

California's Health Care Gamble: Can We Afford the Trend Toward PPO?

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President and Chief Executive Officer

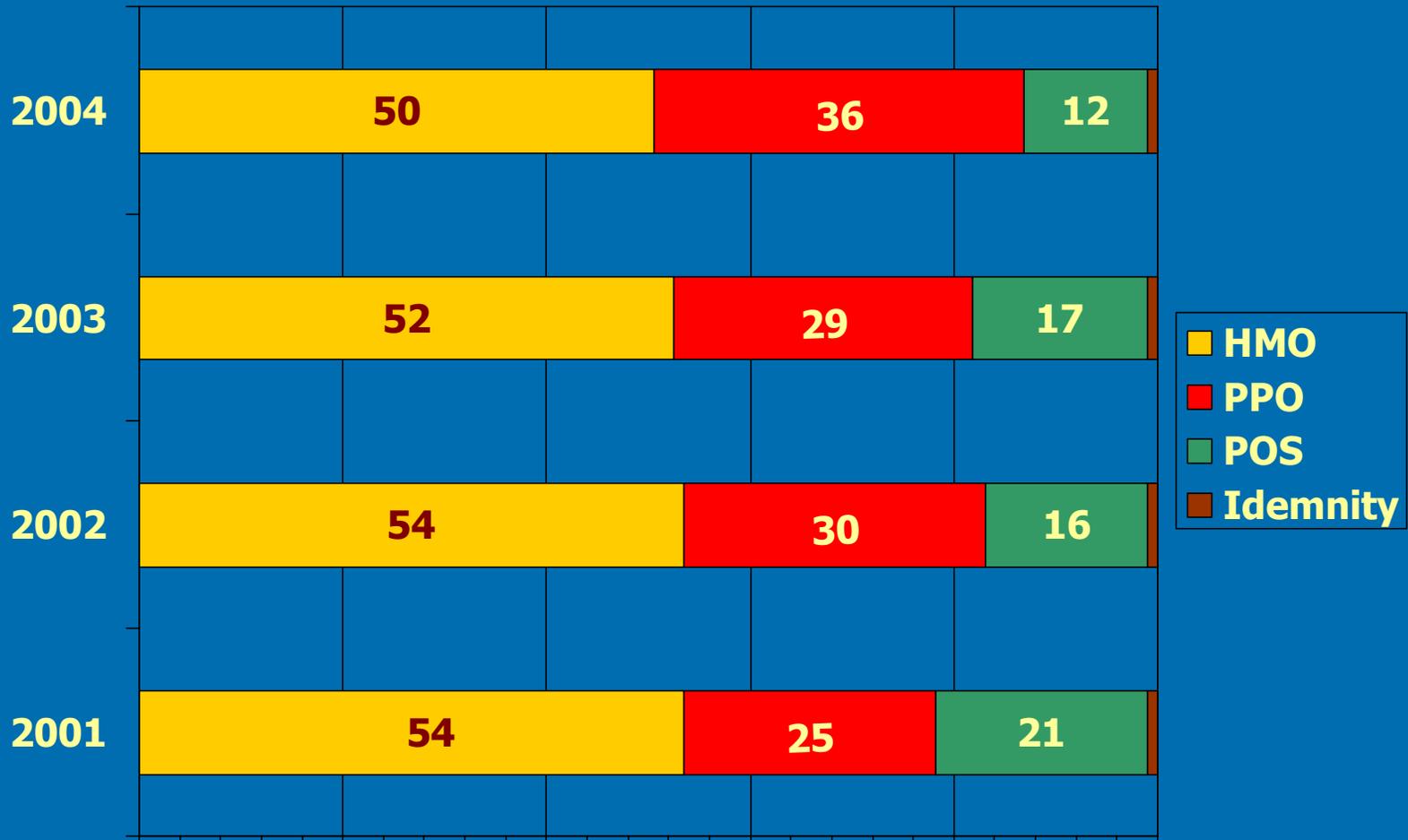
August 23, 2005



CAPPG
California Association
of Physician Groups



The Market Share Shift Has Begun

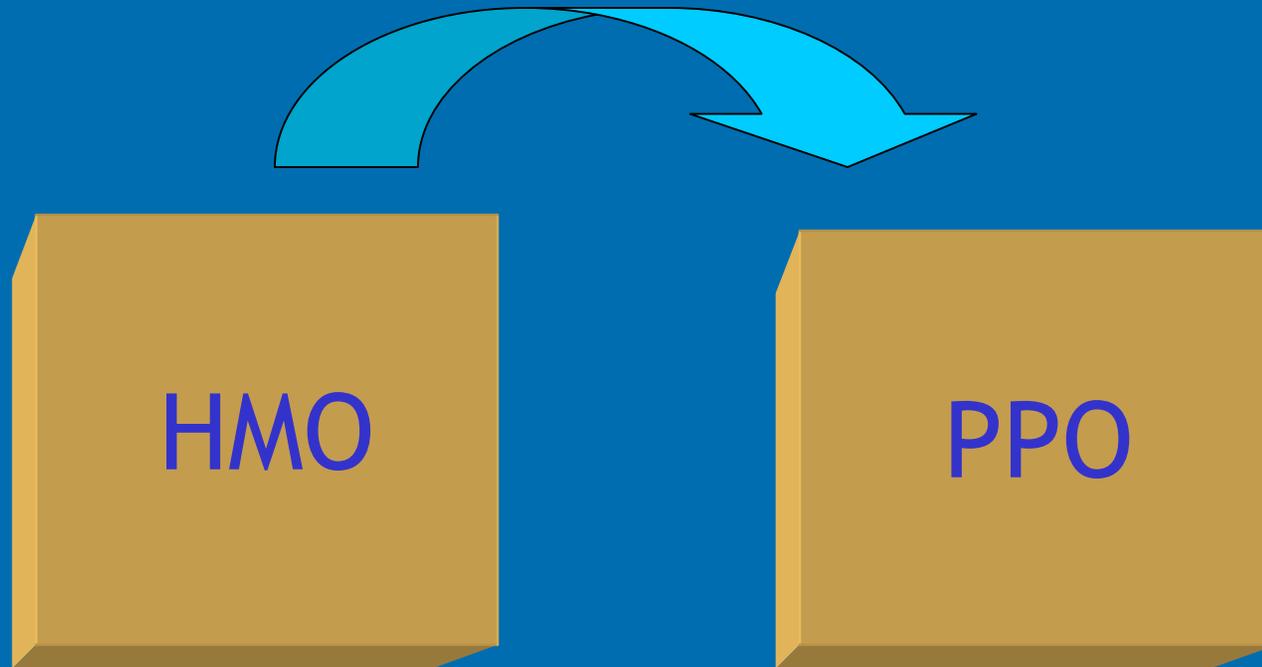


The Driving Forces

National
Employer
Single
Source
Purchasing
California
outnumbered 49:1

Path of Least
Resistance
to
Deductible
Benefit
Design

What's the Big Deal?



The Choice is NOT as simple as
the first-year's savings

More Than A Product Name

HMO

PPO

Organized Care

**Disaggregated
Care**

Prepayment

**Fee For Service
Payment**

**Outcome
Incentive**

**Increased
Services
Incentive**

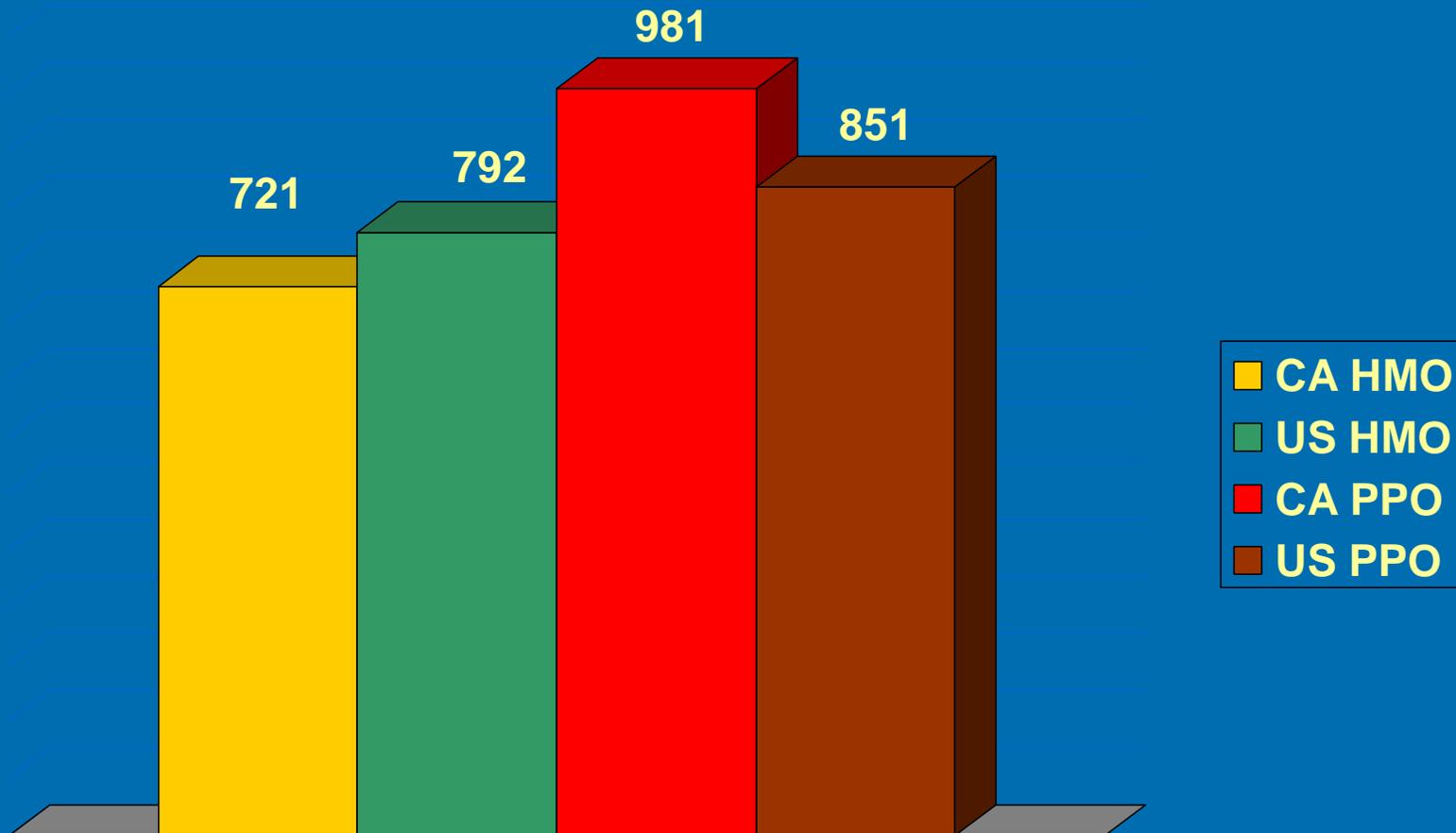
**Embedded Care
Processes**

**Over-layed Care
Processes**

**Efficiency
Reward**

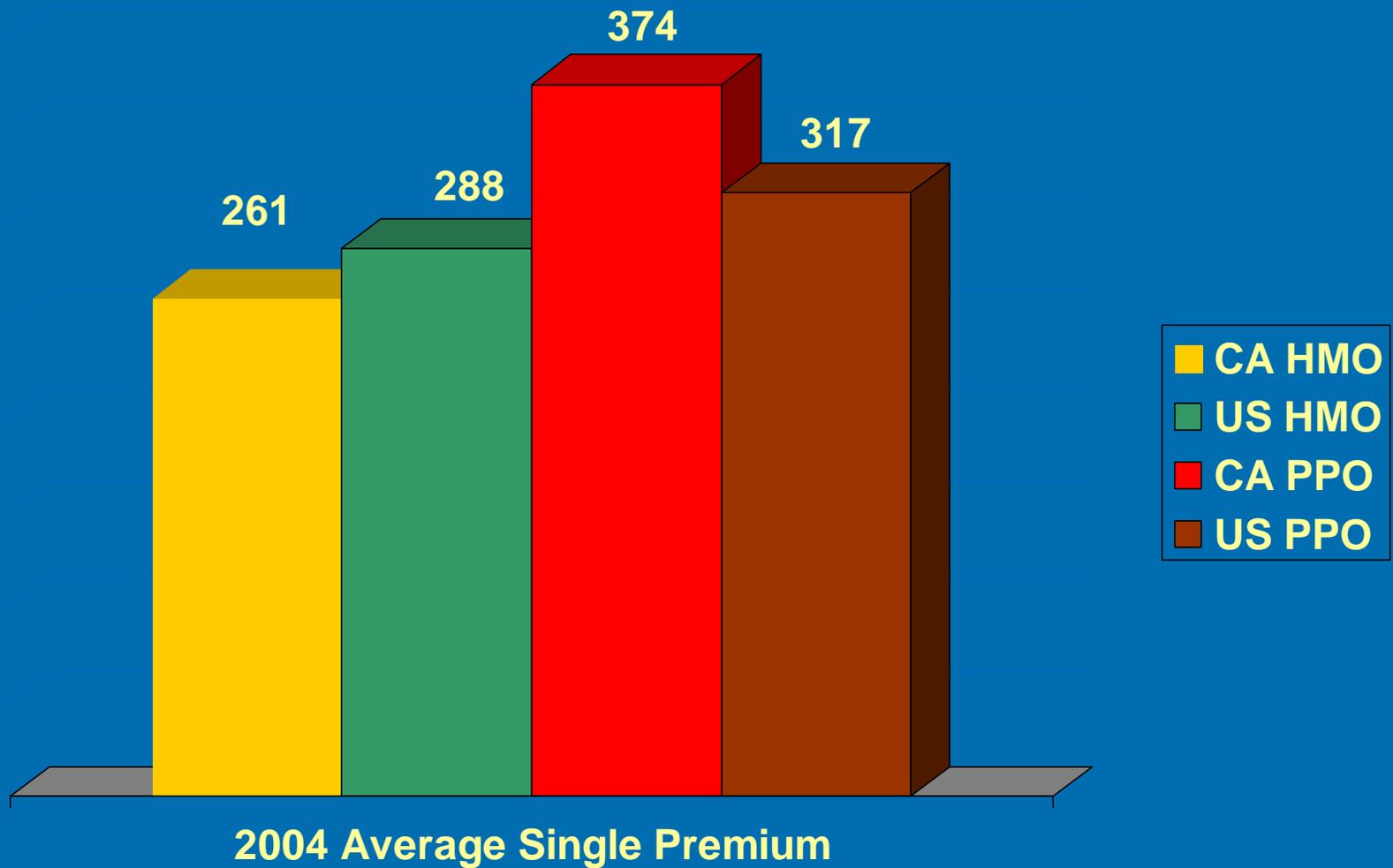
**Efficiency
Penalty**

California HMO Premiums remain highest-value health care purchase

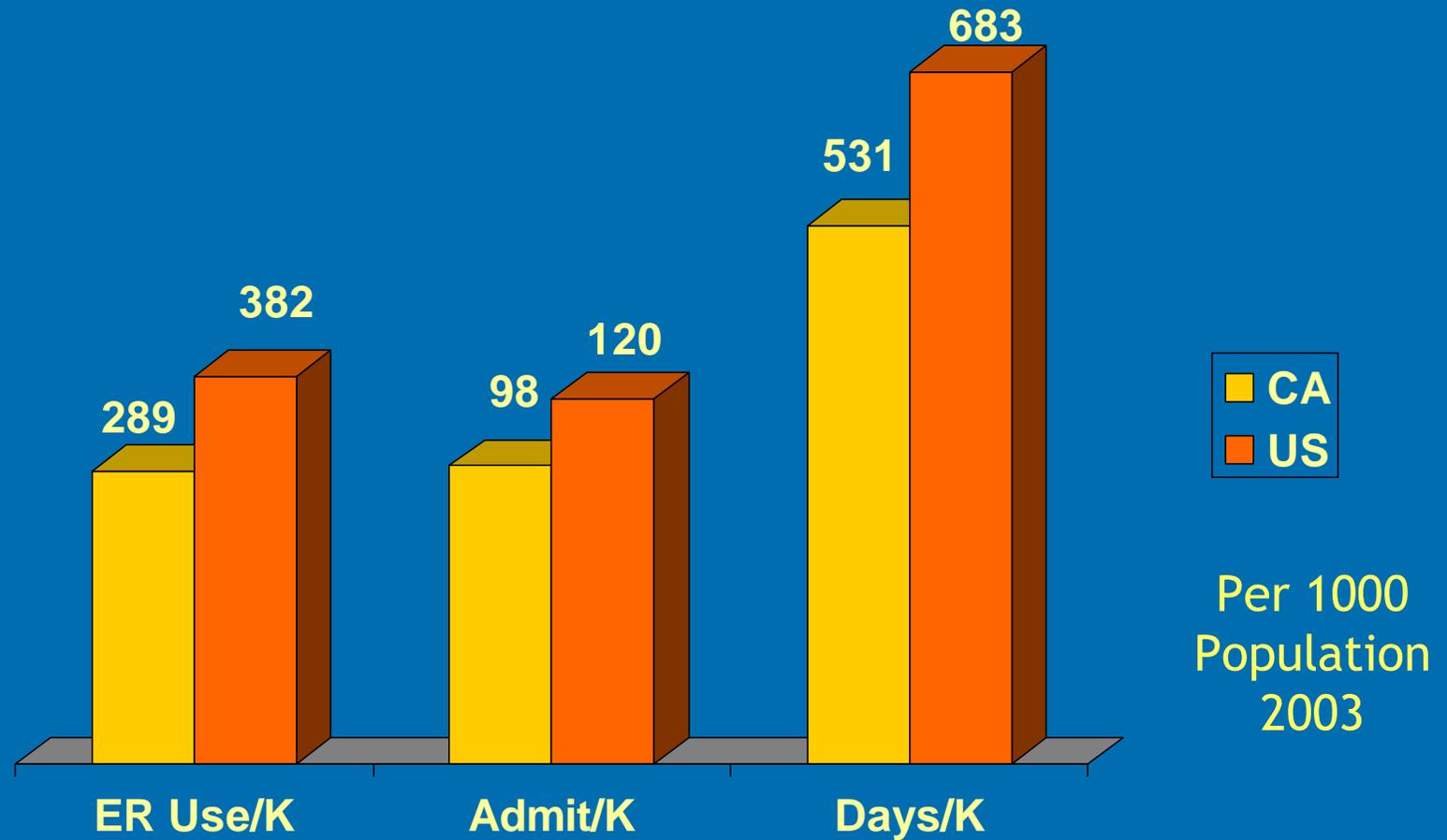


2004 Average Family Premium

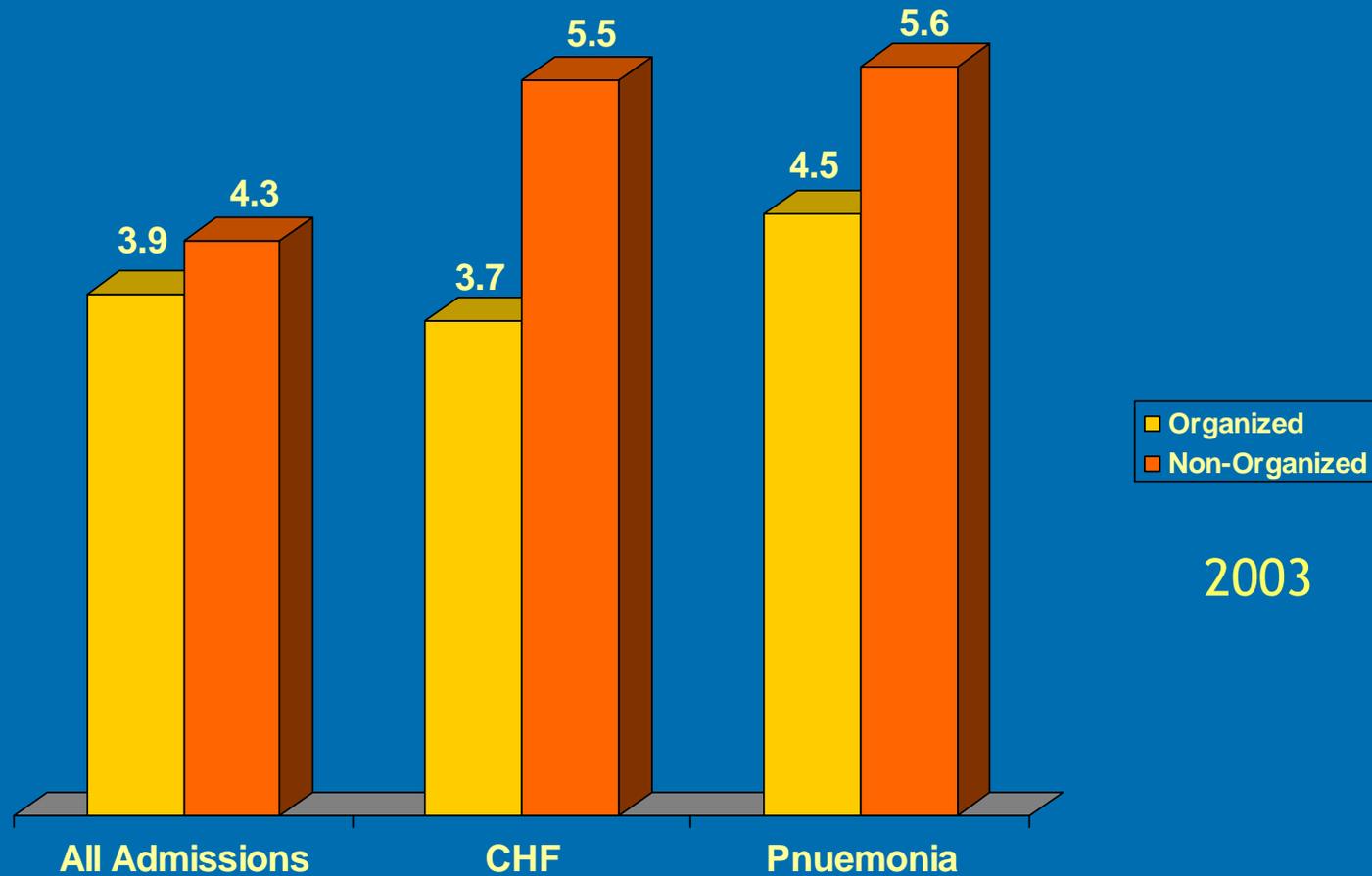
California HMO Premiums remain highest-value health care purchase



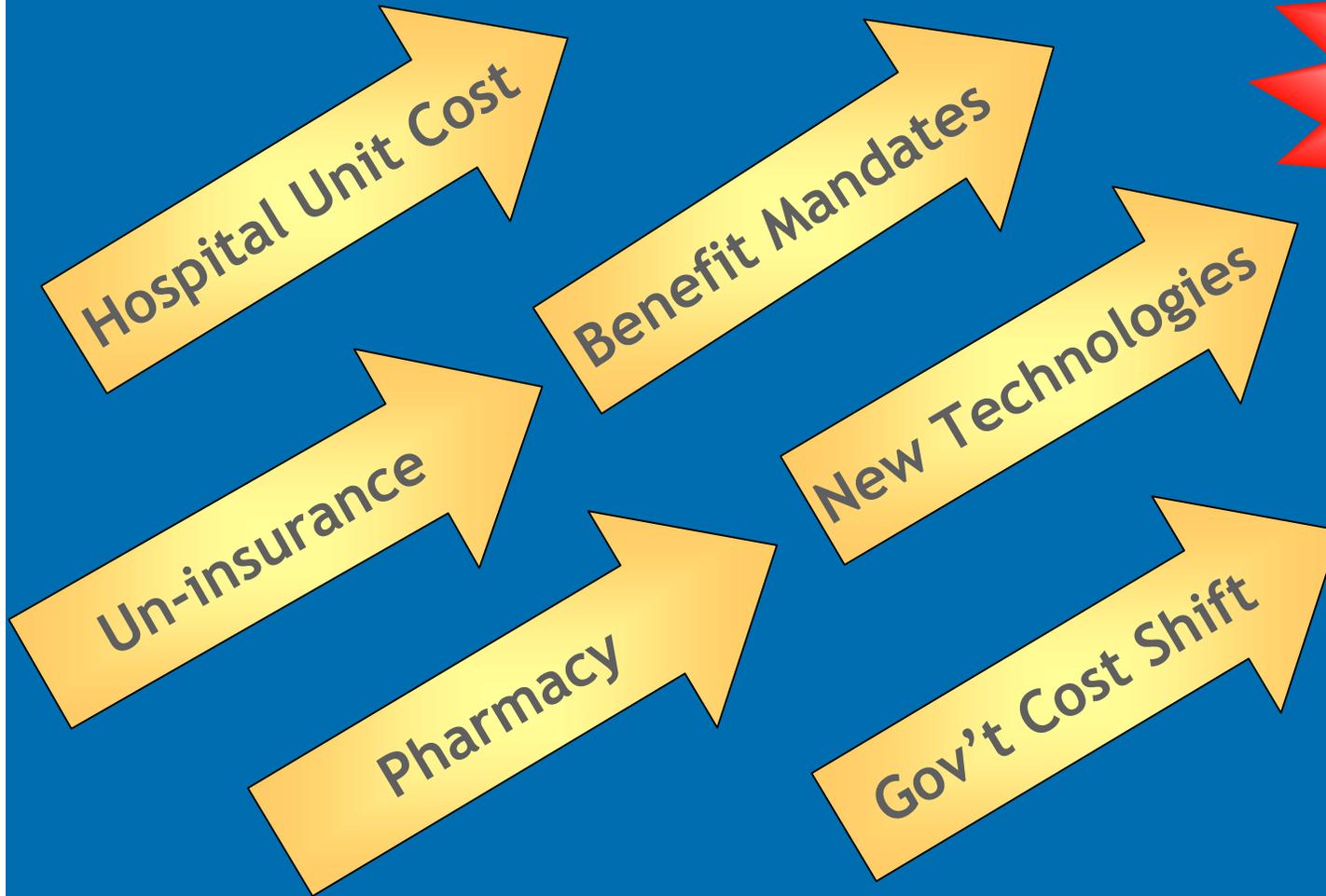
CA Results in Hospital Use Rates Are Superior to National Rates



Hospital LOS Management is Material Driver of Results - Particular in Medical Admissions



The Pressure Is On



Employer Response: The Means and the End

High Deductible
Reduce Benefits
Savings Accounts

Common Wisdom

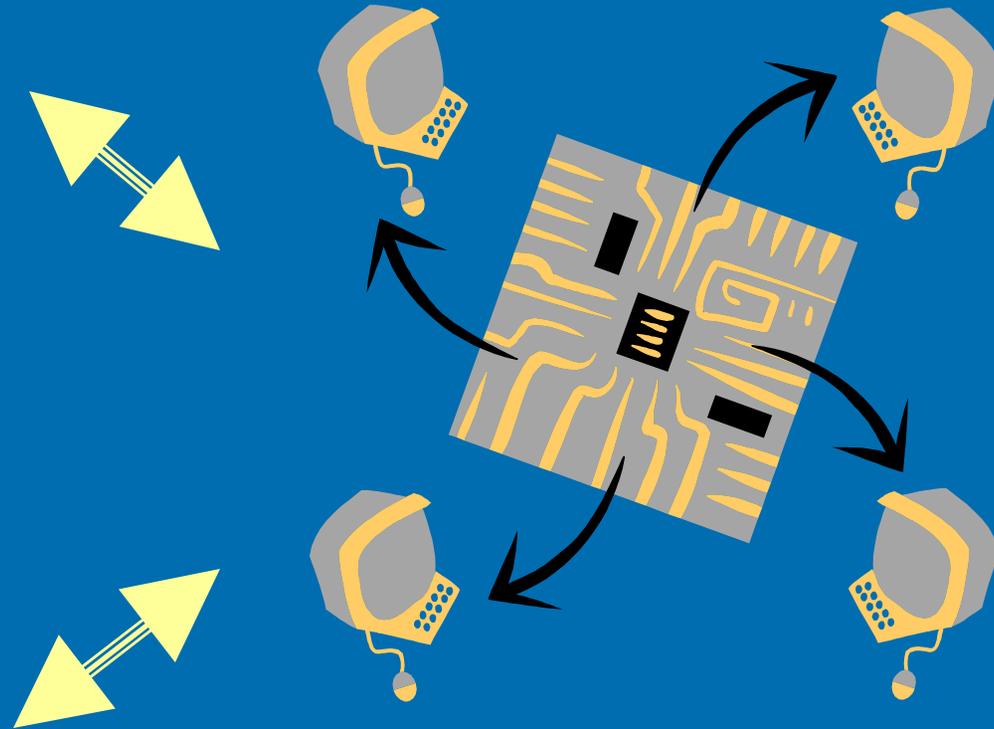
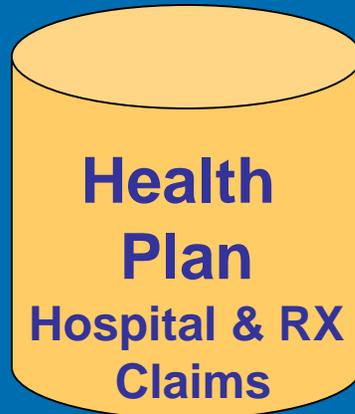
PPO Design
FFS Payment

Chosen Path

Consequences

Undermine Delivery
Model Performance

Inability to Manage Deductibles



**Simultaneous Transacting
Real-Time Accumulators**

Management Principles At Work in Organized Delivery Systems

**Strategic Resource
Allocation**

ROI Mentality

**Staff Recruitment
and Teamwork**

**Organized to
Optimize the Whole**

Data Driven

**Incent Improvement
Organizational → Individual**

**Leverage
Technology &
Volume**

What Gets Lost in the Shift?

~~Strategic Resource Allocation~~

ROI Mentality

Staff Recruitment

~~Organized to Optimize the Whole~~

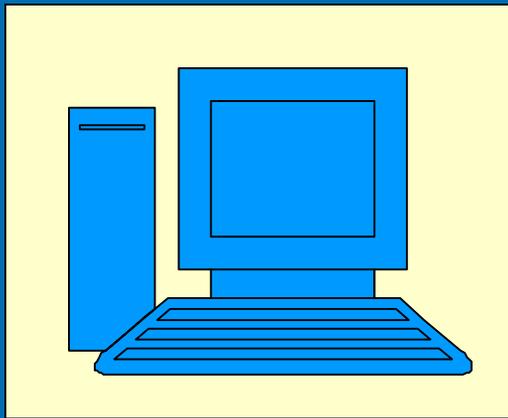
Data Driven

~~Incentive Improvement
Organizational → Individual~~

~~Leverage Technology & Volume~~

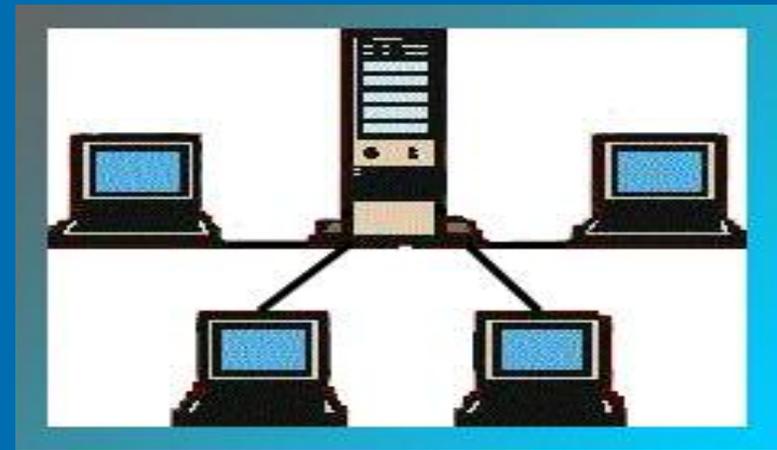
Optimizing Technology

Administrative vs Cost and Quality Improvement



Stand-Alone Office

Integrated Network



**Automation
Record Keeping/Transacting**

**Leverage Communications
EMR → EHR
Registries
Clinical Team Communication**

Pay for Performance Systemic Quality Improvement

**112 Medical
 Groups**

**40,000
 Physicians**



First Year Results

<u>Prevention</u>	<u>Increase of</u>
- Breast Cancer Screening	135,000
- Cervical Cancer Screening	150,000
- Childhood Immunizations	10,000
- Diabetes Testing	18,000

<u>Disease Management</u>	<u>Avoidable Deaths</u>
- Asthma	800-1000
- Diabetes	4,300-9,600
- Heart Disease	6,900-17,000
- Blood Pressure	15,000-26,000
Total Avoidable Costs	\$250 Million

Can't the Plan do it?

Health Plans

Medical Groups

Stand-Alone
Inpatient Services

Hospitalist

Integrated with all
Care Delivery

Engages Member
But Not Physician

Disease
Mgmt

Engages Members
And Physicians

Large Networks
Diffuse Volume

Contracting

Service-Specific
Leveraged Volume



Reality Not Threat: Cost Increases

50% of Members selected a Clinic that changed from Physician Capitation to Fee-For-Service on 1-1-2004

10-Month Experience Periods	Members Covered	Physician Capitation	Physician FFS Claims	Outpatient FFS Claims*	Total M.D. Capitation & Claims
3/03 - 12/03	3,260	\$2,124,577	\$252,180	\$298,491	\$2,675,248
3/04 - 12/04	3,127	\$1,454,009	\$1,795,638	\$674,616	\$3,924,263
% Change	-4%	-32%	+612%	+126%	+47%

* Includes diagnostic x-ray and lab outpatient surgery.

Barney & Barney

The Incomplete Economics

- Deductible-based plans were the norm in the 1980's when trend topped 20% - what will be different?
- The care requiring most management - and most patient engagement - occurs AFTER the first \$1000 is spent
- Physicians control up to 87% of health spending. Current options only incentivize increased spending

Consequences: Disproportional Effect

- Disproportionately affects low wage-earning employees - resulting in under-care
- Effects of under-care ultimately cost the system more

2004*

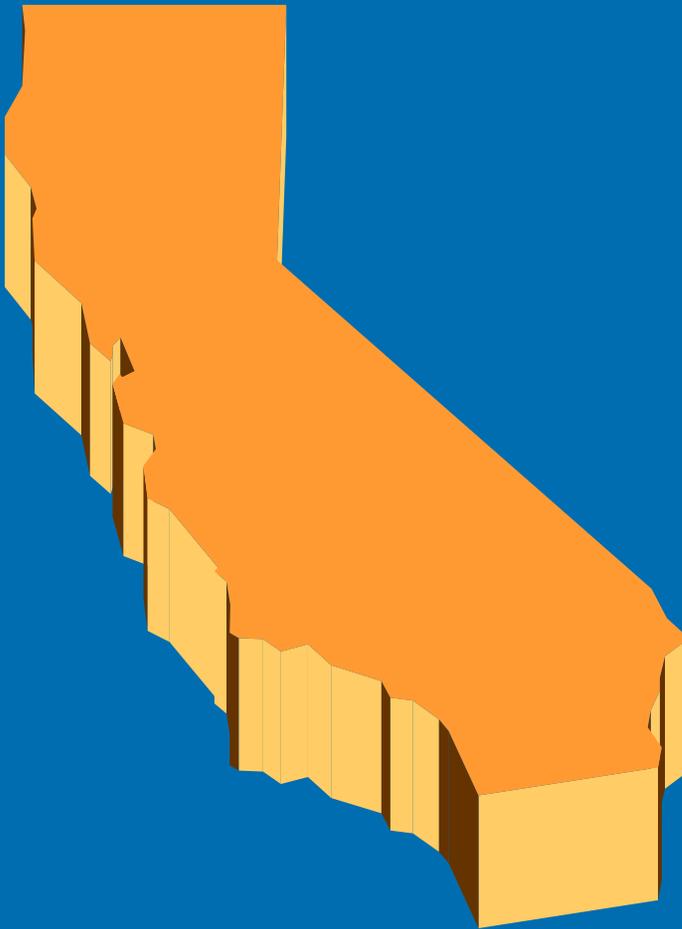
<i>Because of Cost...</i>	All CA	Income <25,000
<i>Did not obtain a preventive service</i>	17%	24%
<i>Did not visit doctor for known condition</i>	15%	20%
<i>Did not follow medical advice</i>	16%	23%

Eventual Increase in Employer Trend

	<u>Year One</u>	<u>Year Two</u>	
		Option A	Option B
		10% Trend Increase	
Per Person			
Medical Costs	\$3,000	\$3,300	\$3,300
Deductible	<u>-\$1,000</u>	<u>-\$1,000</u>	<u>-\$1,100</u>
Benefit	<u>\$2,000</u>	<u>\$2,300</u> +15%	<u>\$2,200</u> +10%



Can We Afford the Migration?



**\$8.5 Billion
Per Year**

**14,000,000 Californians in
Commercial HMOs**

X

\$609 per year = \$8,526,000,000

Per Person Per Month CA HMO Costs: \$259.25

Per Person Per Month US PPO Costs: \$310.00

Difference: \$50.75/mo → \$609/yr

Seizing the Opportunity

Financing &
Delivery
Model



Product &
Benefit
Design

Co-Insurance Based
Benefit Design



Physician Engagement in
Cost & Quality



Effectively Leveraged
Data & Info Technology

Long Term Success Requires Alignment on Direction

