Drive the Issue

Annual Growth Rates

NHE vs. CPI

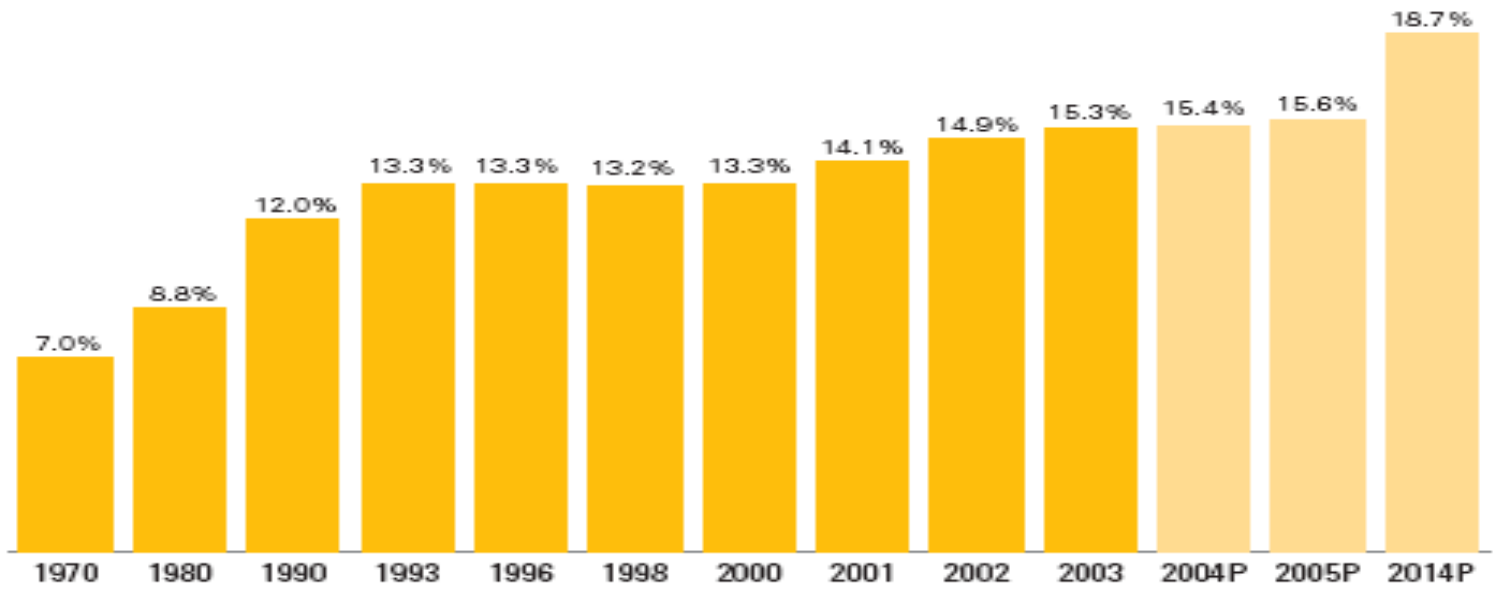


Note: Health spending refers to national health expenditures (NHE). CPI is the consumer price index.
Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary; Bureau of Labor Statistics (CPI-U, U.S. city average, annual figures).

(CHCF Health Care Costs 101, 2005)

Stunning Increase in Wallet Share

National Health Spending as a Share of Gross Domestic Product

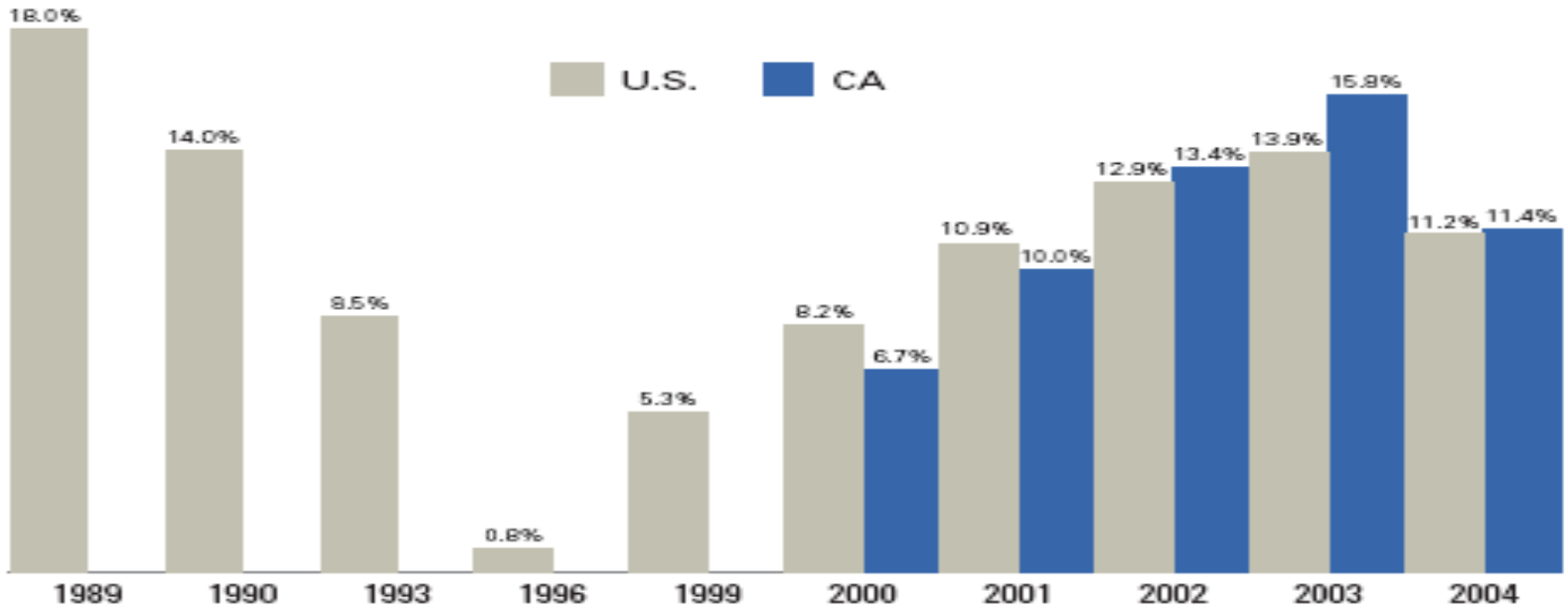


Note: Selected rather than continuous years of data are shown prior to 2000. Data for 2004 forward are projections.
Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary.

(CHCF Health Care Costs 101, 2005)

What the Employer is Reacting To

Annual Growth in Private Health Insurance Premiums



Notes: Data on premium increases reflect the cost of employer-based health insurance coverage for a family of four as reported by employers. Percent increase represents the growth over the immediate prior year. Selected rather than continuous years of data are shown prior to 1999.

Sources: KFF/HRET *Survey of Employer-Sponsored Health Benefits, 2004*. CHCF/HRET *California Employer Health Benefits Survey, 2004*. California survey not conducted prior to 2000.

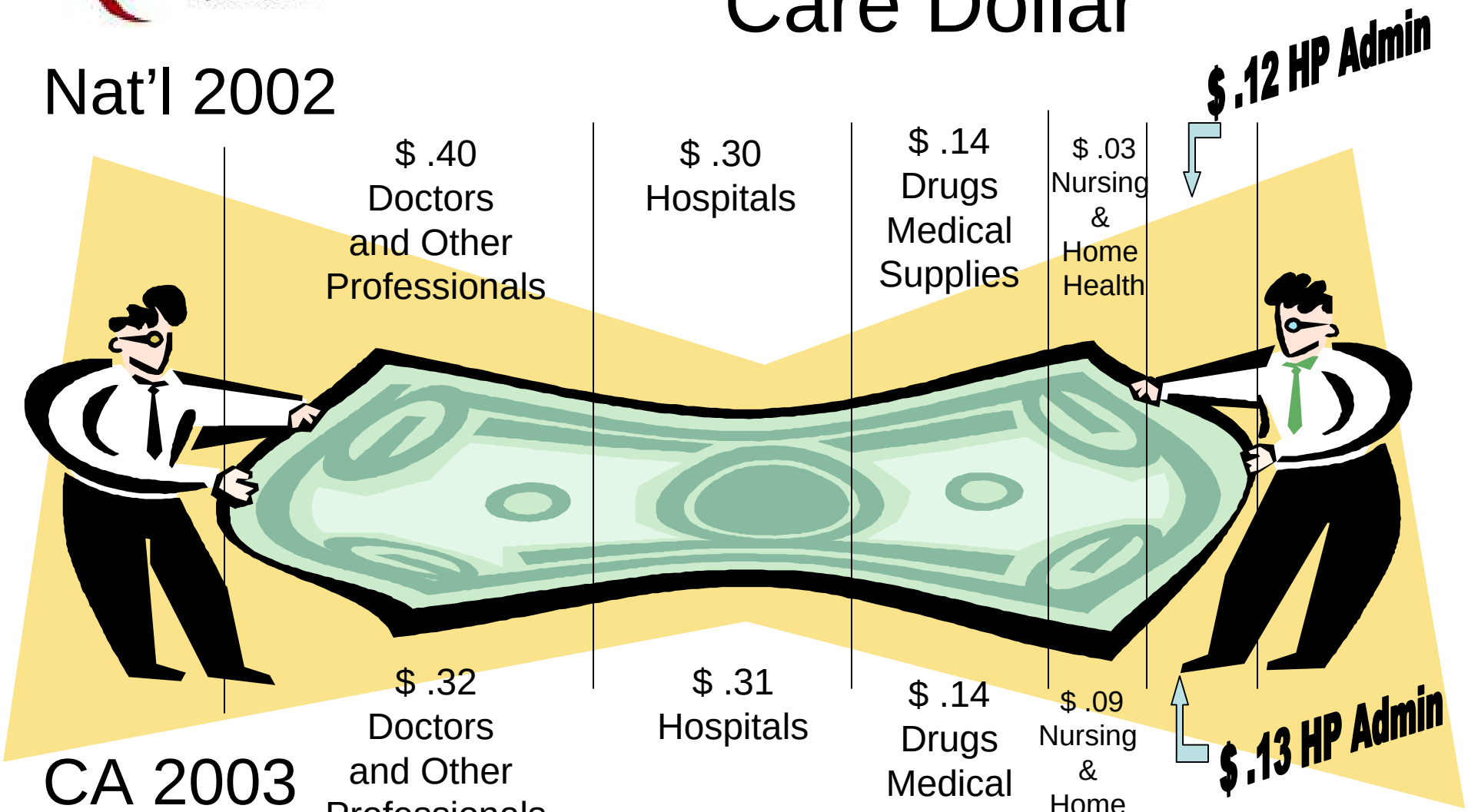
(CHCF Health Care Costs 101, 2005)

Cost Increases Likely to Continue

- Sources of cost increases are intractable
  - Technology
  - Hospital prices
  - Aging of population
  - Others

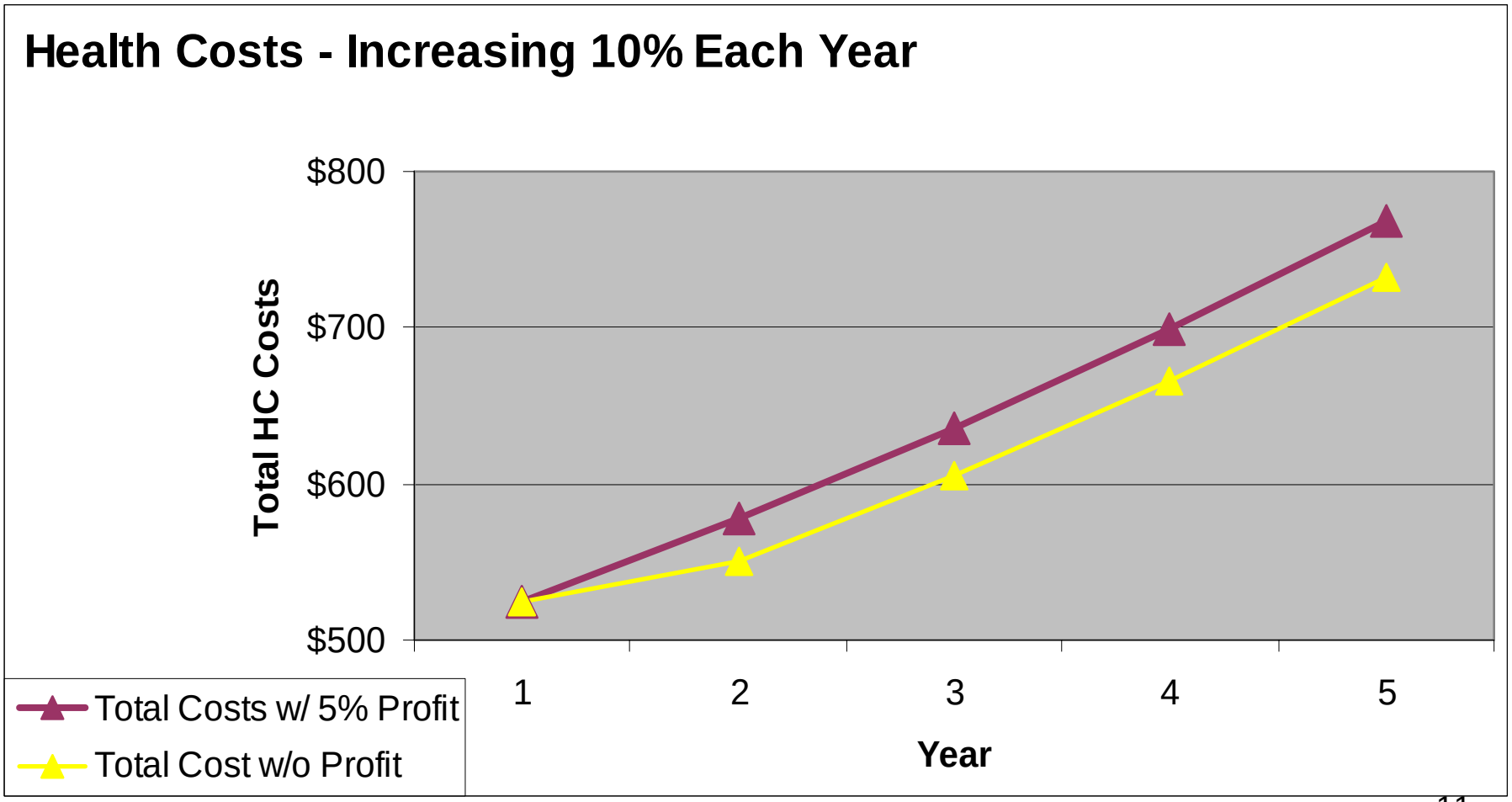
- Reality Used to Be a Friend of Mine

The Premium Health Care Dollar



Nat'l – AHIP Issue Brief, Sept 2002; CA – CHCF Snapshot Healthcare Costs 101, 2005

Health Plan Profits Don't Drive Healthcare Costs



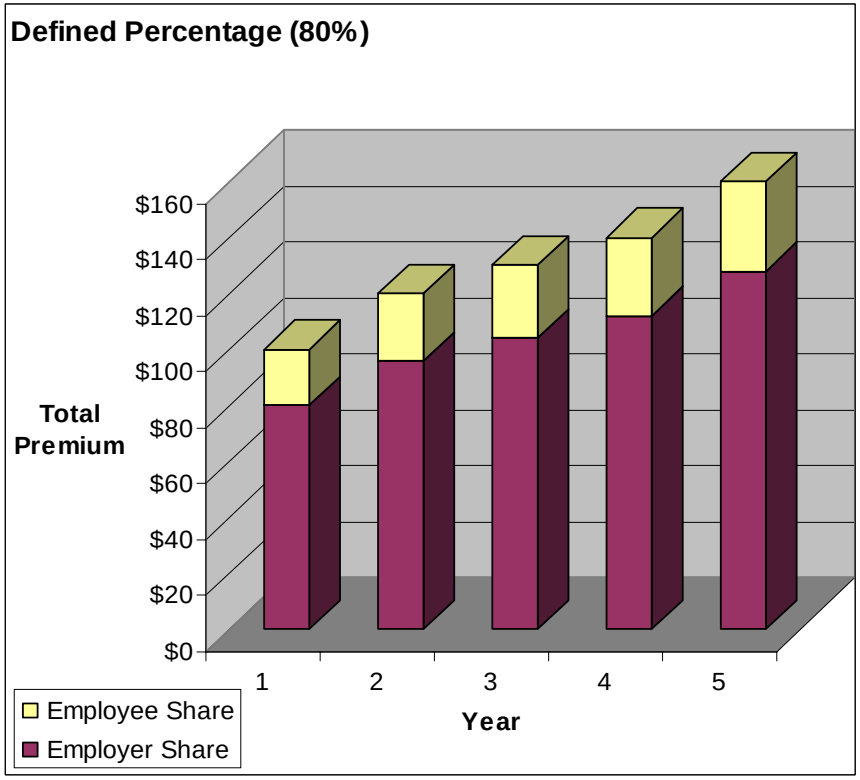
The Brutal Reality: Consumers Face Higher Costs

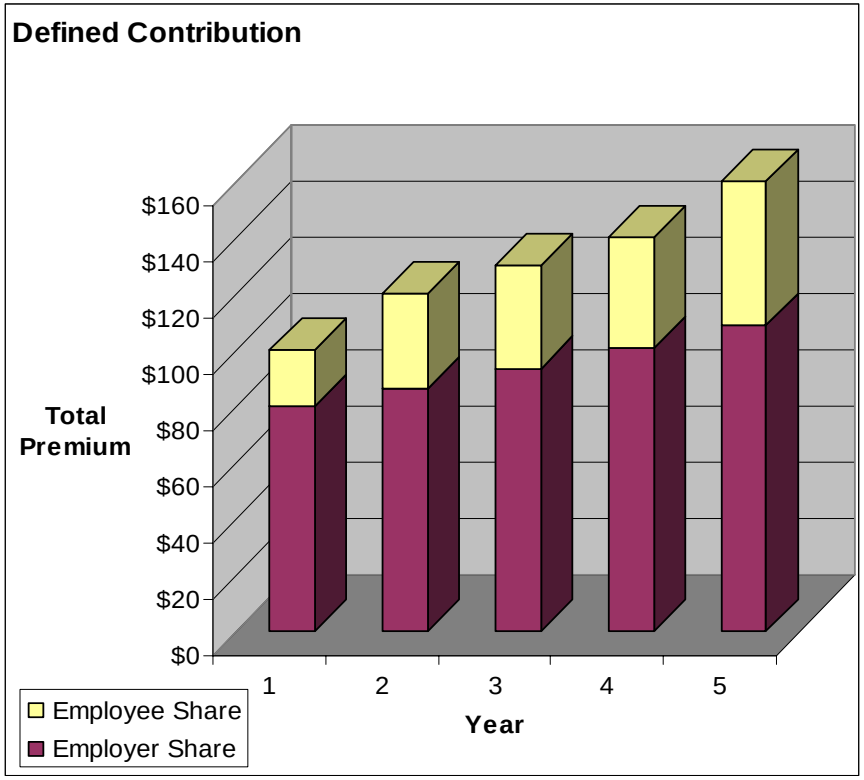
- Employers, facing global competition, face harsh limits on cost structures
  - "this rapidly rising health care burden is not, in fact, unique to GM – it is a critical national competitiveness issue for the United States, affecting our entire economy's long term strength"
    - GM Chairman and CEO, Rick Wagoner, upon announcing the layoff of 25,000 workers largely due to GMs inability to afford increases in health care costs for employees (June 7, 2005)
- Taxpayers say they will pay for the uninsured, but political leadership isn't going there
  - 80% of those surveyed stated it is more important to provide health care coverage for all Americans even if it meant raising taxes, than to hold down taxes but leave some people uncovered.
    - ABC News-Washington Post poll (October 9-13, 2003).
- Consumer engagement should be part of the solution

Employers Demanding New Product Choices and Price Points

- Employer response to over five years of premium increases is to shift costs to employees through:
  - Premium increases
  - Benefit changes
  - Restructure benefit plans (e.g., CDHP)
- Products are increasingly a key point of competition among health plans
  - A large health plan produced:
    - 2000: 15 Mid-Market Products (6 HMO, 9 PPO)
    - 2005: 51 Mid-Market Products (20 HMO, 31 PPO)

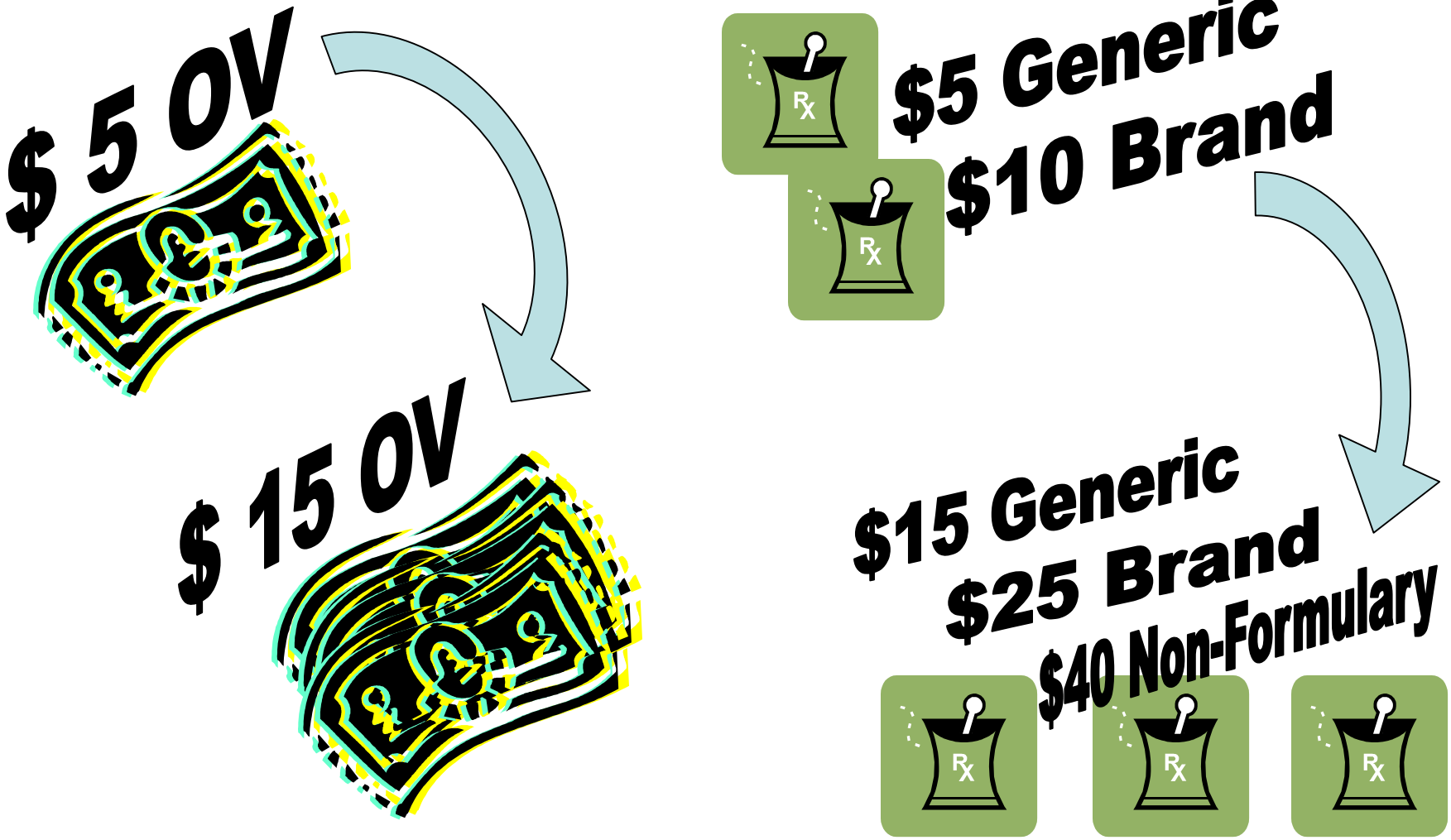
Higher Employee Share of Premium





- Defined Percentage (Employer pays 80% of Total Premium)
  - Employee contribution remains at 20% of premium, increases from $20 to $32 over 5 years.
- Defined Contribution (Employer Pays defined $ amount with 8% annual est. increases)
  - Employee contribution increases 20% to 32 % of premium, increases from $20 to $52 over 5 years.

Benefit Plan Changes



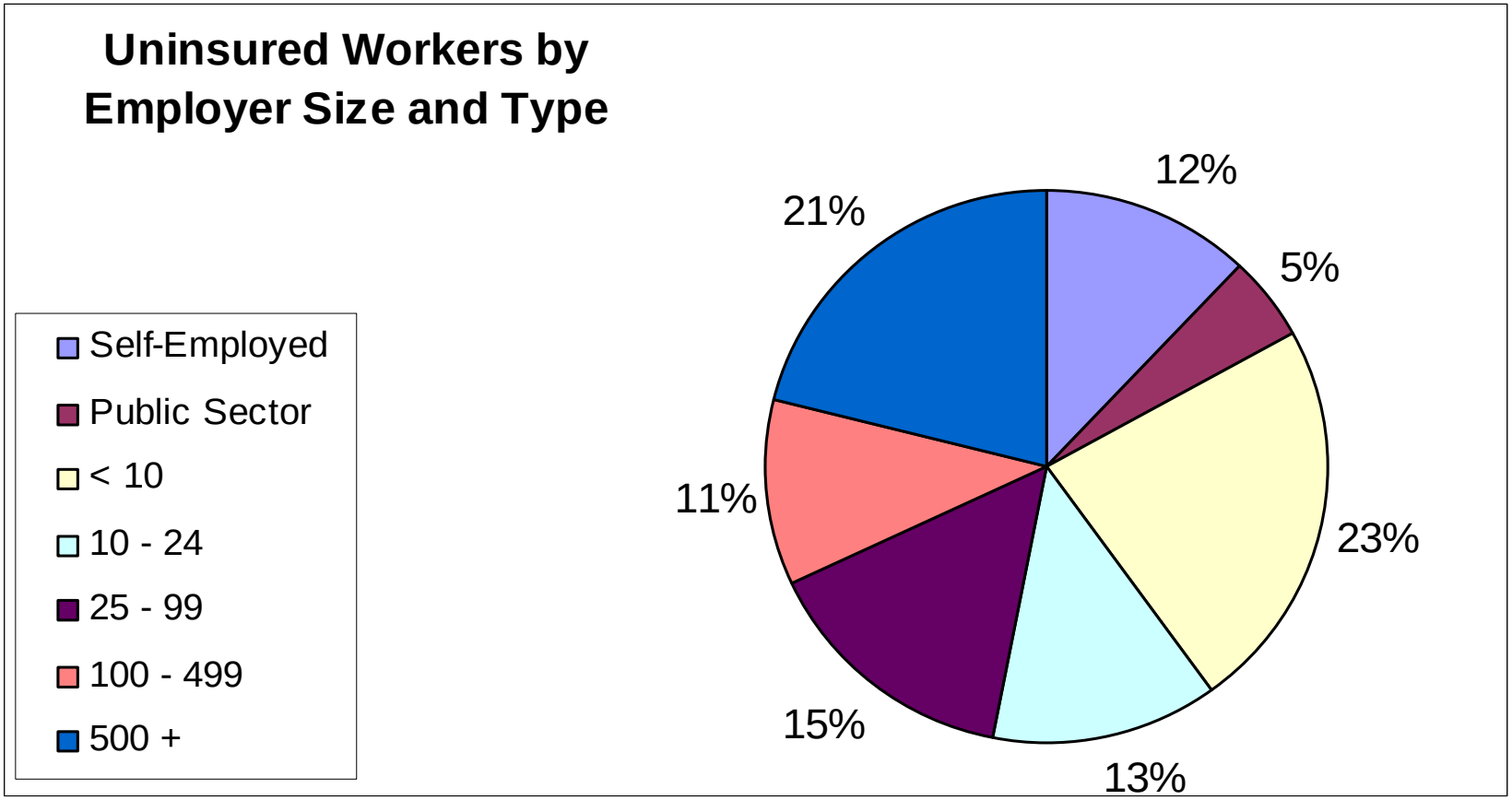
Restructure Benefit Plans

- Adoption of high deductible PPO plans generally with some mix of tax advantaged funding
  - HSAs, FSAs, HRAs, or MSAs

- Consumers gain considerable freedom in selecting doctors and hospitals
  - Per service costs are expensive and hard to predict
  - Lose the benefits of coordinated care through the delegated model

Fourth Alternative

- Dropping coverage altogether



(CHCF, Snapshot of the Uninsured 2004)

The Brutal Reality: Markets Are Efficient

- Knox Keene Act has Comparatively more Regulatory Requirements
  - Knox-Keene law has long history of increasing mandated benefits on top of a rich benefit base
    - 26 mandated benefits bills implemented in last 5 years
  - Regulatory initiatives have added cost
    - UR processes have been limited; claims process more complicated
  - This pushes drives up the cost of the delegated model
- DOI regulation is less oriented to benefits than to insurers' ability to meet financial obligations
- Push DOI to become like Knox-Keene and self funding under ERISA becomes viable
  - CA: 31% of enrollees in employer-funded coverage are self-insured,
  - Nat'l: 54% of enrollees in employer-funded coverage are self-insured

    (CHCF California Employer Health Benefits Survey, 2004)

Two Steps to Support the Delegated Model

- Continue progress at DMHC in drive to consistent and market responsive regulation of plan design and new products
  - Health plans compete on product and there is a "market" for regulatory choice
- Build new business relationships between health plans and delegated groups which capture the benefits of the delegated model, and drive down the cost of the HMO product

New Business Relationships

- Benefit plan linked capitation rates impacts cash flow of RBOs
- Greater portion of physician income from co-pays and co-insurance
  - Physician offices will need discipline and skill in calculating and collecting funds from patients
  - Clarity in contract terms between plans and RBOs will be crucial
  - Loss of encounter data could impact quality and rate negotiations

Key Implications for RBOs

- RBOs with unfunded claims liabilities most at risk when volume shrinks
  - Member volume
  - Scope of services volume
- SB 260 standards and corrective action plans are key to avoiding disruption

Reality Used to Be a Friend of Mine

Our Old Reality

- No or little consumer out of pocket with comprehensive benefits
- Stable products
- Full funding by employers

Our New Reality

- Substantial consumer out of pocket
- Rapid introduction of new products to meet employer budgets
- Less funding by employers

Will we -- health plans, RBOs, DMHC and others – embrace this reality, and forge ahead to bring the delegated model to consumers when it can be most beneficial?