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MANAGED HEALTHCARE AND INTEGRATED DELIVERY SYSTEMS:

A MODEL FOR GETTING AHEAD OF THE CHANGE CURVE

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Business Administration

by
Philip Sheridan Carney, Jr., M.D., M.P.H.

September 2002

MANAGED HEALTHCARE AND INTEGRATED DELIVERY SYSTEMS:

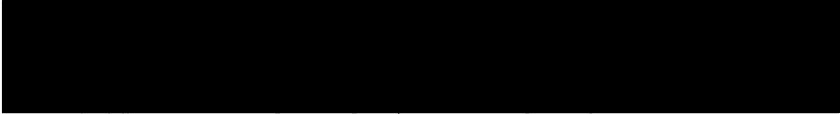
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ABSTRACT

Managed Care became the dominant model for moderating healthcare costs in the 1990's. The later half of this past decade witnessed early signs of a return to escalating premiums. Providers and consumers have reacted negatively to perceptions of health plan micro-management and restriction on choice. Hospital system consolidation and capacity reduction have given new negotiating power to inpatient providers. Medical groups in California still face widespread financial instability and have not yet consolidated to critical mass for negotiating leverage. However, consumers have rallied for choice and benefit coverage with regulators, legislators and in the media. Preferred medical groups have thus indirectly gained some ground in leveling the negotiating playing field. Since the dot.com bubble burst, employers are no longer willing to simply absorb rising healthcare costs.

In response to the pressure of global competition and a weakened economy after September 11, they have decided to pass on premium costs to the employee rather than reduce benefits. This has taken the form of Defined Benefit moving to Defined Contribution. It worked successfully for pensions and is now being applied to healthcare. Furthermore, healthcare is not a core

competency of most employers, so outsourcing is an attractive option. Along with this movement is the reduction of Medicare reimbursement via the Balanced Budget Act. HMO drug coverage is an additional cost shift challenge for the Medicare beneficiary. Options for funding to moderate premium costs are limited. Thus the healthcare marketplace has entered the first of a number of years of cost shifting. This project examines these trends and their effect on a vertically Integrated Delivery System (Kaiser Permanente) where the author is an Area Medical Director. It demonstrates the utility of the Balanced Scorecard in leading and managing high velocity change in a complex operating unit. The Balanced Scorecard is presented as a useful tool for tactical planning in addition to strategic alignment and monitoring. Finally, it offers the ability to create feedback loops for early detection of adverse impact of this cost-shifting trend on quality and access to healthcare. This concept and application of the Balanced Scorecard may have utility in other health care settings.

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CHAPTER ONE

INTRODUCTION

Healthcare becomes personal when it's about you. High quality, accessibility and affordability are part of one's expectation. What's a "decent minimum" of health care for all citizens? How do we create it--and how do we pay for it? Healthcare is complex. Advocacy, trust and confidentiality are essential to the doctor-patient relationship, but the provision of healthcare does not occur in a vacuum. Support staff, technology, an aging population, employers and regulators all have an impact. The marketplace is a relatively new arrival on the scene. It's power and influence in the past decade is unmistakable. While dynamics in the relationship between health plans, hospitals and providers may change over the next decade, marketplace power and influence remains. Leaders of healthcare organizations will be even more challenged to search for the optimal balance point on the quality, service and cost equation. The pace of change will quicken. The margin for error is slim indeed. Information overload is always a risk in the Information Age.

This paper discusses these challenges and how to deal with them in the setting of an Inland Empire Integrated System in which the author works. It emphasizes the utility of the Balanced Scorecard in organizing focus on key performance indicators while avoiding information overload. It introduces the dimension of accelerated planning in the face of reduced transition time for change. This further structures tactical planning and helps cope with increased change velocity. Finally, it reviews early implications of the trend to move from employer based Defined Benefit to Defined Contribution for healthcare coverage. By using this example to demonstrate application of the Balanced Scorecard in high velocity change environments, it seeks to position operational unit leaders to get ahead of the change curve.

Proactive posture promotes competitive advantage in the decade to come. Key decisions will need to be made on imperfect information within shorter and shorter timeframes. Experience counts but track record is the best predictor of success. This model is offered as an aid in the search for optimal balance point to provide this complex and essential service of delivering healthcare. It has been "field tested" in the real world of one vertically integrated delivery system. Insights gained may

be applicable to others. Getting ahead of the change curve is now an essential survival skill. Advantage goes to the prepared. The opinions and editorial comments in this paper are those of the author and cited sources and do not necessarily represent official views Kaiser Permanente.

CHAPTER TWO

THE HEALTHCARE SCENE

Our employer-based health care coverage system was born after World War II. A rising industrial economy plus governmental tax breaks for costs of health insurance solidified support of this model at the time. Federal and state governments became major payers of health care services in 1965 with the passage of Medicare and Medicaid legislation. This past decade has witnessed unprecedented change in healthcare. Pre-1980 healthcare was characterized by cottage industry, stability, regulatory insulation from marketplace competition and fee-for-service as the predominant reimbursement model. Accelerated healthcare costs above the rate of inflation and emerging global competition prompted employers to demand moderation in healthcare premiums. The mid-1980's saw the arrival of for-profit health plans along with Diagnostic Related Group prospective payment to hospitals by Medicare. Cost-plus reimbursement was a thing of the past. Marketplace competition became a reality. Workers' health care coverage cost auto makers more than the steel they put into their cars. Additionally, people were living

longer. The over eighty-year-old group is the fastest growing decade of the population.

Research of the prior decades bore fruit to improve peoples' lives--at a cost. Consolidation of hospitals and medical groups created the framework for health plan, hospital and physician group interactions which have characterized Southern California as a managed care trendsetter. In the early 1990's, large employers formed coalitions such as the Pacific Business Group on Healthcare (PBGH) and the California Public Employees Retirement System (CALPERS) to leverage size in negotiations with Health Plans. These groups embraced the Quality, Service and Cost challenges of Managed Care. They placed accountability for performance on Health Plans who then shifted it to providers. Insurance companies transformed themselves into Managed Care companies. They went from middle-men to actively managing resources. They assembled enrollments of large numbers of employees to drive price concessions from providers. Small groups of physicians were no match for well-funded, information rich and Wall Street driven Health Plans. Physicians who were price makers under fee-for-service became price takers in the new world of managed care. Low lying inefficiencies were wrung out of the healthcare system. But the climb

became steeper and more difficult as time went on. No finish line was visible. Quality was difficult to measure. It was assumed. Service emphasized primary care access. The sick, complex, resource intensive patient and attending physician encountered the hassle factor.

Physicians, with their careers in cottage industry, small business mentality and a culture of independence were ill-equipped to deal with Wall Street entities. Anti-trust laws prevented these independent physicians from negotiating health plan contracts as a group. They were learning by experience, but not fast enough. Creating a level playing field was out of reach in the marketplace. The first half of the 1990's saw premium price moderation via a managed cost approach to contracting on the part of Health Plans with providers. Profit-driven ethical scandals and regulatory transgressions with resultant penalties symbolized over-reaching in the name of quarterly earnings. This was not a good time for hospitals or physicians.

There is a general sense that we have now entered another era of sustained healthcare price escalation. In the last few years the demographic impact of the baby boomers has driven a rise in hospital admissions and drug utilization. Hospitals and physicians have recaptured some

of the negotiating power they lost earlier in the 1990's. The cost structure of health care is now increasing at a rate of 10-15% per year. Over the past few years, insurance companies have raised premiums to the point where they can anticipate they will more than fully cover their financial risk. They're shying away from being a risk bearing entity. There has also been a noticeable trend from closed panel (pre-set list of physicians) to high deductible Preferred Provider product (discount from pre-set list but option of increased cost sharing from provider not on list to provide choice). The jury is still out whether increased choice and cost containment are compatible or mutually exclusive. Employers are now looking to limit their financial liability for health care coverage for their employees. They saw the financial bottom line and planning advantages of defined benefits moving to defined contribution in pensions. They're now looking at the same approach for health care coverage.

Along with demographics, hospital capacity is emerging as another critical factor in driving up health care premiums. Hospital admissions have grown at the rate of 1% per year and are anticipated to grow at 2-3% per year over the next decade as Baby Boomers age. Over the past decade, total inpatient bed capacity has decreased by

20% as Managed Care wrung out "inefficiencies" in the system. Average daily hospital census, another measure of efficiency, decreased from 75% to 58% as the average length of stay (LOS) decreased along with the admission rate. Discharge rates (data format for hospital admissions) were cut in half from 1980 to 1999⁽¹⁾.

Preferred Provider Organization (PPO) and Point of Service (POS) products come with looser restrictions on utilization. While they have become more popular in the past few years, their inherent increased cost structure will drive up premiums and some employers back to more tightly managed care models in the interest of cost containment. Demographics are anticipated to raise occupancy rates to 65% in five years. A hospital's peak sustainable capacity is about 75-80% in view of surge capacity needs and seasonality (e.g. flu)⁽²⁾. Additionally, hospital bed capacity in this country is not matched with

¹ Todd Richter, "The Healthcare marketplace, 2002," presentation at CMA 5th Annual Leadership Academy, "Money, Power and Medicine - Turning Adversity into Opportunity" (Nov 16, 2001, La Quinta, CA)

² Todd Richter, "The Healthcare Marketplace, 2002," presentation at CMA 5th Annual Leadership Academy, "Money, Power and Medicine - Turning Adversity into Opportunity" (Nov 16, 2001, La Quinta, CA)

geographic needs based on population shifts and aging. In the past, hospitals granted financial concessions to Health Plans in contracting to avoid loss of market share and shrinking hospital census. This is no longer the case. Pricing will follow capacity as supply follows demand.

Hospital capacity also needs to be defined in terms of "staffed beds." California has one of the lowest ratio of nurses to population in the country. Additionally, the average age of an RN in California is 47. It is even higher for specialized nurses (e.g. OR RNs). The latest State-mandated hospital RN staffing ratios will exacerbate this issue by requiring more staff at a time when the pipeline of new RN grads is lean. No quick fix is on the horizon⁽³⁾. Recent proposals to expand the number of nursing school places will help. Former dot.com workers are now considering careers in the healthcare field as a more stable option. But it will take a decade to re-balance this part of the supply-demand equation. Pharmacy costs continue their relentless rise (17% last

³ Jeffery C. Bauer, Ph.D., "Workforce Trends," presentation at CMA 5th Annual Leadership Academy, "Money, Power and Medicine - Turning Adversity into Opportunity" (Nov 16, 2001, La Quinta, CA)

year). Unless legislators intervene, there is no end in sight. Industry consolidation combined with the synergy of computers and biotechnology firms for research have yielded some significant therapeutic advances. However, a fair amount of the cost of this progress represents "me-too" drugs of limited therapeutic advantage.

Additionally, the pharmaceutical companies spend more on marketing than research. Direct to consumer advertising has been particularly successful in the past few years. Advertising budgets for this seem to double each year. Pharmaceutical companies are extremely well capitalized (3 Trillion) as opposed to the delivery system (300 Million book value). They have a long history of artful, well funded lobbying. Patent rights protect market share. Insurance companies are shying away from a risk bearing entity role. The Patient Bill of Rights is essentially about their legal liability for being involved in health care decisions. With its emphasis on quarterly earnings, Wall Street is entirely too short sighted to advance long term health policy.

It will take legislative intervention to change this marketplace dynamic. 50% of the health care dollar is spent by Federal and State government (Medicare and Medicaid). Trying to predict the next five to ten years

must take this into account. It would appear to be a relatively benign environment. Following the tightening up of Managed Care on the commercial side, the government started reducing payments in 1997. The cross-subsidy of commercial members by Medicare ceased. Some hospitals and medical groups became financially insolvent. Given the bankruptcy of an additional number of providers in Skilled Nursing Facilities and Home Health after the Balanced Budget Act (BBA) of 1997, Washington's appetite for further cuts is limited. Additionally, regulatory mandates usually add to the cost structure and some times generate unintended consequences. Witness the recent Health Insurance Portability and Privacy Act (HIPPA) efforts to protect confidentiality while creating barriers to access to care for patients. The appointment of Tommy Thompson, formerly representing hospitals, as head administrator of Center for Medicare and Medicaid Services (CMS) is another hopeful sign. HMOs have pulled out of less financially desirable counties (Federal government reimburses Medicare by County) and reduced drug coverage in an effort to maintain financial margins in face of reduced reimbursement via BBA.

The rising activism of Medicare patients in the face of reduced HMO drug coverage may be a catalyst for change.

Globally, it will take more money to stabilize the system. However, evaporation of budget surplus from energy crisis in California and weakening economy after September 11, 2001, at the Federal level, constrain any possible option for restoring budget cuts at the Federal level. The dilemma is transparent to all in Sacramento and in Washington, D.C.

CHAPTER THREE

THE AMERICAN PUBLIC AND MANAGED CARE

Managed Care was successful in controlling costs in the first half of the 1990's. Increasing costs and the public's backlash against Managed Care have raised serious questions in the minds of some as to whether this is a sustainable model for the future. Expectations of the consumer extend beyond traditional choice. As many out of pocket dollars are spent by the modern consumer on alternative care as are spent on mainstream health coverage. Cultural expectations about healthcare are largely driven by the economic status of country. This ranges from survival (i.e., reduced mortality) in third world nations to reductions in morbidity, increased functionality, feeling good and, lastly, looking good. The volume of cosmetic surgery in the United States is testimony to our economic strength and how far our expectations on healthcare have come.

A major problem is that there has been no finish line defined for quality and cost in healthcare. We Americans feel the more technology, the better--and everyone should have access to it. We believe there should be a solution

for every problem. Other countries developed more nationalistic, and, at times, socialistic ways of dealing with the problem of allocating the limited resource of healthcare coverage. Some allow part time fee-for-service, private practice models. Others officially prohibit it but underground economies develop for priority access or obtain a wider range of services. Barters and bribes may be accepted by individuals and society. More recently, the British have experimented with market reforms in their National Health Service. Several South American countries are now looking at US Managed Care for solutions to some of their own quality/service/cost dilemmas. But ultimately resources and revenues are limited. You can't spend the same dollar twice. Healthcare currently takes up 14-15% of our Gross Domestic Product. Other countries have a lower percentage for healthcare but have tolerance for backlogs of non emergency care and lower expectations which would be unacceptable to Americans. Priorities and tradeoffs must be articulated. Decisions must be made.

A fundamental dilemma for Americans is the disconnect between unlimited expectations and limited resources. We can't have it both ways. This is particularly prominent in healthcare where the prospect of explicit rationing (the "R" word) of resources raises ethical uneasiness in the

populace and political risk for policy makers. But somebody needs to do this difficult job. Who's going to tell people they can't have what they want. This also begs a definition of a "decent minimum" of healthcare.

Government and the public are currently disenchanted with the ability of Managed Care to continue in this role.

Retreat from costs in the name of choice to manage public backlash may accelerate the rise in premiums.

Politicians talk a lot about health care but rarely make bold moves to do something about the problems. They can buy votes by raising health care costs and lose votes by lowering health care costs (a.k.a. reduce benefits). During lean years, it's just a question of who gets the cuts--hospitals or physicians. Recent provider financial instability limits this strategy. The budget deficit and softening economy clearly constrains choices on the upside. Politicians are more comfortable sitting on the periphery and criticizing. Indeed, the ultimate victory of the ill fated Clinton health reform initiative may not be "Harry and Louise" commercials but, rather, the arrival of Managed Care on the scene in the middle "hot seat" allocating resources and, in the process, containing costs. Even faced with rising ranks of uninsured, there is little support in Washington for a National Health

Insurance Program. Diversity and Federalism traditions in the U.S. also resist big Government intrusion into healthcare.

Employers are also now prefer an arm's length relationship for themselves in providing healthcare in contrast to the paternalism of the past. They see the Managed Care backlash aiming for them if they play a more active role in resource allocation to control costs. Someone has to say "no" but they want someone else. The Patient Bill of Rights presents additional legal risks for them if they become too involved in healthcare decisions. The pockets of the Fortune 500 are deeper than the likes of the top five Health Plans. Life time employment is no longer assumed in the face of global competition. Corporations are retrenching into their core competencies. Providing healthcare for their employees is not one of them. Costs out of control make budgeting difficult. Healthcare is personal, complicated, emotional and litigious. It's not easy. Corporate America has recently completed a successful transition in Pension Plans from Defined Benefit to Defined Contribution. Employers contribute some money and offer informed choices. They are neither parent or middle man. The parallel in health care is unmistakable. They want out of the "hot seat."

Insurance companies also want out. Short term responses have been to pull out of unprofitable markets and downsize. There is still another round of consolidation to go, yielding two or three Plans in California. They want to return to strictly insurance role of the past. They'll predict cost and charge premiums to cover. They're moving onto the sidelines of influencing the delivery of healthcare. Providers, especially in California, built networks and delivery systems to take on this role and manage risk. Physicians, by virtue of their education, training, code of ethics and regulatory oversight, might be viewed as best able to take on this role. However, physicians are culturally lone wolves and do not run in packs. They frequently lack organizational structure and function to produce state of the art management. Investing in the organization is viewed by many as administrative waste. Being the bad guy who says "no" runs against the grain of their culture as patient advocates.

Enter the consumer. People want more control over their health care decisions. Unfortunately, some consumers are rational and plan ahead. Others are impulsive and poor planners. Thus the stage is set for legislative gridlock, transformation of for-profit HMOs back to pure insurance

companies, employer retreat from health care decisions, provider cultural reluctance and inability to financially manage the inherent risk. The consumer will be in the "hot seat" over the next decade by design and by default. With responsibility comes accountability. Rising ranks of the uninsured and softening economy will accelerate trends. Increased consumer participation in cost will overcome the illusion of the five dollar co-pay as cost of care. But how will \$1500-2500 copay deductibles fit with ability of consumers to cover unforeseen expenses? Will "underinsured" migrate to the ranks of the functionally "uninsured." Where is the safety net for these circumstances. Increased cost sharing will be inevitable in the next decade. The tolerance and ability of consumers to handle this role will determine their ultimate degree of control in both decision and design in our healthcare system. Consumers, careful what you ask for.⁽⁴⁾

⁴ James C. Robinson, Ph.D., "The End of Managed Care," in JAMA, Vol 285 No 20.

CHAPTER FOUR
KAISER PERMANENTE AND MANAGED
CARE

Kaiser Permanente is the largest private provider of healthcare in the world. The organization serves over eight million members in 11 states and the District of Columbia. Over six million of these members reside in California. The Inland Empire Service Area has over 570,000 members currently. The concept of comprehensive pre-paid health care, which has been the traditional model of Kaiser Permanente, originated with Dr. Sidney Garfield, a young surgeon who had opened an office in Indio, California in 1935. He was receiving emergencies coming off the construction site when the Parker Dam was being built on the Colorado River to improve the water supply to Los Angeles. He told Henry Kaiser and four other contractors that if they contributed \$0.10 daily for each of the five thousand workers at the construction site, he could enlarge his facility, hire more help, put in six hospital beds, and give much better care. Kaiser and the others agreed. The plan was put into effect and proved very successful.

During 1936-1938, Mr. Kaiser had the contract to build the Grand Coulee Dam in Washington State with about forty thousand people living in the wilderness. Again, he counted on Dr. Garfield to establish prepaid care. A hospital was built and staffed with doctors and nurses. The experiment proved to be a huge success. In December, 1941, the United States entered World War II. Henry Kaiser had the contract to build "liberty ships" for the war effort in Richmond and Fontana, California. One hundred thousand workers were involved. Again, Dr. Garfield set up a successful prepaid medical program. In 1943, a small pre-paid medical group along with "Southern Permanente Hospital" were established to offer "Health Protection within the Financial Reach of All." This was the forerunner of our current facility at Fontana Medical Center. In 1953, the Southern California Permanente Medical Group officially came into being with its own Board of Directors. Their slogan at that time was "How can we give good medical care at a reasonable price?." ⁽⁵⁾ Out of the 1995 Kaiser Permanente meeting at Lake Tahoe was

⁵ Raymond Marcus, M.D., "The Early Years," in Southern California Permanente Medical Group SCPMG Presentation at LA Medical Center, 7/13/99

born the Medical Service Agreement which defines roles for Kaiser Foundation Health Plan and the Permanente Medical Groups. This agreement has stood the test of time intact to this day. It codifies the medical management partnership which has become a core competency of Kaiser Permanente.

Linking the delivery of care with the financing of care is the key. Separate but cooperating entities function as a vertically (people plus bricks and mortar as opposed to virtual, i.e. contracts) Integrated Delivery System. Kaiser Foundation Health Plan is a national, non-profit corporation which contracts employer groups and individuals for comprehensive, predominantly pre-paid health care. This is provided in California through mutually exclusive contracts with the Southern California Permanente Medical Group in Southern California and The Permanente Medical Group in Northern California. Twenty seven non-profit community hospitals are currently operated by Health Plan in California. The Permanente Medical Groups are regional and independent multi-specialty medical groups which do their own physician recruitment and staffing. In 1995, Kaiser Permanente celebrated its 50th Anniversary.

1996-1998 were soul searching years for Kaiser Permanente. Competition constrained KP growth. Nurse strikes and financial losses from operations forced the organization to reflect on its identity and rethink its strategy. Health Plan and Medical Group relationships were severely strained. Health Plan contemplated outsourcing and centralized two Regions into one Division in California. Health Plan highlighted frustration in trying to make decisions with 11 Regional Medical Groups. The Permanente physicians disagreed with both outsourcing and centralization but acknowledged the need to present one face and one voice for key decisions with Health Plan. Thus was born the Federation of Permanente Medical Groups which was delegated certain powers by all Permanente Medical Groups. All other authority and control not specifically delegated to the Federation was retained by the Regional Groups. Permanente Medicine became better defined. Customized, coordinated care in the context of a not-for-profit Health Plan brought to the forefront expectations of quality medicine, Permanente-Patient relationship and resource management. The structure of Permanente Medicine emphasized group responsibility, self-governance and self-management. Underperforming Regions were sold or shut down.

The need to refocus on core operations under financial stress brought with it a renewed cooperation by Health Plan and the Permanente Medical Groups. A three year turn around strategy was successful. The program is now stronger than ever. A recent study by the University of California compared Kaiser Permanente with the British National Health Service. The editor of the British Medical Journal, ⁽⁶⁾ in which the article appeared, commented that "Both have similar inputs but Kaiser has much better performance." Kaiser Foundation Health Plan, with a current enrollment of 8.2 million members, now appreciates the benefit of a large, stable medical group for the provision of services. The Medical Groups understand more clearly the business imperative of service and cost in the quality/service/cost equation.

Current challenges now relate to the external pressures of rising healthcare costs and employer limits on what they are willing and able to pay for coverage. The recent defined benefit to defined contribution trend is reflective of this. Physician practice patterns will

⁶ Richard Feachem, "Getting More for Their Dollar: A Comparison of the NHS with California's Kaiser Permanente," British Medical Journal (Jan 19, 2002).

change in Kaiser Permanente with the arrival of the electronic medical record over the next few years. This sets the stage for national linkage of our information. Non profit Kaiser Permanente will also be challenged to expand capacity over the next decade in addition to seismic hospital rebuilds. Our organization does not have access to Wall Street capital as do for profit competitors. Kaiser Permanente has been very conservative on debt (1 billion on 18 billion annual revenues). A combination of equity and debt may be necessary to meet capacity for growth over the next decade.

The Kaiser Permanente Medical Center in Fontana serves 370,000 Members in San Bernardino and adjacent Los Angeles and Riverside counties. It is the second largest of eleven Medical Center Areas in Southern California. A four hundred twenty five licensed bed hospital and clinic at Fontana are complemented by ten outlying primary care and mental health clinics. The Medical Center Administrative Team consists of the Area Medical Director (author), Medical Group Administrator and Service Area Manager. This is the leadership group for oversight of the operating unit and local decision making. A sister facility in Riverside completes the Inland Empire Service Area delivery system. Reporting relationships are defined

for each member with Regional and Divisional Offices in Pasadena and Oakland. The Inland Empire will be a major growth center for Southern California over the next decade. Managing the quality/service/cost challenge is accomplished within the context of the medical management partnership.

Healthcare is complex. It's personal. Regulatory and ethical considerations plus managing independent minded professionals add to the challenge. Competition and consumerism raise the bar on performance expectations. Managing and leading in the next decade will not be easy. Knowing the outside world, knowing your organization and knowing yourself will not be enough. Things are moving too fast.

CHAPTER FIVE

THE BALANCE SCORECARD

Leading and managing healthcare organizations in the 21st century will require creating information out of data, motivating people to perform to their full potential, reading trends early and planning wisely. Healthcare is ultimately about people. Aligning everyone to focus on goals is key. Operational planning has traditionally been a year to year event. Strategic planning in prior, more stable, times looked out over a 10 year horizon. In the past few years it has become clear that operational performance has little margin for error and sets the stage for possibilities in strategic planning. Strategic planning horizons now describe three year to five year plans. Thus, tactical planning merges into strategic planning within the complex environment of healthcare. So how is one to make sense out of this in order to manage and lead?

Enter the Balanced Scorecard.⁽⁷⁾ In their book, The Balanced Score Card: Translating Strategy Into Action,

⁷ Robert S. Kaplan and David P. Norton, "The Balanced Scorecard," Harvard Business School Press (1996).

Kaplan and Norton look at four perspectives to be balanced for optimal outcomes. Financial, customer, learning and growth, and internal business metrics not only monitor performance but articulate a company's strategy. Using the Balanced Score Card becomes a method of management. The Balanced Scorecard approach from the bottom up after senior management communicates strategic objectives and results to all employees. In healthcare, this integrated Scorecard lists quality clinical outcomes and the business into a single platform (Appendix p 102). This has been successfully used in a number of other sectors in our economy. It's beginning to make inroads into healthcare. Maintaining priorities and focus in the face of information overload is the challenge. Transforming information from data isn't enough. The Information Age has placed human resources front and center for competitive advantage. People are, in one respect, a tangible asset which shows up as Full Time Equivalents on a budget balance sheet. However, their most important contribution to healthcare organizations is in their performance for competitive edge. This performance makes or breaks a successful year for both patients and finance. Healthcare is a field with characteristically low margins. The most expensive instrument a physician has ever held is

the ball point pen. He or she creates expenditures of 80 cents on each dollar in the course of giving care. Eighty percent of healthcare budgets is labor. People count. They spell the difference between success and failure.

How to align people to focus on goals and perform sets the stage for competitive edge. The balanced scorecard links vision and strategy. It also measures performance. It's the tool for clarity out of chaos. Information overload is a risk these days. Data is everywhere. A balanced scorecard needs to be constructed carefully. Too many goals and metrics blur focus. The scorecard reflects not only an organization's yearly operating performance but also strategy for the future. It serves as a framework for organizational change and cultural shift. The executive team starts to construct the balanced scorecard by getting key players in the same room for a discussion on vision and strategy. Financial managers, Human Resources personnel, IT managers and representatives of key business units all play a role. Kaplan and Norton, in their book "The Strategy Focused

Organization", ⁽⁸⁾ delineate five principles to becoming a strategy focused organization. First, mobilize change via executive leadership. This relates to both governance and strategic management. Secondly, make strategy a continuous process. Become a strategic learning organization by creating analytical and information systems. Link strategy with budgets. Third, cultivate strategic awareness via personal scorecards and balanced paychecks. This makes strategy part of everyone's daily job. Fourth, align the organization to the strategy. This means promoting business unit synergies that support overarching strategy. Lastly, translate the strategy into the balanced scorecard.

Putting these principles into practice for a successful balanced scorecard requires leaders to "unfreeze" the organization to arrive at alignment with the vision. The balanced scorecard is actually a change process rather than a metric process. Collaboration vs competition between operating units must be dealt with.

⁸ Robert S. Kaplan and David P. Norton, "The Strategy Focused Organization: How Balanced Scorecard Companies Thrive in the New Business Environment," Harvard Business School Press (2001).

Conscious decisions for the amount of money at risk will need to be identified. Trade off is inevitable. For example, operating units used to competition in performance metrics may find it difficult to take the risk to help other units. At risk compensation may be an incentive for some to cut corners or exhibit dysfunctional behavior. The law of unintended consequences is always at work in complex environments. Leaders play a key role in managing these dilemmas. By highlighting cross-functional accountability as a strategic theme, executives promote teamwork.

Lastly, and most importantly, Kaplan and Norton emphasize that using the balanced scorecard effectively involves a change in culture. After strategy is clarified, translating this into operational terms is the next step. Making this relevant to the front line staff involves incorporating finance, the customer, internal processes and organizational learning. The balanced scorecard is not about "just one thing." It is about organizing priorities for strategy alignment. Yet, too many metrics confuse. Human can focus only on a few things at a time. This is especially true in the complex world of healthcare. Thus, creating order and clarity out of chaos and information overload puts the spotlight on choosing metrics carefully

to reflect both strategic planning and operational performance.

One's track record on strategy depends on accurately identifying cause and effect relationships. A good balanced scorecard describe the organization's strategy. Measurement helps clarify vague concepts. It is used not to control but to communicate. What's needed is a balance of outcome measures (e.g. financial performance and customer satisfaction) and process drivers (internal processes plus learning). Business unit strategies need to be set up to integrate overall organizational goals and mission. Internal customer relationships are facilitated by scorecards for shared services units. Ultimately, the goal is strategy alignment from top to bottom. Executives communicate corporate strategy to business units via scorecard. Shared metrics promote the search for integration and synergy between business units and shared services. This formalizes the need for cooperation rather than competition. Paychecks reflecting Balanced Scorecard performance, personal goal alignment and education focus the workforce on strategy.

The process starts top down but success depends on bottom up. Strategy needs be internalized by front line staff to execute it successfully. Every communication

vehicle must be used. Under communication is the risk. Change is ever present. Strategy is a continual process. Thresh-hold, target and stretch metrics link strategy with performance on the balanced scorecard. An organization with the capacity to learn tests the causal linkage between metrics and business strategy by critique and dynamic simulation to refine the balanced scorecard. Closing the gap on performance may require revised resource allocation in addition to new products and services. Joint venture and geographic expansion may also be included. Certain points are key for the relationship between strategic planning and the balanced scorecard. They include target setting for breakthrough performance, identifying initiatives and capital projects to achieve targets, withdrawing from non strategic initiatives and investments, designating financial and non-financial short term targets and periodic operational review to assess progress on closing the gap.

Vulnerabilities are another key point to identify ahead of time. Lack of senior management commitment stands out. Optimal balanced scorecard performance is not about one individual. It's a group effort. Teamwork counts. This means communicating, building a critical mass of support and networking throughout the organization. Perseverance

is required. Paralysis of analysis has killed many a good project. Creation and implementation of a Balanced Scorecard is not a "project." It is a symbol and a reality of transformational change. Consultants without cultural sensitivity and people skills will be not only ineffective but detrimental. Setting expectations for major change and commitment spell the difference between success and failure. Senior management must take on this challenge. Finally, the balanced scorecard is not just about finance. It is about optimizing organizational performance. It reflects both short term and long term priorities.

Healthcare has undergone a sea change over the past two decades. The industry has moved from physician centered toward more patient centered. Marketplace intrusion has focused emphasis on the financial bottom line. The connection between clinical outcomes and financial performance, however, remains in place. Quality counts but resources are limited. CEOs and COOs actually control a small component of a healthcare organization's financial performance. The majority is dependant upon clinical practice patterns and not traditional business processes. Physicians actually deliver the care. With their pen and order sheet, they determine costs as they deliver care. Medicine is a team sport in 2002 as

mentioned above. Eighty percent of most healthcare organization budgets are labor. While this highly regulated and highly educated workforce can profoundly influence financial performance, their primary motivator is patient care. To improve financial performance, senior administrative leaders must engage and align physicians. Otherwise the financial performance gap will persist. The gap can be viewed as conflict or opportunity.

Physician executives are positioned to bridge this gap by explaining the value proposition to both sides. Administrators and clinicians need to view a common vision as part of the same team. Performance management systems and the Balanced Scorecard need to create a common platform for all to measure and assess performance. Physicians need information on practice patterns so they can become more efficient in their practice. Practice support systems need to be created to help with this goal. Resource allocation for this should be carefully chosen to reflect physician commitment and feasibility of positive outcome.

The Balanced Scorecard is a tool to link the practice of medicine with the business of medicine. It can focus and align all disciplines around a strategic agenda of quality, service and cost. It's also used for aligning

goals, identifying gaps and measuring progress. Finally it serves as an communication and education tool. A balanced scorecard identifies priorities and provides focus for each front line worker. Parsimony becomes the order of the day. Front line health care personnel work in already complex environments. A specific department staff member can probably remember a maximum of three aspects of the Balanced Score card for individual performance in the course of their work day. Periodic scorecard overviews supplement their contribution to performance by building organizational identity. Obtaining buy-in from front line staff is the ultimate payoff for the Balanced Scorecard. High level strategic planning with good mission, strategy and objectives linkage sits on the shelf unless it translates into action on the front lines. Ownership and accountability for each aspect of the balanced scorecard must be assigned. Otherwise the pure complexity of the work environment will diffuse responsibility.

Parsimony is the first rule for Balanced Scorecard development in the complex world of healthcare. Ideally, somewhere between six and twelve key metrics need to be chosen for a single integrated and consolidated reference source. Subsets may be available for specialized interest groups. How these metrics are chosen is critical. Quality,

service and cost must be represented for the marketplace. Certain regulatory parameters may be chosen if they are viewed as high priority. The limit of six to twelve metrics must be respected at all costs. Hundreds of metrics are available in the Information Age and more are appearing each year as computers become more sophisticated. Secondly, leveraging Information Technology will enable more sophisticated ongoing analysis of performance. Timely data and information is key. Results that are six to twelve months old are rarely actionable. Timely information helps move the organization from crisis to early pattern recognition for response, and, finally, to proactive planning. Coupled with enhanced communication and educational opportunities, this timely reporting sets the stage for organizational learning as a third stage of using the Balanced Scorecard as a transformation tool. Drill downs, modeling and further analysis uncover new strategies to improve clinical quality and financial performance.

Thus clinicians learn about the world of the administrators and administrators understand better the world of clinical practice. Success depends upon bridging this gap between clinical and financial drivers in healthcare. The physician executive is a human bridge who

can communicate the value proposition to both groups and link all into a common strategic vision. Thus the integrated Balanced Scorecard becomes both the brain and the heart of organizational performance. The scorecard also becomes a diagnostic and treatment tool plus preventive measures for the organization as patient. This is the win-win of practice of medicine partnering with the business of medicine in healthcare for 2002 and beyond.

Intangible assets are of inestimable value in healthcare. Clinical quality depends in large part on the expertise, clinical judgment and commitment of the healthcare team. Financial margins are inherently thin in healthcare. Letting one's foot up a little on the gas pedal can stall the engine. Staff efforts on the bottom line mean the difference between black ink and red ink on the ledger. The balanced scorecard provides a framework for translating strategic objectives into meaningful performance measures and creates feedback loops for assessment and learning. Quarterly earnings reports are short sighted financial measures and fail to focus on areas of interest for the clinicians. They de-motivate over time. Opportunities to develop customer and patient loyalty for value over a lifetime are missed.

Balance is essential. Metrics chosen must be at least partially within the control of those expected to manage and contribute. This encourages behavior change which ultimately transforms the organization. A mixture of process and outcome measures is usually chosen. Outcome measurement is called a lagging indicator because it measures what has happened (revenue increased, costs decreased, service satisfaction survey increased or decreased). Driver measurements are leading indicators because they measure the capabilities of building capabilities to improve performance. Examples are per cent compliance with care pathways, per cent application of preventive health measure to population served, exit surveys of care experience, and per cent of management trained in team building skills. The optimum scorecard lists a limited mixture of drivers and outcome measures which have a cause and effect relationship to performance. As an example, a major driver for cost of care is the inpatient utilization rate. This is a parameter within control of clinicians and directly links to financial performance. Reduction of length of stay via care pathways is an actionable process measure which leads to reduced bed days per thousand members as an outcome. Highly satisfied patients lead to stronger bonding, reduced

member turnover. This saves some replacement new member entry costs. Expanding market share via this performance metric creates negotiating power and leverage with purchasers which may reflect premium price and, ultimately, financial margins.

A number of steps are involved in building the Balanced Scorecard: 1) Identify the business case (clinical, operational and financial), 2)select strategies (effectiveness, cost, marketing), 3)designate tactical objectives (human resources, internal processes, customers and financial), 4)define performance measurements (outcome and driver with cause-effect relationships), 5)identify data sources (and limitations) for calculating the measurements (existing and new), 6)create a data warehouse, integrate disparate data via carefully selected information technology, 7)create the balanced scorecard report using a limited number of key metrics as described above (including data extraction and measurement-calculation routines), 8)actively manage the strategy via the balanced scorecard (highlight achievements and recognize gaps), and 9)refine tactical objectives in support of the strategy (refine or add as indicated). The result is that health care organizations align in the process of developing the balanced scorecard

and assess their progress toward common strategy and vision by measuring performance against pre-established goals. This process forces leaders to derive clear, meaningful and actionable measures from complex constructs. It displays objective evidence of contributions and progress toward the goal. The internal business measures can be focused to the department level. For example, decreased OR turnover promotes efficiency with financial impact in a very expensive environment. This focus on a limited number of measurable activities reinforces priorities and maintains focus on the "main things." It also communicates contributions to wider audiences.

The emphasis on balance promotes a 360 degree look at organizational performance. This is particularly important for independent professionals in the complex world of healthcare. Both the process and outcome of balanced scorecard creation, with emphasis on Internal quality processes, patient and staff satisfaction, and information capabilities--not just financial performance alone--show linkage between activities and results plus bridge the gap between clinician and administrator. Both the journey and the destination can be win-win. Value-added has gained traction in the marketplace with purchasers and patients.

High performance on quality, service and cost are the goals for success. Organizations must decide which areas to emphasize and reflect this on the balanced scorecard. Volume as a surrogate for quality, highly satisfied as surrogate for bonding strength and on-line multi-hospital system purchasing cooperatives are examples of emphasis areas which can be translated into metrics on a balanced scorecard. Tracking value delivered by a healthcare organization involves envisioning a consumer's balanced scorecard in quality of life terms. Ultimately, quality is outcomes of care, not merely volume, structure or processes. Until accurate, reliable and mutually agreed upon acuity indexing is widely implemented, however, surrogate measures for quality must be chosen. In patient satisfaction, perception is reality. Quality of Life surveys measure patient functioning (e.g. SF-36). They can enhance a balanced scorecard by adding an outcome dimension of importance to the patient and/or family. Incorporating customer insights, refocusing internal operations, re energizing internal stakeholders, enhancing customer acquisition efforts, and strengthening customer relations promote loyalty and returns of value. These give the balanced scorecard a dynamic dimension beyond monitoring metrics and measuring gaps. Thus the

organization uses this tool to both promise and deliver value.

CHAPTER SIX
THE BALANCED SCORECARD AND
KAISER PERMANENTE

As an Integrated Delivery System, leaders in Kaiser Permanente uses a balanced scorecard which includes a variety of metrics to assess Health Plan, Hospital and Medical Group performance. Actual composition of the Scorecard may vary, depending upon leadership and management responsibility and accountability. Performance metrics may be influenced by external benchmarks, internal comparisons and local historical trends. The following categories are used for general oversight of operating units:

Growth

The first metric, Growth, is linked to revenue by business line (Commercial, Medi-Care, Medi-Cal and Individual) and varies by geographic delivery unit. Accurate forecasting is a difficult task. Budgets are built on anticipated revenue and services are modified according to significant service line mix. Open enrollment in October, membership effective in January and physician recruitment in July create timeline disconnects which result in an element of contingency planning from year to

year. Marketing and enrollment functions are coordinated at a Regional level. At the operating unit level, planning for growth involves resource allocation decisions, capacity assessment and delivery system process change which may involve significant lead time. Annual operating budgets may overlap capital investment funding to plan in a coordinated fashion. The monthly growth numbers on the balanced scorecard serve as an operational metric for tracking supply-demand issues.

Quality

Quality is an intrinsic metric of health care performance on the Balanced Scorecard. For many years the US health care system delegated quality oversight to physicians in the form of peer review. The Clinical-Pathological Conference was, and still is, a time-honored way to exert formal peer review of individual patient cases. The New England Journal of Medicine to this day highlights its CPC section in alternate issues. The American College of Surgeons played a key role in initiating review of surgical indications and treatment for patients which was the forerunner of the Joint Commission on Healthcare Organizations. JCAHO has evolved its quality focus from individual patients in its early

days to individual departmental studies in the 1970's to systems analysis and improvement in the 1980's. This was followed in the early 1990's by the establishment of oversight Quality Assurance committees ("find the bad apple" approach). More recently, Quality Assurance has given way to Quality Improvement, which emphasizes a systems approach to quality performance. The supposition is that most errors are the result of human beings interacting with a flawed or sub-optimal system. Only occasionally is the individual solely at fault.

The advent of marketplace medicine drove change initiatives ahead of traditional regulatory approaches. The National Committee on Quality Assurance (NCQA) focused on Health Plan performance and accountability (as opposed to individual physician and hospital). Health Employer Data Information Set (HEDIS) metrics became mainstream for Health Plans to submit for review and periodic inspection for NCQA accreditation. Large employer consortiums appeared, like the Pacific Business Group on Healthcare (PBGH--3 million covered lives), and governmental purchasers, like California Public Employees Retirement System (CALPERS--1.2 million covered lives and largest purchaser of healthcare after the Federal Government). They required NCQA accreditation to be considered on their

short listed of recommended and offered health plans. These market driven initiatives became mandatory metrics on the balanced scorecard. They include preventive screenings, childhood immunizations, mammography and pap screenings. Beta-Blockers after heart attack, appropriate antibiotic usage for middle ear infection, depression diagnosis and treatment, prenatal and post-partum care, management of chronic diseases such as diabetes and hypertension, and smoking cessation. Disease State Management matured to Population Management with stratification of at-risk populations for an epidemiological approach to chronic disease monitoring and treatment. Kaiser Permanente also monitors a large number of additional Clinical Strategic Goals, like colo-rectal cancer screening and hypertension control.

Finally, coalitions of large commercial and governmental purchasers came together to create marketplace patient safety initiatives in response to the Institute of Medicine's two reports. The first cited the incidence of medical errors, which has been downscaled in subsequent peer review journals but still remains a significant challenge for the future. The second report highlights lack of communication and coordination in the present healthcare system. Information technology usage

and evidence-based guidelines are emphasized plus failure to systematically record and report outcomes. The analogy with airline safety is referenced. The Leapfrog Initiative⁽⁹⁾ was created by a group of large employer coalitions and consumer networks on a national level. It focus on three main issues for improving patient safety: implementing computerized physician order entry systems; channeling complex surgical patients to institutions above a threshold procedure volume as surrogate for quality, and profiling hospitals who staff (and who don't) intensive care units with doctors formally trained in critical care medicine. Hospital self reporting is verified and placed on a website by Leapfrog for consumer review.

Healthcare has lagged behind other industries in quality measurement. Complexity, a fragmented delivery system, and historic lack of statistically valid outcome data for clinical subsets are part of the explanation. The physician-driven, insular culture has been one of individualism and autonomy in decision-making, rather than a multidisciplinary, team-oriented culture that values the

⁹ Dag mona Sarudi, "The Leapfrog Effect," Hospital and Health System Networks (May 2001) 32-36.

best skills and experience available. Flexible Information systems with open architecture are necessary to provide the kinds of data that are essential to understanding quality. We all await the Electronic Medical Record. This will enable ongoing monitoring and improvement with credible information believed by the critical mass necessary to make change happen. The current legal environment discourages information sharing in an open and supportive way. The no-fault reporting model of the airline industry has been used as a template for the California Medical Association's Medical Error Bill. If a no fault environment can be defined for system errors, the stage will be set for accelerated improvement.

Currently, in the Kaiser Permanente integrated delivery system, the quality metric on the Balanced Scorecard is represented by the Health Employer Data Information Set (HEDIS) categories listed above plus internal KP population specific initiatives on Asthma, Diabetes, Congestive Heart Failure and Coronary Artery Disease. This results in a quality subset of about eight metrics on a scorecard. Additional measures are tracked at interdisciplinary and departmental levels plus clinical strategic goal performance via a separate tracking system. Medical Center performance is then rolled up at a Regional

level, which is reported to National Commission on Quality Assurance (NCQA) for Health Plan performance. Important points to emphasize under the quality section of the Balanced Scorecard are systems approach, regulatory and marketplace drivers, plus cutting edge initiatives such as Leapfrog. Keeping quality measures down to a reasonable number for oversight will be a challenge. Process metrics will give way to outcome results. Patient and consumer quality of life measurements will become more sophisticated and prominent in the quality section of future Balanced Scorecards.

Service

The age of consumerism is upon us. We are moving from a provider-centric to a patient-centric system. Market forces exerted via health plans have impacted this evolution but not the ultimate direction. The health care system in the old provider-centric world emphasized technical performance and quality via peer review as described above. Patient satisfaction was an afterthought. Supply-demand balance and traditional, paternalistic relationship between physicians and patients promoted passive acceptance of the system by the patient. The appearance of competitive market forces in the private,

commercial, employer-based insurance coverage system of the United States plus changes in lifestyles via fast food drive-ins, cell phones and the computer ushered in the Information Age as mainstream for the person on the street. Competition fostered health plans searching for a competitive niche. As cost competition hit the basement a few years ago, differentiating products on service became the competitive edge. Marketing surveys became the order of the day. These were later picked up by NCQA and currently comprise the Consumer Assessment of Health Plans Survey (CAHPS) format, a national survey of multiple patient satisfaction metrics. There are a few summary metrics which are used in NCQA scoring for accreditation and have been incorporated internally into several scorecards. Patients Evaluation of Performance in California (The Picher Institute) focuses on hospital care and received significant media attention in the past year. This survey measures patient and member perceptions about attributes of the care process. Surveys will continue to appear but the fundamentals are the same.

The American public is saying that they want access to a stable network so they can choose their personal physician and visit specialists when they feel it is necessary. The option of choice, even though many don't

exercise it, is important. How much choice and at what cost are the two key variables. Perceptions of competence and communication are added to accessibility. The next stage, just around the corner, is a health care system driven via empowered consumers. Internet information is always accessible but not always reliable. More patients are appearing with Internet downloads to try to interact with their physicians as informed patients. Physicians have a new role to filter and place in perspective this overwhelming amount of information for patients.

The fundamentals, however, haven't changed. Essentially, the Balanced Scorecard metric for Service contains measures of Access and Personalized Care. Access metrics include Same Day appointments along with waiting times for initial Specialty Consult visits. Routine and return visits are also monitored. Surgical procedure waiting times are being incorporated also. Personalized Care is the other major category, including measures of provider clinical competence plus communication and attention to the patient. The critical nature and depth of the physician-patient relationship has been undervalued to date. Members may be willing to change the color of their health plan card every year if they can keep their physician. This is particularly important with Medicare

patients, patients with chronic diseases and members who proactively request a personal physician. The value-added of primary MD assignment for the twenty something generation who expect efficient urgent care for minor illness to "get on with my life" is uncertain. Access can be measured by days or hours. It's a "hard" metric though some may challenge the chosen number. Personalized Care, on the other hand, is a "soft" metric. It is a summation of patient and family impressions. While they can't often judge the technical quality of care, they are aware of outcomes and do form impressions of physician performance on the basis of "human" (as opposed to "business") interactions.

Health care involves professional judgment, scientific technology and human relations. Other sectors of our service economy have a longer tradition of emphasizing customer satisfaction. While less technically challenged, they can teach us how to deliver high service levels. The "Keeping Skills Alive" ⁽¹⁰⁾ service initiative at Kaiser Permanente-Fontana is one of a number of similar

¹⁰ "Keeping Skills Alive," Internal Service Initiative, Kaiser Permanente Inland Empire.

activities undertaken at Medical Centers in the name of service improvement. This initiative took lessons from other industries and applied them to the healthcare setting. Seamlessly integrating the business side of medicine with the human side was taught in a multidisciplinary setting. Member call backs after visits with identification of specific behaviors via follow-up questions reinforced learnings and performance levels. This initiative involved the entire medical center, took two years to implement, and has had lasting results to this day.

Again, the challenge will be to limit and refine Medical Center performance metrics on Customer Service to a manageable number under the basic categories of Access and Personalized Care. External surveys, driven by a competitive marketplace, will become dominant in the future and may replace earlier, internal surveys. Finally, when it comes to Service Quality, perception IS reality. Service quality, as perceived by customers, can be defined as the degree of discrepancy between the customer's expectations or desires and their perceptions. The key to ensuring good service quality is to meet or exceed what customers expect from service. Management guru Tom Peters states "There is no single, true, inelastic reality; that

is, there is no one certain measure of service, quality or value. We inevitably fail to give perception its enormous due." ⁽¹¹⁾ Service quality is more difficult for customers to evaluate than the quality of goods.

A patient's assessment of the quality of health care services is more complex and difficult than his or her assessment of the quality of automobiles. Patients do not evaluate service quality solely on the outcome of service. They also consider the process of service delivery. Antibiotics may have resolved a strep throat infection, but if discourtesy and an uncaring attitude marked the patient's interaction with the provider, the perception may well be "poor service quality." Appearance, attitude, body language and tone of voice, attentiveness, tact and advocacy via problem solving are personal attributes of a good service provider. Organizational process issues to be addressed in the name of good service include time management, work flow, communication channels, flexibility for anticipation and accommodation, patient feedback loops and supportive supervision. Only patients can judge

¹¹ Personal Trauma of Illness Can Offer Some Pertinent Lessons for Business, by Tom Peters;
<http://www.dmdoptions.com/tom%20peters.htm>

Service Quality. If they think they got good service, then they did. Perception is reality.

Utilization Management

This category on the Balanced Scorecard addresses the "appropriate" utilization of resources, i.e. high quality AND cost effective. Variation in medical care adds waste to the system. Pacific Business Group on Healthcare estimates there is currently 25-30% waste in the system. The actual percentage is controversial but the presence of some waste in the healthcare system is a given. Identifying the waste in the complex healthcare environment is a challenge. Evidence-Based Medicine is a relatively recent trend which seeks to reduce wasteful variation via statistically significant outcome studies. It seeks to identify what really makes a difference. David Eddy, M.D., Ph.D., Kaiser Permanente Clinical Guidelines expert, comments that "the main breach is that physicians continue to do lots of things for which there is little evidence...There are no claims that it (Evidence-Based Medicine) cuts costs, but if we stop doing things we shouldn't be doing or do things we should be doing and

improve processes, there is a potential to save money."

⁽¹²⁾ Paul Wallace, M.D., Executive Director of the Care Management Institute at Kaiser Permanente in Oakland, California, says Evidence-Based Medicine is a "process of ensuring that we are being as rigorous as we can about sharing data that is consistent, honest and reproducible with physicians.

EBM offers a better way to organize and access the breadth of evidence that is now available. It is a refinement of what clinicians have always done but offers a way to prioritize knowledge and to establish a relationship between knowledge and care." ⁽¹³⁾ Clinical appropriateness criteria are not perfect but correlate with better outcomes on retrospective reviews. Comprehensive computer databases may help analyze and refine appropriateness criteria in the future. This awaits arrival of the electronic medical record over the next few years.

¹² David M. Eddy, "Clinical Decision Making: From Theory to Practice," Jones and Bartlett, (1996) 339.

¹³ "Knowledge Transfer and Organizational Learning," at Planning Session The Permanente Executive Conference (Napa, California, May 7, 2002).

Today's conflicting mandates in healthcare include reduce the cost of care, avoid medical errors, hire and retain staff in the midst of a nationwide shortage of healthcare workers, and maintain good relationships with medical staff. To foster high quality and cost effective (i.e. appropriate) care, many institutions have turned to the full-time inpatient physician model to provide care for hospitalized patients. Maintaining and advancing quality of care while demonstrating reduction in length of stay without physician burnout requires infrastructure support. The hospitalist movement is evolving from the pre-hospitalist era (every primary care physician follows their own patients in the hospital) to rotating roster of full day rounding physicians to full time inpatient physician. Handoffs and communication with primary provider in the clinic are two key points which must be addressed to make this program work. As outpatient practice becomes more intense with older, more complex patients being managed in the outpatient clinic setting, a necessary division of labor fosters the hospitalist movement.

Best practices reduce variation in care. Imbedding clinical care guidelines in pre-printed orders and collecting appropriate data to measure compliance are two

examples of specific initiatives under this metric. The modern Emergency Department is a major portal of entry for patients into the hospital. Emergency Department consultation rates and consult admission rates are two additional metrics. More global monitors include bed days/1000 members, over and under 65y.o. throughout the continuum of care. This includes short stay units, acute inpatient units and chronic care facilities. The Acute Physiology and Chronic Health Evaluation (APACHE) scoring system for Critical Care Centers monitors high risk and low risk patients for appropriate utilization of critical care beds. Inpatient care is a major driver of cost but quality must be maintained. Minimally invasive surgical techniques and better short-acting anesthesia options have resulted in 70% of scheduled surgery now occurring in the outpatient setting. Monitoring OR "cut to close" time and OR "turnover" time are two key metrics in this arena. Care Management initiatives in chronic diseases like asthma, diabetes, congestive heart failure, coronary artery disease and end-stage renal disease enable risk stratification of the population. High risk segments usually require case managers to actively monitor individual patients. Low risk populations can be approached via leveraging computer databases for disease

state monitoring and therapy compliance checks. This represents the optimal balance between needs and resources.

E-health will present new opportunities for on-line chronic disease management in the future. Pilot studies are now underway to explore this opportunity. Same day visit availability and new consult visit waiting time represent important monitoring areas in outpatient resource management. Return visit frequency and format are another area in which change in the name of appropriate care is being pursued. Ritualistic revisits use scarce resources and add cost at a time when can ill afford it. Group visits and nurse clinic visits for chronic disease management are beginning to appear in multiple disease and practice settings. Precise monitors in these areas are yet to be identified. The Institute of Medicine calls for a restructuring of the American healthcare system to improve quality and coordination of care. The system, they said, produces a "chasm between the kind of care Americans could

receive and the kind they are receiving.”⁽¹⁴⁾ Work is in progress to close that gap. Monitoring resource utilization within the context of high quality and cost effective, “appropriate” care contributes to progress in closing this gap. It has a secure place among key metrics on the Balanced Scorecard.

Pharmacy

Pharmaceuticals have earned a place among the limited metrics of the Medical Center Balanced Scorecard because of the medical advances via consolidation, biotechnology and computer research and development. Additionally, accelerated cost trends have made drug expense a major budget issue in the delivery of healthcare. Again, the overarching theme is “appropriate” care. As an example Xigris is a new drug therapy for sepsis. It is effective for some patients and not for others. Medicine is an inexact science. The cost is \$5,000-7,000 per dose. The medical community is currently in the process of

¹⁴ “The Institute of Medicine Report on the Quality of Health Care Crossing the Quality Chasm: A New Health System for the 21st Century,” by the Committee on Quality of Health Care in America of the Institute of Medicine, National Academy Press (2001).

formulating clinical guidelines for its use. Resources are not unlimited and risk/benefit must be considered both for individual patients and population served. Keeping healthcare affordable is a constant challenge these days. Ultimately, this translates into what percentage of Gross Domestic Product we spend on healthcare. The cost of pharmaceuticals now almost equals the cost of running hospitals in most vertically integrated delivery systems.

Evidence-based medicine and expert consensus for the basis of most current formulary decisions. Physician-led formulary development with ongoing input from practicing clinicians is key. However, cost management has become a major challenge. The average margins in most aspects of health care delivery are in the 3%-6% range. The average margins of pharmaceutical companies range from 25%-30%. Quarterly earnings have weathered the Dot.com bust on Wall Street well. Annual health care expenditures in the United States are about 1.2 trillion dollars. Market capitalization of the major pharmaceutical companies far exceeds the book value of the delivery system in this country. Patent protection, effective lobbies and direct to consumer advertising have accelerated cost trends over and above the cost of research and development. It must be

yearly wildcard for balancing quality, service and cost in healthcare delivery systems.

Attempts to carve out lifestyle drugs from capitated benefits or designate additional co-pays meet with consumer, regulatory and legal resistance. Witness the recent Kaiser Permanente Viagra® story, The Department of Managed Care's position was to require Kaiser Permanente to cover Viagra®. Kaiser Permanente maintained this was not a good use of limited resources and impacted social mission of the organization. Maintaining affordable healthcare and limiting co-pays for chemotherapy cancer patients were the organization's higher priorities. Final court adjudication yielded a favorable verdict for Kaiser Permanente but the time, expense and difficult encountered on this one issue took energy and resources away from other aspects of performance for health care delivery. Wellpoint's recent success in lobbying the Federal Drug Administration to make non-sedating antihistamines over-the-counter will help manage capitated drug costs. Many medical groups forced to take pharmacy risk have found it unmanageable. Oncology groups have been particularly vulnerable to the financial impact of new chemotherapy drugs. Generic versus brand options are important.

The ability to move market share from one source to another when bio-equivalence has been demonstrated has proved to be an effective lever in price negotiations. Kickbacks to pharmacy benefits managers have exposed some financial scandals recently. Medicare HMO products (with attached drug coverage options) in San Bernardino County, a low Medicare reimbursement county, are dwindling. Seniors on limited incomes needing costly drug therapy may not be able to cover costs out of pocket under conventional or Preferred Provider Organization Medicare insurance. Drug companies are now coming forward with Senior discount drug cards to modulate the political fall out on drug costs in Washington. It's unlikely that this dynamic will result in major national health policy change. The budget deficit makes it unlikely that incremental drug coverage subsidy via Washington will be possible. Kaiser Permanente monitoring of Pharmacy includes Regional Pharmacy and Therapeutics Committee formulary updates, unit and volume prescription costs which yield overall per member/per month expenses and targeted appropriate care initiatives. At the end of the day, pharmaceutical costs remains a financial wildcard on the annual operational Balanced Scorecard of health care delivery systems.

Cost

Maintaining quality while controlling costs became a dominant challenge in the 1980's as employers reeled from multiple years of double digit inflation of healthcare costs. Successfully competing in a global economy was contingent on meeting this challenge. This employer mandate for change in the name of cost control gave birth to Managed Care. Capitation is a closed economic system. It links the delivery and financing of healthcare. The presence of quality, service and cost metrics on the same Balanced Scorecard operationalize this concept. Healthcare resources are finite, like other parts of our economy. Cost controls and differential resource allocation are inevitable. Appropriate allocation of finite resources to promote the most good for the most people is an essential part of good stewardship. Capitation is essentially shifting the insurance risk from health plans to medical groups and hospitals. Regulation and ethics constrain pure marketplace activity. The further away from the bedside, the more visible the unbridled marketplace. As described above, pharmaceutical and medical device manufacturers usually exhibit the most prominent corporate behavior in healthcare. The cost

trends and implications of pharmaceuticals for health care organizations are discussed above.

Current financial instability may reflect of under-funding of the health care system. The Balanced Budget Act mandates reduction in Medicare reimbursement at a time when an increasingly older population in need of beneficial medical advances increases cost structure to provide state of the art care. A softening economy will eventually create a more flexible labor pool and may make employers more reluctant to accept ongoing premium increases. In California, premiums charged employers are 30% less than the Midwest and 50% less than the East Coast. California Medical Association analysis of medical loss ratios (amount of the premium dollar spent on health care vs administrative, profit and other expenses) shows for profit HMOs in the range of 80-85%% while non-profit Kaiser Permanente is usually listed around 95%. Wall Street engenders financial discipline for operations but also demands quarterly earnings. The number of employers providing healthcare in California is 48%. Nationally, it's 61%. Some predict public policy outcry when ranks of the uninsured increase from 43 million to 65 million in the future. In the meantime, we have a dominant employer

based health care system for those under 65 and federally funded Medicare for those over 65.

Value will be increasingly measured in the future by the newly empowered consumer who will actively make decisions on perceived quality, service and cost in choosing healthcare coverage. If Value equals quality divided by price, consumers will pay slightly more if they perceive added value. Most employers today assume quality and make decisions on cost. Choice is secondary. Consumers want choice. Competitive price and cost control, while maintaining and enhancing quality, become keys to competitive success. Integrated delivery systems responsible for global capitated healthcare must closely monitor their financial performance. Healthcare is complex, personal--and expensive. Margins are narrow. Margin equals revenue minus expenses. Even non-profit health care organizations must pay the electric bill at the end of the month and buy the latest technology when it is truly beneficial. Labor comprises about 80% of most health care delivery budgets. A highly educated, highly regulated workforce with multiple job descriptions and complex interactions creates a cascade effect of each hire generating surrounding expenses. The financial impact of this cascade must be anticipated to manage costs

proactively. Physician hires, in particular, generate ancillary support, technology needs for specialists and new referral patterns. Non payroll expenses include careful monitoring of durable medical equipment for appropriate matching of patient needs with device expense. As mentioned above, inpatient bed day unit cost and volume plus pharmaceutical expenses are major financial drivers.

Tracking internal costs are important but not the whole financial story. Incurred but not reported (IBNR) claims expenses have sunk a number of health care organizations. Anticipating these expenses and monitoring trends are vitally important to the financial viability of a healthcare organization. Non-profit health care organizations need retained earnings for financial reserve, cost of new technology and replacing facilities. Rebuilding facilities usually occurs on a thirty year "useful life" horizon. However, these expenditures are "lumpy" and cash flow is frequently a dominant issue in prioritizing and staging large projects. Inpatient unit cost and volume, outpatient, payroll, non-payroll and outside claims become key categories for financial monitoring on a balanced score card. They roll up to the overall expense metric of per member/per month cost. The other main metric is margin equals revenue minus expenses.

This is dependent on product line reimbursement and cost. A corollary is the need to know which product lines are profitable and which are not. There may be non-financial reasons to maintain an unprofitable product line but this decision should be made with foreknowledge of financial impact. Ultimately, there is a fiduciary responsibility to maintain financial viability while complying with regulatory requirements and maintaining healthcare ethics. "No money, no mission."

Workforce Planning

This is a relatively recent metric which has made its way onto a variety of subset scorecards and may soon have a place on the overall Balanced Scorecard. It illustrates the dynamic nature of the Scorecard and provides another example of the impact of demographics on health care delivery. The looming nursing shortage is probably the largest issue in this category. California has the leanest ratio in the nation. The average age of new nursing school graduates has gone from 21 to 31 in a decade. Average age of RNs now on duty is 47. Average age in the ICU and ED is 52. In 15-20 years, 50% of the RN workforce in California

will retire.⁽¹⁶⁾ California is now in competition with other states for nursing resources in Canada, the Philippines and South Africa. Grow and capacity are two major issues facing all health care providers in San Bernardino County. A built bed is not necessarily a staffed bed these days.

RN person power is critical to keeping healthcare available for our citizens. Many more RNs are needed. Health Plan and hospital local funding of positions in nursing schools is beginning to appear but this incremental approach will be insufficient for future needs. Young people have recently considered other career options. The Dot.com bust has caused some to reconsider careers but this has not impacted project shortfalls to date. Job satisfaction and the attraction of high tech fields are ongoing issues. The trend toward RN unionization reflects an attempt to gain more control over their workplace. Recent California Nurses Association negotiations with University of California Hospitals

¹⁶ Jeffery C. Bauer, Ph.D., "Workforce Trends," presentation at CMA 5th Annual Leadership Academy, "Money, Power and Medicine - Turning Adversity into Opportunity" (Nov 16, 2001, La Quinta, CA)

demonstrated growing unionization influence returning seniority to dominance over performance pay. State mandated RN ratios will help. Kaiser Permanente committed to ratios over and above State mandate. This may help recruitment but will impact cost structure.

The strength of the physician workforce in California is debatable. Lower reimburse from Health Plans and Medicare, managed care hassle factor and attractive opportunities in other States along with early retirement have created a shortage particularly apparent in certain specialties. These workforce planning trends and challenges will escalate over the next decade as Baby Boomers age into Medicare. Incremental responses won't be enough. Major organizational commitment to training and hiring plus State and National health policy responses will be needed. Number of RN and MD vacancies plus type and duration of unfilled positions are being actively monitored. They're being coupled with recruitment and retention redesign emphasis. These metrics will grow in prominence over time.

Regulation

Regulation has always been with health care. We are used to working in highly regulated environments. However,

the degree of regulation, coupled with the recent rise of consumerism, has placed this arena front and center in all aspects of health care delivery. Witness the transition of Managed Care Organization oversight from the Department of Insurance to the Department of Consumer Affairs to a separate Department of Managed Health Care. This agency is under scrutiny to protect consumers from the perceived excesses of marketplace Managed Care. They have assumed a more active monitoring role in Health Plan performance.

Quality, service and cost all have agency metrics. Oversight of outside referrals, experimental treatment requests, member complaint hot lines and financial solvency are being applied to health plans, hospitals and medical groups. Recent audit showed 25% of medical groups are financially unstable. Joint Commission on Accreditation of Healthcare Organizations, National Commission on Quality Assurance and Center for Medicare and Medicaid Services plus the State of California under, additionally, the Department of Health Services, all conduct their own regulatory oversight. Kaiser Permanente has enlarged a separate Regulatory Department within Health Plan to manage compliance and relationships in response to this growing trend. Consumer pressure for DMHC to become more active on patient rights and escalating

Health Plan fines for regulatory variance point to more regulatory prominence in the future. Regulatory compliance metrics are on subset scorecards and may occupy a position on the internal delivery Balanced Scorecard in the near future.

CHAPTER SEVEN
MANAGING CHANGE IN HIGH
VELOCITY ENVIRONMENTS ⁽¹⁷⁾

The rapidity of change in today's health care system requires quick assessment and prompt response to stay competitive, let alone get ahead of the curve. Increasingly, leaders in health care systems are challenged to make major policy decisions and operational changes in shorter and shorter timeframes. This begs the necessity for an organized, comprehensive approach to managing change. The balanced scorecard described above creates a basic framework for monitoring operations. Time, however, is another key element in constructing a tool to help the modern day health care manager and leader cope with has become a high velocity change environment. Referencing the Balanced Scorecard to anticipate the impact of change transforms the Balanced Scorecard from contemporary monitor to strategic planner. Failure to anticipate major shifts or trends exposes one to the risk

¹⁷ Paul L. Stephanovich and Jennifer Uhrig, MHA, "Decision Making in High Velocity Environments: Implications for Healthcare," Journal of Healthcare Management (May-June 1999, Vol 44, No 2).

of being overtaken incrementally by competitors. There's an additional risk--being blindsided by disruptive technology from smaller, leaner organizations climbing up the commodity to custom ladder with focused energy and lower cost structure.

Change has become an essential part of management and leadership in 21st century healthcare. Compression of time and events have generated speed and volatility which have evaporated much of the "change float" that used to characterize bygone eras. Slower change processes allowed for more adaptive time and the luxury of mistake and recovery before the full impact of change. Institutions have been slow to react and adapt to this reality. Command and control models of management coupled with linear thinking have resulted in a "pull a lever and get a result" expectation. More collaboration and coordination will be needed in the future. Barriers are in the minds of stakeholders. The Information Age will usher in new models of care which directly challenge closely held beliefs and assumptions. Anticipation and alignment are critical to survival and success in this type of environment. Consequently, the healthcare leader must adopt a comprehensive, structured approach with his/her management team.

The first challenge is identifying emerging issues. "An issue ignored is a crisis invited." ⁽¹⁸⁾ Demographics usually yield predictable trends with approximate time tables. The impact on health care can, at least in part, be anticipated. Scanning, monitoring and forecasting are tools of recognition and anticipation. Challenging assumptions in the way things have been done in the past versus the ways they could be done in the future can lead the way to getting ahead of the curve. Kaiser Permanente had its origins in the desert, under Sidney Garfield, M.D., where alternative methods of delivering and financing medical care were non-existent. Necessity is the mother of invention. World War II led to Henry Kaiser's request of Dr. Garfield to provide care for his shipbuilders. After the war, union alliances created the substrate for rapid growth. The medical establishment at the time resisted this new form of medical care delivery.

As described above, cost pressures at the time led to employers turning to managed care concepts for help. Today, managed care has become mainstream. Changes of this

¹⁸ William C. Ashley and James L. Morrison, "Anticipatory Management: Tools for Better Decision Making," The Futurist (Sept-Oct 1997, Vol 31, No 5) 3.

degree will probably be required in the future to cope with the increasingly difficult Quality-Service-Cost challenge. Conducting issue vulnerability audits allows the organization to look at itself in relation to change and disruption. You can be your severest critic privately. New competitors, new regulations, medical advances and media events all need review for significance and impact on the organization. Strategic issues are thus identified before they reach a crisis level and response options become constrained. Writing scenarios gets at what if questions and helps to manage uncertainty. Low, medium and high risk scenarios must be compulsively evaluated to yield proper sensitivity testing as a basis for planning. Preparing issue briefs summarizes concisely an issue for leadership's consideration. It includes statement of issue focus, background, trends, driving forces with invested people, along with future prospects and implications for the organization. Prioritizing issues by probability and importance is the next step. Immediate action, surveillance or future revisit for strategic planning are follow up options.

Evaluating performance on decisions requires metrics to assess the before and after impact on the organization. These should be identified early on so success or failure

can be recognized sooner rather than later. Tracking how other organizations are dealing with similar issues points to a competitive intelligence unit with ethical standards about how information is acquired. An anticipatory management model promotes better accountability for decisions. Key steps include assigning responsibility for the anticipatory management function, forming a steering committee, managing the issues and informing leadership. This provides a systematic and formal way of understanding the "external" world's impact on the organization and promotes proactive planning.

Implications for healthcare on decision making in high velocity environments builds on the experience of other industries. Timely information is needed for analysis. Alternatives must be evaluated and considered simultaneously. Independent, knowledgeable internal consultants can help speed up the time to set the stage for a decision by clearly articulating critical elements in decision support systems. This avoids the danger of "locked-in" group-think. It's the author's bias that large organizations can generate sufficient internal consultative resources to meet most of their needs. This has the further advantage of leveraging pre-existing relationships and a thorough knowledge of organizational

culture. The well know phrase of culture eating strategy for breakfast is never more truer than here. The process of decision making needs to resolve conflicts promptly through "consensus with qualification." Gone are the days when we could wait for everybody to get on board with a decision. To not act is to be left behind. Short cycle implementation requires a structured process that cuts across disciplines and levels. Information goes quickly out of date in high velocity environments. Refreshing data and reading patterns early become critical. Mid course adjustments should be expected by leaders, managers and staff. Validating directionally correct decisions and titrating the pace of change require periodic looks at how we're doing.⁽¹⁹⁾

Health care is complex, personal and expensive, both on an individual and societal level. Marketplace, regulation, workforce human resource issues and ethics all have a part in delivery of this essential service to our citizens. High velocity change must be accomplished within

¹⁹ Dee Hock, "Birth of the Chaordic Age in Health Care," presentation at CMA 5th Annual Leadership Academy, "Money, Power and Medicare--Turning Adversity into Opportunity" (Nov 16, 2001, La Quinta, CA).

a very complex environment. The "change float"⁽¹⁹⁾ is gone. Strategic planning horizons have collapsed from ten to five to three years in these times of rapid change and uncertainty. Tactical planning which used to be made in 12-18 month intervals is now requiring 2-3 month response times. In this environment, fast decisions with reevaluation and, if necessary, mid course correction, gain a competitive edge for organizational performance. Fast decision makers use more information, development more alternatives, obtain advice from experienced counselors, actively resolve conflict using consensus with qualification and integrate strategic with tactical planning in the face of reduced time frames for decision and response. Paralysis of analysis, pursuing an exhaustive list of alternatives, consulting all sources, waiting for unanimous decisions and waiting for full detailed integration plans are all vulnerabilities. Healthcare needs to borrow from lessons learned in other high velocity environments. Survival and success depend upon this.

CHAPTER EIGHT

PHYSICIANS AND CHANGE

The challenge of managing and leading in high velocity environments raises the bar for physician executives. Change becomes the only constant. Most physician leaders work within conservative organizations and lead independent minded, risk averse fellow physicians. Physician traditions and cultures are uniquely resistant to change. "First do no harm." Uncertain impact at the bedside always has to be considered. Physicians develop ways of doing things which they standardize individually over time. Part of the basis for this is, indeed, personal risk adverse coping behavior in a complex environment. Change in a complex process risks introducing error. There is a zero error tolerance mentality deeply imbedded in the culture of physicians. This is sometimes a barrier to a realistic systems look at things in the interest of quality improvement via change initiatives. Risk and benefit tradeoffs are difficult to identify for sure.

The other dimension to these issues involves using the physician as a tool to improve overall system performance. However, not uncommonly, this change process

involves more work for the physicians in the interest of a pay off of system improvement for someone else in the system. Physicians are strong patient advocates. However, data entry to satisfy someone else's information needs when time is so precious makes alignment of incentives difficult. "More change always demands more leadership." Traditionally physicians view their leaders as advocates, protectors, communicators, and first among equals. They view themselves as CEOs at the bedside with very high control and information needs. Inefficient decision making via consensus along with difficulty identifying shared commitments and accountability hamper adaptation to change in high velocity environments. The new world leader is required to foster advocacy in perspective, sponsor change, facilitate physicians working collectively toward common goals, embrace collective accountability for quality, service and cost, model change and meet fellow physician needs for recognition. New mental models need to be presented. Gap analysis concepts need to become mainstream in physician thinking on systems performance. This is as applicable to group dynamics on alignment as it is to consumer satisfaction surveys.

The physician executive needs to be seen as a leader sensitive to the frontline physician viewpoint but also

realistic about what is required for successful performance of the organization. How to close the gap and get there presents an opportunity for the leader to allow fellow physicians some control over both the process and their destiny. It's a chance for front line practitioners to influence their own work environment by participating in organizational change. Identifying respected physician champions becomes critical for change initiatives. They build the critical mass to create a sense of ownership. This is preamble to a shared vision. Developing a discrete, shared vision which compels alignment and movement in the direction of desired change is the personified work product of a true leader. This develops not at one point in time, but by engaging others in a dialogue over time. Teamwork, listening, openness to innovation, measured risk-taking and delegation of authority become new expectations. Aligning the team, developing tension for change, addressing resistance and building consistency and commitment eventually become part of the fabric of the culture and make subsequent change initiatives easier. These change process fundamentals are as applicable in health care settings as they are in other sectors of our economy and society. They are about people

dynamics. New habits of behavior become mainstream. A learning organization is born.

Physician executives are indeed the bridge between physician advocacy and business unit performance. They're always on the bubble. Balance is the key. Quality, Service and Cost are always on the table. Leadership skills can spell the difference between success and failure of a health care organization, just like any other organization. The margin for error is narrow. The Medical Director serves as the compass around which clinical decision-making revolves. "Walk-around" management numbers are reflected on the Balanced Scorecard. They assist in the day to day medical management of a patient population. For a Medical Director to be successful in change management, he or she must generate a high level of trust within the organization, foster teamwork across all departments, reward innovation and create a patient-centered environment.

The Medical Director must also manage the momentum of change. Change must be prioritized with a timeline. Traditional convoy approaches to change move too slowly in this high velocity environment. Integrating the practice of business with the business of medicine at an ever increasing pace has moved leaders to newer and faster,

rapid cycle, models of change. Dealing with conflict, resistance, realism, flexibility and optimism are essential traits of a successful leader in this age. One must be action oriented. Planning is good but execution counts. A sense of consistency and stability in the midst of great change is an essential ingredient for sustaining success. Managers emphasize performance in the present. Leaders position people for success tomorrow. This has become, in some respects, a "just around the corner" view with frequent iterations to titrate fast moving change in the face of uncertainty. Trust to follow vision as a work in progress becomes the bottom line in leadership. It's ultimately about believing in someone else strongly enough to take a risk and align. For traditional, independent-minded physicians this is not easy. But increasing numbers recognize it as the only pathway to success in the future.

CHAPTER NINE
DEFINED BENEFIT BECOMES
DEFINED CONTRIBUTION

Under Defined Benefit the health plan has a contract with employer and employee listing covered benefits and terms for providing those benefits. Defined Contribution, on the other hand, describes the role of the employer in funding the health plan coverage for the employee. Defined Contribution enables the employer to commit to a fixed dollar amount to fulfill his/her agreement for employee healthcare coverage. This money can be used by the employee to choose among options for health care coverage. The amount may or may not cover the lowest cost option. If it does not cover full cost, employees must pay the difference. If it does but the employee purchases a more expensive plan, he or she must pay the additional amount. If employees choose a plan less expensive than employer contribution, he or she may use the money toward other benefits. This cafeteria style approach has been used successfully by the Federal Employees Health Benefit Program, The California Public Employee Retirement System, the Buyers Health Care Action Group in Minneapolis and a number of other large employers and coalitions. Their size

enabled them to absorb administrative costs connected with choice activity. Recently, the Web has made similar approaches feasible for small and medium sized businesses.

The key to making these programs work is teaching employees to make good choices. The current dearth of quality information must improve for employees to truly make knowledgeable tradeoffs and good decisions. Accurate acuity indexing is a barrier. Currently, the Pacific Business Group on Healthcare in California is attempting to create quality scorecards by using volume as a surrogate for quality. Recent surveys have shown that nearly half of employers would like to get out of directly managing healthcare decisions. Over half also stated they would support legislation permitting individual tax credits for purchase of health insurance. This is a key step toward making defined contribution more appealing to individual consumers. Another sign of gaining momentum for defined contribution was Blue Cross' April, 2001, roll out of a flexible benefits program containing a defined contribution option to small employers.

Defined Contribution encompasses many designs. The fundamental principle is that employers provide a pre-determined amount of money for health coverage. This could take the form of a voucher for the employee to

purchase coverage on the individual market. It could partially or fully fund a cafeteria menu approach as described above. Finally, there is a third type, Self-Directed Health Plans, emerging. These firms are currently primarily funded by venture capital. Business model details vary but generally involve catastrophic insurance coverage, employee directed spending accounts, and access to on-line information and tools. These models are not part of the Medical Savings Account pilot project but have obtained Internal Revenue Service letters of understanding that they meet the test of tax deductibility. One model puts together 100% preventive service coverage with Web directory of physicians offering discounts to members. Deductible gap insurance coverage is also available. Unspent personal account funds can be carried forward into future years. This model proposes to achieve savings by fostering more cost-conscious members who, through web tools, make better choices. Decision support and chronic care management tools are being developed.

Thus far Self Directed Health Plans have focused on the self-funded employer market. To be successful, however, they will need to penetrate the insured market. Self Directed Health Plans are not currently licensed nor

do they have the financial resources to take insurance risk. Enrolling a disproportionate share of good risk worries many health policy experts. How much coverage do you give to whom on these programs. Will the chronically ill shoulder a financially unmanageable burden under this model. This is an ethical dilemma just around the corner. Medtronic, a Minneapolis based medical device firm, and the University of Minnesota are two large employers who have made this model mainstream in their coverage options. Besides still uncertain tax law interpretation, the employer risks damaging employee relations if this program is too complex for the average consumer to feel comfortable with their new role as decision maker. Pacific Business Group on Healthcare plans to partner with Definity Health to offer their "breakthrough" option to large employers in 2003. ⁽²⁰⁾

Rather than cut benefits, employers currently are asking employees to assume more of the extra cost of premiums. Benefit design becomes a critical issue as rising levels of cost sharing and reduced retiree coverage

²⁰ Clark Miller and Chris Delaney, "Pacific Business Group on Health Unveils Groundbreaking Alternative to Managed Care," Definity Health (Nov 8, 2001, San Francisco, CA)

stress the middle class to cope with this major marketplace trend. Some experts estimate the middle class will use up their discretionary income ability to subsidize this trend in about four to five years. Those with chronic disease may experience the dilemma sooner. Current chemotherapy co-pays in some for-profit health plans have risen from \$40 to \$400 in the past year and a half. Tiered pricing has been applied to both pharmacy and hospital admissions. Will cost management overwhelm quality considerations at some point as trade-offs become more difficult over time. How far down this road should healthcare ethically go? Will Seniors have to make decisions between drugs and food? Will the ranks of the "under-insured" grow as the widening insurance "gap" places actual coverage out of reach of most? This, plus growing ranks of uninsured, may activate reluctant Washington. Ultimately, we must more closely match our individual expectations with our ability to pay for these expectations. It's a reality check long overdue.

CHAPTER TEN
DEFINED CONTRIBUTION AND
KAISER PERMANENTE

Kaiser Permanente has had a long tradition of comprehensive, close to first dollar, healthcare coverage. Employers have reacted to a slowing economy and recent healthcare premium escalation by cost shifting to employees. Kaiser Permanente exists in the same marketplace as competitors and is not immune to these trends. 2002 represented the first step in benefit design to reflect marketplace migration from defined benefit to defined contribution. Employers requested this change not only to contain costs, but also to facilitate comparison shopping for both employer and employee. Overall, these changes resulted in closer alignment between Kaiser Permanente and competitor health plans. Core changes included \$50 Emergency Department co-payment, \$50 Emergency (911) Ambulance Co-payment, 20% Durable Medical Equipment Co-payment, designated contraceptive coverage under basic benefit, two-tier drug plan with Medicare drug cap, Personal Advantage \$500 Labor and Delivery Co-payment, and Medicare Individual Kaiser Permanente Senior Advantage \$200 inpatient co-payment. Office

co-payments also rose from \$5-\$10 to \$10-\$25. ⁽²¹⁾

Purchasers had the option of buying out the cost sharing in premium negotiations.

Benefit design also reflected efforts to mitigate quality concerns about cost being a barrier to access to care. While the Emergency Department co-payment applies to in-plan and out-of-plan Emergency Department visits, it is waived if the patient is admitted to the hospital . Medically necessary non-emergency ambulance will be provided at no charge. This includes hospital-to-hospital transfers and Medicare bed-confined patient transfers as per CMS guidelines. Durable medical equipment copay does not apply to that provided during a covered hospital or SNF stay, or to internally implanted devices. Pharmacy changes included 30 day supply limitation applied to a few very expensive medications, plus emergency contraceptives and injectable contraceptives moved to base benefit at no charge. The two tier (generic/brand) drug benefit has a lower copay for generic drugs and a higher co-pay for medically necessary brand drugs. There are a variety of tiered copay options, ranging from \$5/\$10 to \$10/\$25. In

²¹ "New Benefit Design," Kaiser Permanente Timeline

addition, there is a \$20000 annual drug cap for Medicare members. ⁽²²⁾ Chronic disease and Medicare members at risk for exceeding drug cap in whom nature of disease and treatment presented quality dilemma were forecasted for economic risk. Funding of the Medical Financial Assistance Program for 2002 was adjusted to reflect the impact of this change. Medicare member monthly dues changes were county specific.

Each of these benefit design changes has implications for health care delivery operations. Benefit design was set in Spring, 2001, negotiations with very large strategic groups. Communication of these changes to key internal and external audiences took place in the second half of 2001. Internal audiences included Health Plan regulatory groups, administrative managers and physicians with responsibility for oversight of operations, staff physicians and ancillary medical personnel involved in direct patient care, and support staff who interface directly with members. This includes a wide spectrum of job descriptions, ranging from check-in receptionists to Member Services representatives. Individual member letters

²² "New Benefit Design," Kaiser Permanente Timeline

were sent to each Medicare member in the Fall.

Informational brochures for the commercial (under age 65) population were also distributed during Fall, 2001, open enrollment. Communication tools, including talking points and Q&A guidelines, for staff to speak with Members about the changes were distributed in the Fall also. Hotline and #800 for staff and Members with questions about the changes were also designated. Current KP publications were also utilized to communicate change. Member News, Partner News (for SCPMG physicians), California Wire (Electronic KP newspaper to designated staff), KP Drug Bulletin (internal for Pharmacists and Physicians), inter-regional video conferences, local pharmacy and therapeutics committee Emails, and SCPMG administrative Emails. Kaiser Permanente is a large, complex organization involved in an industry sector noted for its inherent complexity. Consequently, communication alone presented a formidable challenge, given the magnitude and speed of change. However, communication about change was only the first step. Making change a reality would depend on how well front line operations could execute. ⁽²³⁾

²³ "Defined Benefit to Defined Contribution Implementation

Developing an organized approach to tactical planning for operations in the face of such complexity and speed of change required a framework for reference. The balanced scorecard was a tool familiar to many already as a monitoring tool and reflective of priorities in strategic planning. It was applied to the KP defined benefit to defined contribution initiative for tactical planning. While there was prior experience with this application in smaller projects and incremental change, this represented a more rigorous test of the instrument. It performed well. Fourth quarter of 2001 and first quarter of 2002 were used to plan and gain early experience with the tactical response. Each element on The scorecard was examined for operational implications. Groth impact included general risk of small businesses opting out of healthcare provision all together, adverse selection in Medicare from more favorable drug coverage in addition to other HMO pull out because of low county by county reimbursement. Competitors with new products, such as high deductible PPOs and consumer driven plans represented another threat. On the opposite side was financial instability among

by Quarters," Kaiser Permanente Timeline.

medical groups, leverage of size, stability and trust in the face of competition. Trending was in the same direction and disparity was mostly a matter of degree. Overall, Member growth was anticipated to be adequate to good.

Quality was a clear concern from providers. ED, hospital and ambulance co-pays were discussed. As an integrated delivery system, KP had the ability to track hospital readmits and ICU admits as sub-groups to detect adverse trends. Pharmacy caps were another area in the quality discussion by providers. Certain chronic disease populations were particularly vulnerable. Formal financial discussions were deemed not appropriate for the exam room and doctor patient relationship. In addition, actual individual financial responsibility required computer reference to detect employer co-pay buyout, etc. Therefore, systems were set in place to refer patients to Member Services and Medical Financial Assistance. Another concern was unintended Member behavior to cope with co-pay. Inappropriate presentation of certain medical conditions in urgent care settings to avoid ED co-pay was a potential problem. This was resolved by a single co-pay per visit policy which reflects the physician's clinical triage decision.

Utilization concerns included increased pressure on providers for phone management by some members to avoid co-pays. While healthcare has been slow to enter the Information Age and physician Email accessibility is in an early stage of development, some clinical issues must be dealt with face to face. Distance evaluation and treatment would increase risk to both patient and provider. This also had implications for Member Services when patients requested co-pay refunds. The practice of medicine is both an art and a science. Results cannot be guaranteed. Standard of care is clarified by experts using peer review. Member requests for co-pay refunds must be viewed within this frame of reference. \$5 co-pay rising to \$25 was anticipated to increase these issues. In the interest of avoiding perception of barriers to care, it was decided that hospital co-payment would not need to be collected at time of admission from ED. Conversely, however, \$500 OB delivery co-pay would be discussed with the Member early in pre-natal visits to allow enough time for resolution of any issues. Member satisfaction surveys may be influenced by higher expectations from higher co-pays. Tracking of these internal scores will help assess perceptions and possibly point to problem areas in operations.

Pharmacy was commented upon above. In addition, Pharmacy and Therapeutics committee physicians and pharmacists compiled a list of alternative generic drugs of similar therapeutic efficacy to contain costs on behalf of patients. This was distributed to physicians. It is helpful to members with chronic disease on limited incomes who might not qualify for medical financial assistance. This whole trend from Defined Benefit to Defined to Contribution has been largely driven by economic priorities. Co-payment collections are counted on to help fund operating budgets for the provision of care. They now comprise a more prominent percentage of the revenue. Collection policies and cash control systems required modification to deal with a higher volume of transactions handling a larger amount of money. This evolved from Health Plan policies to front line in-service training to monitoring tools for compliance.

The Patient Business Services department had major policy revisions and funding augmentation to reflect its new role in implementing medical financial assistance. 300% of the Federal Poverty Line was chosen as the threshold to qualify. Toll free informational lines were established. Direct referral capability by physicians and staff was developed. Providers received local reference

memos to help assist in patient referrals. Rapid turnaround for Medical Financial Assistance qualification and provision of service even if MFA status is pending or not yet initiated were put in place to preserve quality and protect patients. ⁽²⁴⁾ Each of these implementation projects required teamwork of key stakeholders. In strategic planning, Kaiser Permanente lobbied for a level playing field regarding delivery co-pays for individual and employer based OB coverage. By the end of 2001, key changes were communicated, and by the end of first quarter, 2002, successfully implemented.

²⁴ "Communication Example: Medical Financial Assistance," Kaiser Permanente Timeline.

CHAPTER ELEVEN

CONCLUDING REMARKS: GETTING
AHEAD OF THE CHANGE CURVE--A
WORK IN PROGRESS

The balanced scorecard provided a very useful framework for comprehensive implementation and oversight of the Defined Benefit to Defined Contribution change initiative in a compressed time frame. It's a tool. Leadership and management need commitment, focus and discipline to collaboratively engage staff to execute successfully. Proactive tactical planning has become more critical in these times of rapid change. The other key issue around the corner is how far down the road of defined benefit to defined contribution should we as health care organizations and as a society go? Healthcare is not free and too much insulation of the consumer from true costs is neither preferable nor sustainable. On the other hand, cost-sharing obligations beyond the reach of the middle class begs an ethical dilemma for access to needed care. Gaps in coverage may not always be apparent to the individual purchaser until need arises in time of crisis. The marketplace has moved swiftly in California. Regulators have been catching up with marketplace excesses

over the past few years. However the leading edge of change in healthcare is still the marketplace.

Defining a "decent minimum" of health care for all insurance products to protect consumers and mitigate ethical dilemmas has yet to be determined. The author contends this will become a burning issue over the next few years as "gaps" in coverage become exposed in media and regulatory arenas. A final driver on change is HMO pull out from San Bernardino County by several Medicare HMOs. This is prompted by relatively low reimbursement rates from the Federal government in this county. Variation county by county is based upon historical trends which are probably no longer true, given the rapid growth and evolving independent economic base of the Inland Empire. Legislative updates proceed slowly. The "decent minimum" ethical dilemma will most like be upon us before such change happens. Most feel the cost shifting trend will continue over the next few years as middle class consumers use up discretionary income to accommodate this trend. The most recent cost-shifting model is the tiered approach to hospitals and medical groups. Health Plans have approached this tentatively and some have temporarily pulled back. Higher priced providers have cited Quality and scope of practice in addition to community service as

reasons why there is a difference. Health Plans have not felt up to tackling this in the media--yet.

With geriatrics and technology as accelerating trends in provider cost structure and employers dealing with a softening economy and global competition, cost shifting will continue. The money has to be found somewhere.

Tiering will be revisited. The balanced scorecard for tactical planning will be a yearly tool for operational managers and leaders. Monitors after implementation will serve as critical feed back to marketing and benefits designers to indicate early when the marketplace may have gone too far in cost shifting. This begs a challenging discussion in Washington on national health policy. Thus the Balanced Scorecard has become, in addition to a strategic alignment tool, a dynamic tactical planning, monitoring and, now, policy feed-back tool.

The new cycle for 2003 is about to begin. The Balanced Scorecard will occupy a prominent place at both strategic and tactical planning tables for next year and well beyond in at least one vertically integrated delivery system. It has become part of both survival gear and competitive edge in this time of rapid change. The author submits his experience is not unique and the utility of the Balanced Scorecard application described above can be

generalized to other healthcare delivery settings.

Healthcare leaders of the coming decade won't be able to lead without it.

APPENDIX A
NATIONAL HEALTHCARE
EXPENDITURES AND HEALTH
MAINTENANCE ORGANIZATIONS
GROWTH RATES

BY THE NUMBERS • HEALTHCARE ECONOMICS

National healthcare expenditures by type of service

Figures for 1999, in billions of dollars

Service	Amount	Service	Amount
National health expenditures	\$1,210.70	Retail outlet sales of medical products	\$147.10
Health services and supplies	1,170.80	Prescription drugs	99.60
Hospital care	390.90	Other medical products	47.60
Professional services	396.50	Durable medical equipment	16.90
Physician and clinical services	269.40	Other nondurable medical products	30.70
Other professional services	37.90	Government administration and net cost of private health insurance	72.00
Dental services	56.00	Government public health activities	41.10
Other personal healthcare	33.20	Investment	39.80
Nursing home and home health	123.10	Research	22.20
Home healthcare	33.10	Construction	17.60
Nursing home care	90.00		

Source: Centers for Medicare and Medicaid Services
7500 Security Blvd., Baltimore, Md. 21244
Phone: 410-786-3000, www.cms.gov

Mr. Adams

HMO growth rates

Year	Number of enrollees (in millions)	Percent of U.S. population enrolled in HMOs	Annual growth rate
1992	37.6	14.7%	7.1%
1993	41	15.9	9
1994	45.2	17.3	10.2
1995	50.1	20.3	10.8
1996	58.2	24	16.2
1997	66.9	27	14.9
1998	76.2	29	13.9
1999	81.1	30	6.4
2000	80.4	28.1	-0.9
2001	79.5	not available	-1.1

Source: InterStudy Publications
2610 University Ave. W., Suite 350, St. Paul, Minn. 55114
Phone: 800-844-3351, www.hmodata.com

U.S. Census Bureau
Population Division
Population Estimates Program
Washington, D.C. 20233
Phone: 301-457-4608, www.census.gov

* Survey to January

Mr. Adams

National healthcare spending, as percent of the GDP

In billions of dollars; figures for 2000 and beyond are projections

1980	2000
8.9%	13.1%
1985	2005
10.3%	14.9%
1990	2010
12.2%	15.9%
1995	
13.7%	

Source: Centers for Medicare and Medicaid Services
7500 Security Blvd.,
Baltimore, Md. 21244
Phone: 410-786-3000
www.cms.gov

Mr. Adams

Source: Modern Healthcare By the Numbers 2001 Edition, December 24, 2001, pp. 2-7

BY THE NUMBERS · HEALTHCARE ECONOMICS

Cost of healthcare coverage

Average 1999 premiums for employer-based health plans, based on single coverage. North Dakota and South Dakota were not ranked.

States with highest premiums	Average annual premium	Percent paid by employer
New Jersey	\$2,735	82%
Connecticut	2,685	79
New York	2,600	83
Alaska	2,558	91
Massachusetts	2,530	78
Rhode Island	2,537	83
Wisconsin	2,502	80
Maryland	2,461	80
District of Columbia	2,455	87
Michigan	2,435	83
Vermont	2,419	81
Illinois	2,403	82
Indiana	2,400	83
Montana	2,396	84
Pennsylvania	2,385	83

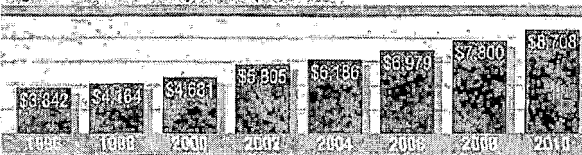
States with lowest premiums	Average annual premium	Percent paid by employer
Hawaii	\$2,208	91%
Tennessee	2,208	79
Virginia	2,208	77
Minnesota	2,198	80
Oregon	2,187	85
Utah	2,175	75
California	2,152	84
Kansas	2,149	82
Arkansas	2,144	81
Kentucky	2,136	81
Alabama	2,135	76
Arizona	2,097	83
New Mexico	2,068	80
Nebraska	2,056	80
Idaho	1,973	86
U.S. average	2,325	82

Source: Kaiser Family Foundation
2400 Sand Hill Road, Menlo Park, Calif. 94025
Phone: 650-854-9400; statehealthfacts.kff.org

MH/John Hall

Healthcare spending per capita

Figures for 2000 and beyond are projections.

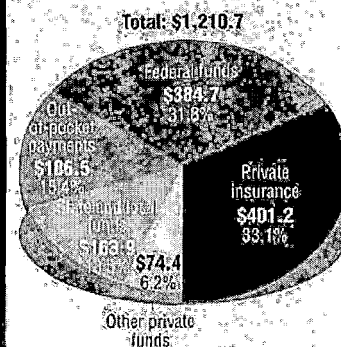


Source: Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, Md. 21244
Phone: 410-786-3000
www.cms.gov

MH/Wilm 500

U.S. healthcare spending by payer source

Data are for 1999, in billions



Source: Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, Md. 21244
Phone: 410-786-3000
www.cms.gov

MH/John Hall

Health plan cost increases

Based on a 2001 survey of 200 employers.



Source: Health Care Costs 2002
Watson Wyatt Worldwide
1717 H St., N.W.
Washington, D.C. 20006
Phone: 202-715-7000
www.watsonwyatt.com

MH/Karen Darr

BY THE NUMBERS · HEALTHCARE ECONOMICS

Uninsured by state

State	Three-year average 1998-2000	State	Three-year average 1998-2000
Alabama	14.2%	Montana	18.3%
Alaska	18.1	Nebraska	9.5
Arizona	19.5	Nevada	17.5
Arkansas	15.3	New Hampshire	8.6
California	19.2	New Jersey	12.9
Colorado	14.1	New Mexico	22.6
Connecticut	9.5	New York	15.3
Delaware	11.2	North Carolina	13.7
Dist. of Columbia	14.5	North Dakota	12.1
Florida	17.2	Ohio	10.2
Georgia	15.2	Oklahoma	17.7
Hawaii	9.8	Oregon	13.7
Idaho	16.5	Pennsylvania	8.3
Illinois	13.3	Rhode Island	6.9
Indiana	11.3	South Carolina	13.8
Iowa	8.2	South Dakota	12.0
Kansas	11.0	Tennessee	10.8
Kentucky	13.1	Texas	22.2
Louisiana	19.5	Utah	13.2
Maine	11.5	Vermont	10.3
Maryland	11.9	Virginia	12.9
Massachusetts	9.2	Washington	12.8
Michigan	10.6	West Virginia	15.2
Minnesota	8.2	Wisconsin	9.3
Mississippi	15.7	Wyoming	15.1
Missouri	9.0	United States	14.4%

Source: U.S. Census Bureau's Poverty and Health Statistics Branch
4700 Silver Hill Road, Suitland, Md. 20746
Phone: 301-457-3213, www.census.gov

MR/Adam Dai

National healthcare expenditures

In billions of dollars; figures for 2000 and beyond are projections

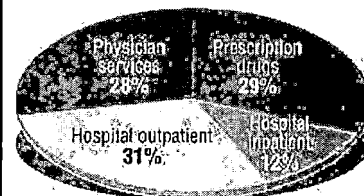
1996	2004
\$1,038.0	\$1,789.8
1997	2005
\$1,093.0	\$1,919.4
1998	2006
\$1,146.1	\$2,051.0
1999	2007
\$1,210.7	\$2,186.3
2000	2008
\$1,311.1	\$2,327.4
2001	2009
\$1,424.2	\$2,477.5
2002	2010
\$1,541.9	\$2,637.4
2003	
\$1,666.2	

Source: Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, Md. 21244
Phone: 410-786-3000
www.cms.gov

MR/Adam Dai

Sources of healthcare cost increases

Healthcare spending per insured person increased 7.2 percent in 2000, the highest increase since 1990.



Source: Center for Studying Health System Change
600 Maryland Ave., S.W., Suite 500
Washington, D.C. 20024
Phone: 202-484-5261, www.hischange.org

Source: Modern Healthcare By the Numbers 2001 Edition, December 24, 2001, pp 2-7

APPENDIX B
MANAGED CARE ORGANIZATIONS

BY THE NUMBERS • INSURERS AND MANAGED CARE

10 largest managed-care organizations

(as of March 2001)

Company by enrollment	Enrollment in millions
Aetna, Hartford, Conn.	18.3
UnitedHealth Group, Minneapolis	16.5
Cigna HealthCare, Philadelphia	14.3
Wellpoint Health Networks, Thousand Oaks, Calif.	9.8
Kaiser Foundation Health Plans, Oakland, Calif.	8.2
Health Net, Woodland Hills, Calif.	6.5
PacificCare Health Systems, Santa Ana, Calif.	3.8
Humana, Louisville, Ky.	2.4
Coventry Health Care, Bethesda, Md.	1.7
Oxford Health Plans, Trumbull, Conn.	1.5

Company by premium revenue	Premium revenue
Aetna, Hartford, Conn.	\$5.1 billion
UnitedHealth Group, Minneapolis	\$5.0 billion
Kaiser Foundation Health Plans, Oakland, Calif.	\$4.9 billion
Cigna HealthCare, Philadelphia	\$3.8 billion
PacificCare Health Systems, Santa Ana, Calif.	\$3.0 billion
Humana, Louisville, Ky.	\$2.4 billion
Wellpoint Health Networks, Thousand Oaks, Calif.	\$2.4 billion
Health Net (formerly Foundation Health Systems), Woodland Hills, Calif.	\$2.1 billion
Oxford Health Plans, Trumbull, Conn.	\$1.1 billion
Coventry HealthCare, Bethesda, Md.	\$751 million

Source: Atlantic Information Services

1100 17th St. N.W., Suite 300

Washington, D.C. 20036

Phone: 800-521-4323

www.aishhealth.com

*Includes enrollment in HMO, point-of-service, PPO and indemnity plans.

MH/John Hall

Hospitals owning insurance products

	2000	1999	1998	1997	1996
HMO	870	1,009	1,099	1,166	1,153
PPO	1,028	1,156	1,303	1,543	1,588
Indemnity, fee-for-service	286	303	387	493	536
Total	2,184	2,468	2,789	3,202	3,277

Source: American Hospital Association

One N. Franklin St.

Chicago, Ill. 60606

Phone: 312-422-2100

www.aha.org

MH/John Hall

Number of Blue Cross and Blue Shield plans

Year	Number of plans
1987	128
1990	72
1995	67
1999	50
2001	45
2006	25 (projected)

Source: Blue Cross and Blue Shield Association

225 N. Michigan Ave.

Chicago, Ill. 60601

Phone: 312-297-5954

www.bluecross.com

Source: Modern Healthcare By the Numbers 2001 Edition, December 24, 2001, p. 28

APPENDIX C
MEDICARE AND MEDICAID

Medicare spending

Amount in billions; figures after 1999 are projections

Year	Spending (billions)
1996	\$200.3
1997	211.2
1998	211.4
1999	213.6
2000	227.0
2001	243.0

Source: Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, Md. 21244
Phone: 410-786-3000
www.cms.gov

MH/Adam Del

10 largest Medicaid HMOs

(As of December 2000)

Medicaid HMO plan	Number of enrollees
Blue Cross and Blue Shield Association, Chicago	2,170,134
Health Net (formerly Foundation Health Systems), Woodland Hills, Calif.	641,867
Humana, Louisville, Ky.	616,803
UnitedHealth Group, Minneapolis	555,221
Amerigroup, Virginia Beach, Va.	255,568
AmeriChoice Corp., Vienna, Va.	180,520
Maxicare Health Plans, Los Angeles	168,870
Coventry Health Care, Bethesda, Md.	164,183
Kaiser Foundation Health Plans, Oakland, Calif.	155,371
Aetna, Hartford, Conn.	101,588

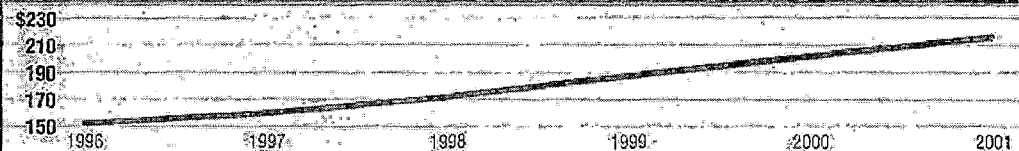
Source: Atlantic Information Services
1100 17th St., N.W., Suite 300
Washington, D.C. 20036
Phone: 800-521-4323
www.aishhealth.com

MH/Adam Del

BY THE NUMBERS: MEDICARE AND MEDICAID

Medicaid spending, 1996-2001

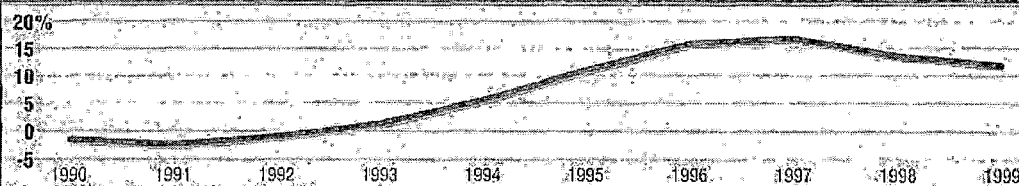
In billions; figures for 2000 and 2001 are projections



Source: Centers for Medicare and Medicaid Services
7500 Security Blvd., Baltimore, Md. 21244 Phone: 410-786-3000 www.cms.gov

MH/Adam Del

Medicare inpatient prospective payment system margins, 1990-1999



Source: Medicare Payment Advisory Commission
1730 K St. N.W., Suite 800, Washington, D.C. 20006 Phone: 202-653-7220 www.medpac.gov

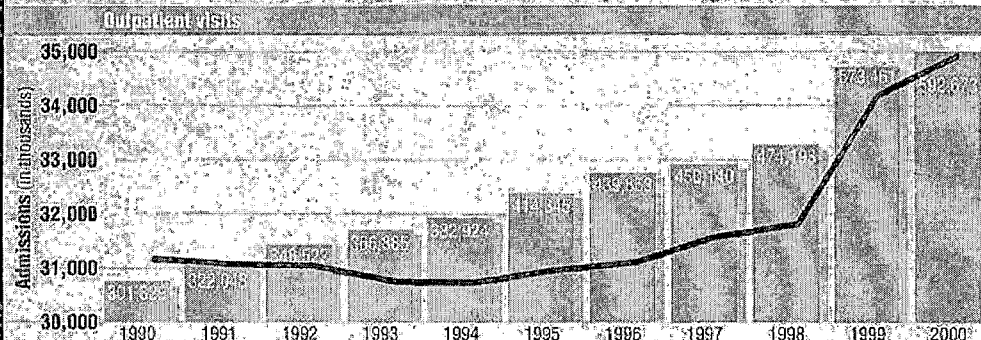
MH/Adam Del

Source: Modern Healthcare By the Numbers 2001 Edition, December 24, 2001, pp 10-11

APPENDIX D
HOSPITAL UTILIZATION, CAPACITY
AND PROFITABILITY

BY THE NUMBERS : HEALTHCARE ECONOMICS

Hospital admissions and outpatient visits for past 10 years



Source: Hospital Statistics, American Hospital Association

One N. Franklin St., Chicago, Ill., 60606

Phone: 312-422-2100

www.aha.org

McGraw-Hill

Hospital utilization rates by state

State	Inpatient admission rate	State	Inpatient admission rate
District of Columbia	225.6	Indiana	115.0
West Virginia	159.3	Rhode Island	113.6
Alabama	153.0	Texas	113.5
Mississippi	149.3	Michigan	111.3
Louisiana	146.4	Maryland	110.8
Pennsylvania	146.2	Montana	110.0
Kentucky	143.9	Delaware	106.3
North Dakota	138.9	Georgia	105.4
Missouri	138.2	Arizona	105.0
Arkansas	137.8	Wisconsin	104.1
Florida	132.6	Virginia	102.7
South Dakota	130.5	Connecticut	102.4
Tennessee	129.6	Nevada	99.8
New Jersey	127.6	California	97.9
New York	127.3	Wyoming	96.9
Oklahoma	124.3	Oregon	96.4
Ohio	123.7	New Mexico	95.4
South Carolina	123.5	Idaho	95.2
Illinois	123.3	Colorado	92.3
Iowa	122.9	New Hampshire	90.0
Nebraska	122.4	Utah	86.9
North Carolina	120.6	Vermont	86.1
Massachusetts	116.6	Washington	85.7
Minnesota	116.0	Hawaii	82.5
Maine	115.5	Alaska	74.8
Kansas	115.4		

Source: Hospital Statistics

American Hospital Association

One N. Franklin St., Chicago, Ill., 60606

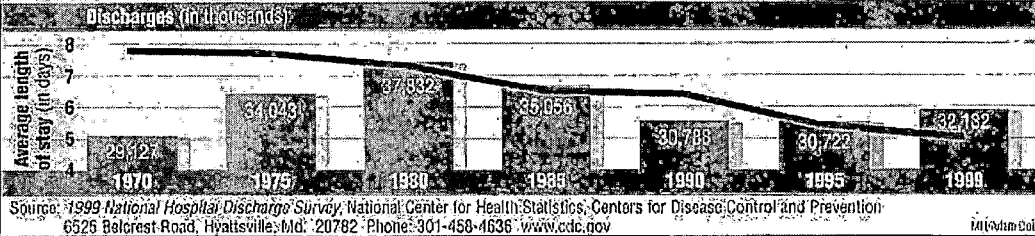
Phone: 312-422-2100; www.aha.org

McGraw-Hill

Source: Modern Healthcare By the Numbers 2001 Edition, December 24, 2001, pp 8, 14-15, 18

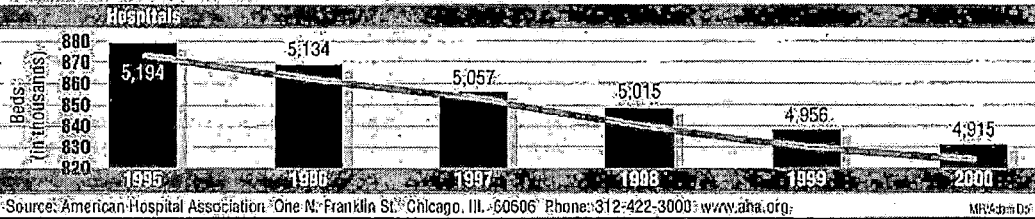
BY THE NUMBERS · HOSPITALS AND HEALTH SYSTEMS

Lengths of stay decline



Number of U.S. hospitals

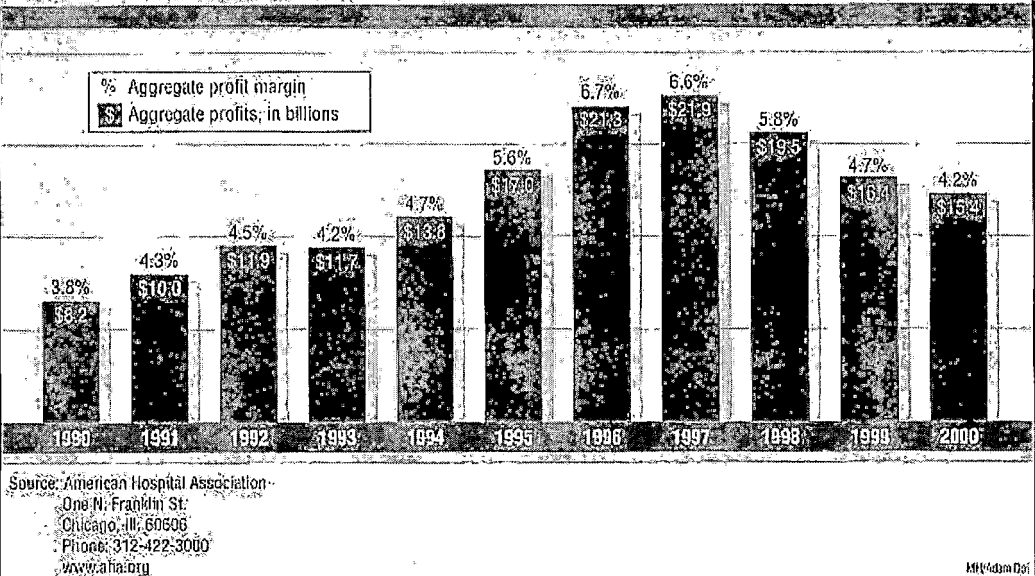
Total U.S. community hospitals



BY THE NUMBERS · HOSPITALS AND HEALTH SYSTEMS

Hospital profitability

Based on data for U.S. community hospitals



Source: Modern Healthcare By the Numbers 2001 Edition, December 24, 2001, pp 8, 14-15, 18

Largest investor-owned hospital chains

General acute care, ranked by revenue

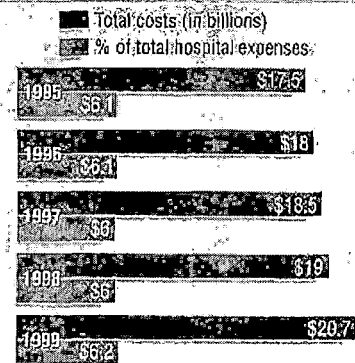
Name	Quarterly revenue (in millions)	Number of hospitals
HCA	\$4,438	189
Tenet Healthcare Corp.	\$3,297	114
Triad Hospitals	\$830	44
Universal Health Services	\$721	69
Health Management Associates	\$491	39
Community Health Systems	\$417	56
Basis Healthcare Corp.	\$217	14
Vanguard Health Systems	\$207	9
LifePoint Hospitals	\$149	21
Providence Healthcare Co.	\$126	16

*For quarter ended Sept. 30, 2001

**Includes acute care and psychiatric facilities

Source: Modern Healthcare 2001 Systems Survey and company earnings reports

Hospitals bring up uncompensated-care costs



Source: American Hospital Association

One N. Franklin St.

Chicago, Ill. 60606

Phone: 312-422-3000

www.aha.org

MF/Adm Del

Largest psychiatric hospitals

Nonpublic hospitals, based on 1999 bed counts

Rank	Hospital name	Location	Beds	Admissions
1	South Oaks Hospital	Amityville, N.Y.	334	815
2	Conifer Park	Glenville, N.Y.	225	2,545
3	Caritas Peace Center	Louisville, Ky.	225	1,856
4	Charter Behavioral Health System	Atlanta	224	2,087
5	Cleo Wallace Centers Hospital	Westminster, Colo.	207	1,929
6	Brentwood Behavioral Health	Shreveport, La.	200	1,963
7	Friends Hospital	Philadelphia	192	4,092
8	Sheppard and Enoch Pratt Hospital	Baltimore	188	5,423
9	Four Winds Hospital	Katonah, N.Y.	175	2,299
10	Charter Lakeside Behavioral Health System	Memphis, Tenn.	174	727

Source: Health Forum, AHA Annual Survey of Hospitals, 1999

American Hospital Association

One N. Franklin St.

Chicago, Ill. 60606

Phone: 312-893-6800

www.aha.org

MF/Adm Del

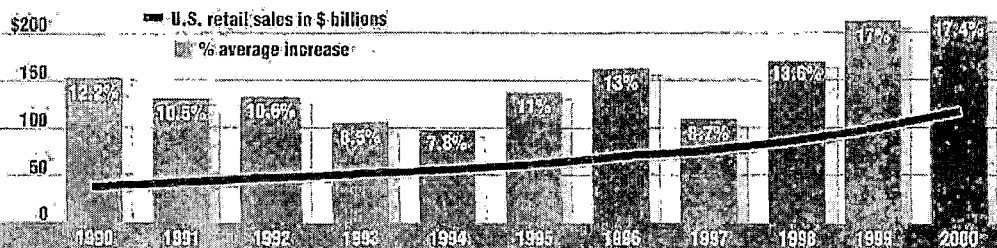
Source: Modern Healthcare By the Numbers 2001 Edition, December 24, 2001, pp 8, 14-15, 18

APPENDIX E
PHARMACEUTICAL TRENDS

BY THE NUMBERS • PRESCRIPTION DRUGS AND SUPPLIES

Outpatient prescription drug expenditures

Based on U.S. retail sales.



Sources: National Institute for Health Care Management
1225 19th St., N.W., Suite 710
Washington, D.C. 20036
Phone: 202-296-4426
www.nihcm.org

Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, Md. 21244
Phone: 410-786-3000
www.cms.gov

MH/John Hall

10 largest purchasing groups based on reported volume

Company	Purchasing volume, in millions	
	Estimated 2000	1999
Novation	\$14,600	\$13,100
Premier	12,500	12,000
AmeriNet	4,600	4,400
Managed Healthcare Associates	3,300	3,000
Health Services Corporation of America	2,600	2,450
Consortia Catholic Resource Partners	2,200	1,562
HealthCare Purchasing Partners International	1,100	965
National Purchasing Alliance	700	700
AllHealth	600	564
Innovatix	600	400

Source: Modern Healthcare 12th Annual Group Purchasing Survey
360 N. Michigan Ave.
Chicago, Ill. 60601
312-280-3173
www.modernhealthcare.com

MH/John Hall

Top 10 prescription drugs

2000 data

Product/Company	Total prescriptions (in thousands)	% growth
Lipitor, Pfizer	48,791	29
Premarin, Wyeth-Ayerst	46,776	-2
Synthroid, Knoll Pharmaceutical Co.	43,504	6
Hydrocodone/APAP, Watson Pharmaceuticals	36,534	20
Prilosec, AstraZeneca	32,082	3
Norvasc, Pfizer	30,765	13
Glucophage, Bristol-Myers Squibb Co.	27,424	21
Albuterol, Warrick Pharmaceuticals	27,415	-8
Claritin, Schering-Plough	26,485	4
Zoloft, Pfizer	25,167	9

Source: IMS Health's National Prescription Audit Plus

Source: IMS Health
660 Gormantown Pike
Plymouth Meeting, Pa. 19462
610-834-6000
www.imshealth.com

MH/John Hall

Source: Modern Healthcare By the Numbers 2001 Edition, December 24, 2001, pp 30

APPENDIX F
HEALTH CARE PREMIUM TRENDS

Spreading the Blame

Health-care premiums in the U.S. rose 14%, or \$67 billion, between 2001 and 2002, driven by the following factors:

	PERCENT OF THE INCREASE	AMOUNT IN BILLIONS
Drug costs	22%	\$15
Rising provider expenses	18%	\$12
General inflation	18%	\$12
Government mandates	15%	\$10
Increased consumer demand	15%	\$10
Litigation	7%	\$5
Other costs	5%	\$3

Source: PricewaterhouseCoopers study commissioned by the American Association of Health Plans

Source: Wall Street Journal, "HMOs Are Driven to 'Tiers'", Thursday, June 6, 2002, D3

Public & Private

Average out-of-pocket expenses in 2001 for health coverage in the private and public sectors:

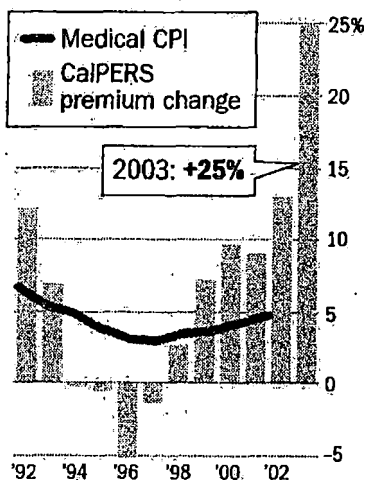
	Private	Public
Premium contribution:		
Employee	24%	20%
Family	33%	29%
HMO office visit co-payment	\$11	\$9
Emergency room co-payment	\$47	\$46
Hospital co-payment	\$245	\$200

Source: Mercer Human Resource Consulting

Source: Los Angeles Times, April 20, 2002, Business Section C, p C1, C3

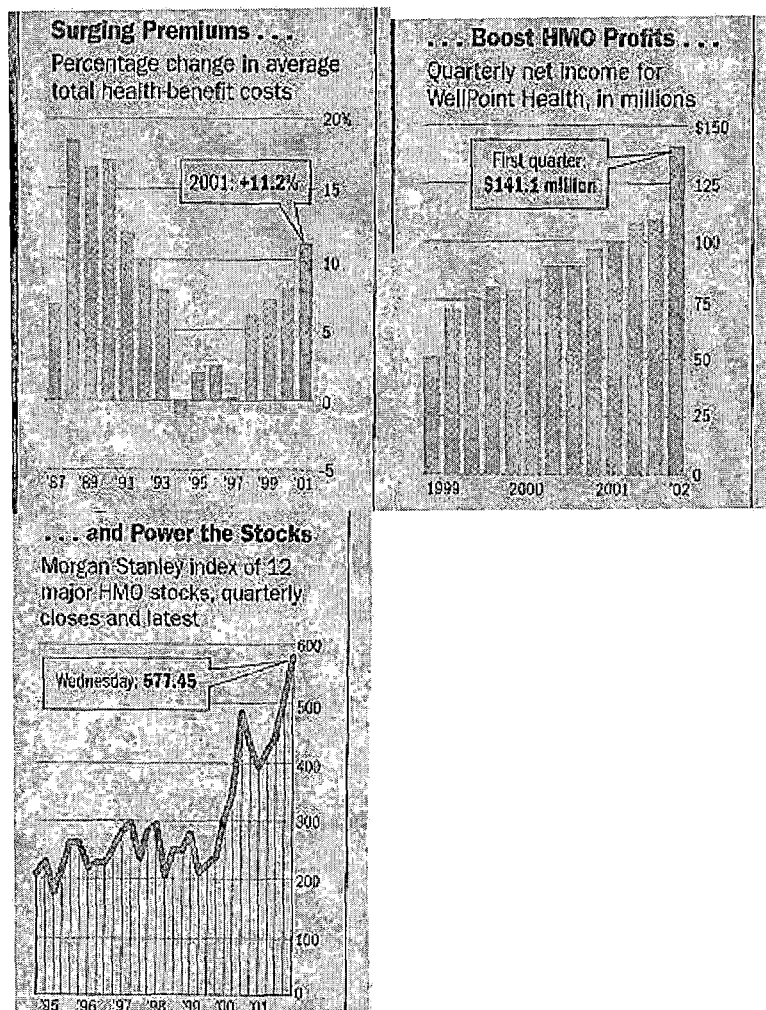
Rising Costs

In recent years, annual percentage changes in health-care premiums for CalPERS members have far exceeded the medical inflation component of the consumer price index.



Note: 2002 increase includes a one-time change to higher co-payments for office visits and drugs.
Sources: CalPERS, Bloomberg News

Source: Los Angeles Times, April 18, 2002, Business Section C, p C1, C3



Source: Los Angeles Times, April 25, 2002, Section C, p C1, C12

Doctors' case: Medicare ills

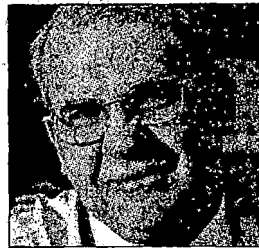
HEALTH: Inland physicians lobby for the program serving seniors by urging higher HMO payments.

BY DOUGLAS E. BEEMAN
THE PRESS-ENTERPRISE

Nearly 200,000 Inland seniors have watched their choice of Medicare HMOs dwindle, their benefits shrink and their costs soar. Now, a handful of Inland physicians is pushing Congress and the White House to save the program.

Four Inland physicians flew to Washington, D.C., last month to press lawmakers and federal officials to increase HMO payments by more than the 2 percent annual raise the health plans have received over the past several years. Two of those doctors have been invited to return to Washington this week to make their case at the White House.

Medicare HMOs say problems have resulted from soaring drug



Dr. Ronald Bangasser is one of two Inland physicians invited to the White House next week.

and medical costs that outstripped payment increases from the federal Medicare program.

President Bush has proposed increasing Medicare HMO payments by 6.5 percent next year. Such an increase would need congressional approval.

The physicians say they are pressing for higher federal HMO payments to ensure that seniors in Riverside and San Bernardino counties continue

PLEASE SEE HMOs, BACKPAGE

MEDICARE HMOs

Who left the Inland area

Maxicare

CIGNA

Health Net*

... and who stayed

Aetna

Blue Cross of California

Blue Shield of California**

InterValley Health Plan**

Kaiser Permanente

SCAN

Secure Horizons

* except employee-sponsored plans

** except the Coachella Valley

Source:



KAISER PERMANENTE®

Fontana Medical Center

Produced by Public Affairs and Communications

For more information contact Jennifer Resch-Silvestri at 8-250-5269

The Press-Enterprise

Page: A1

Tuesday, May 14, 2002

HMOs

CONTINUED FROM A1

to have Medicare HMOs to choose from next year.

"We're right on the cusp in San Bernardino and Riverside counties of getting cut out," said Dr. Ronald Bangasser, a family practice doctor from Beaver Medical Group in Redlands. He is one of two Inland physicians invited to the White House this week.

Painful changes

Inland seniors once had 10 Medicare HMOs to choose from. Now, in most areas, there are just seven. In the Coachella Valley communities of Palm Springs and Rancho Mirage, only five remain.

Seniors once paid little or nothing to see a doctor, had a rich array of insurance benefits and access to an extensive selection of prescription drugs — something traditional Medicare doesn't cover. Lured by such extras, more than half of the Inland region's nearly 400,000 Medicare beneficiaries joined Medicare HMOs.

This year, seniors nationwide saw dramatic changes. In the Inland region, many HMOs imposed stiff limits on prescription drugs and other benefits and higher out-of-pocket fees for such things as hospital care, kidney dialysis and cancer drugs. Three HMOs cut back the areas they served or limited themselves to seniors enrolled in an employer-sponsored health plan.

Medicare HMOs have pulled out of many rural areas of California, and plan officials say they may have to cut benefits or leave still more areas unless they get more money.

"If the money isn't there the program will be challenged (to remain in some areas) . . . and there will be changes in benefits," said Tyler Mason, a spokesman for PacificCare's Secure Horizons, the Inland region's largest Medicare HMO.

One woman's experience

Audrey Rice, a Sun City retiree, is among those Inland seniors struggling to cope. In January, Secure Horizons began charging Rice and her husband \$60 a month in premiums — and wouldn't cover the brand-name drug she said she needed to shake off a nasty case of pneumonia. The drugs cost \$140.70 for a 10-day supply — and her doctor said she would need the pills for at least several months.

"I thought if I'm going to be on the medicine, I can't afford all of that (the medicine and the Secure Horizons premium)," Rice said. She dropped the coverage.

Rice had a fortunate fallback

"If the money isn't there the program will be challenged (to remain in some areas) . . . and there will be changes in benefits."

—Tyler Mason,
Secure Horizons spokesman

position: Her husband is a military retiree, so they qualified for Tricare, the government's supplemental insurance program for military retirees. Tricare has paid for her medication, Rice said.

The physicians pressing Congress and the White House say they want to ensure that Medicare HMOs remain in the Inland region, so seniors can choose an HMO if they want one. The doctors also want to see the HMOs restore some of the benefits that were cut this year — especially prescription drug benefits.

"Basically, what we want is for seniors to get back some of their plan benefits," said Dr. Steve Larson, president of Riverside Medical Clinic and one of the lobbying physicians.

Dr. Marc Hoffing, chief medical officer for Palm Springs-based Desert Medical Group,

said the doctors hope that additional federal money will allow the Medicare HMOs to cover brand-name drugs when no generic drug is available. Hoffing, who will join Bangasser in Washington this week, said prescription drugs are an important treatment tool for physicians.

Three Inland Medicare HMOs dropped coverage of brand-name drugs this year and others capped how much they would pay for drugs.

Some Medicare HMO officials declined to say whether Bush's proposed 6.5 percent increase would be enough to keep them in the Inland region next year.

But Hoffing and Bangasser say the HMOs have assured them that such a raise would keep them here.

Reach Douglas E. Beeman at (909) 368-9549 or dbeeman@pe.com

Source:



KAISER PERMANENTE®

Fontana Medical Center

Produced by Public Affairs and Communications

For more information contact Jennifer Resch-Silvestri at 8-250-5269

The Press-Enterprise

Page: A1

Tuesday, May 14, 2002

Paying more for Medicare HMOs

Medicare HMOs have raised fees for Inland seniors and reduced benefits. Some plans no longer cover brand-name drugs. Here are basic changes for the seven plans covering the Inland region. Contact plans for detailed information.

Health plan (Enrollment) Phone number Web site	Service	2002 fees	2001 fees
Aetna (33,165) (800) 832-2640 www.aetna.com	Monthly premium.....	\$25	\$15
	Office visit.....	\$10/primary care; \$15/specialist	\$5
	Inpatient hospital care.....	\$100/day, maximum per stay, \$500	No fee
	Generic drugs.....	\$10	\$10
	Brand-name drugs.....	\$25, formulary; \$50, non-formulary	\$20
	Drug limits.....	\$1,000/year, brand-name drugs	\$2,000/year, brand-name; \$35 co-pay non-formulary drugs
Blue Cross of California (16,120) (888) 230-7338 www.bluecrossca.com	Monthly premium.....	None	None
	Office visit.....	\$10	\$10
	Inpatient hospital care.....	\$125/day, max \$2,000/year	No fee
	Generic drugs.....	\$8	\$7
	Brand-name drugs.....	Not covered	\$14
	Drug limits.....	No limit on approved generics	\$1,000/year
Blue Shield of California (7,120) (800) 776-4466 www.BlueShieldCa.com	Monthly premium.....	\$55	None
	Office visit.....	\$10	\$10
	Inpatient hospital care.....	\$250/day, \$750 max per hospital stay	No fee
	Generic drugs.....	\$10	\$7
	Brand-name drugs.....	Not covered	\$25
	Drug limits.....	\$500/year	\$2,000/year brand-name
	Other.....	Not offered in Coachella Valley	
InterValley Health Plan (8,468) (800) 251-8191 www.ivhp.com	Monthly premium.....	\$50, Riverside Co.; \$30, S.B. Co.	None
	Office visit.....	\$10	\$8
	Inpatient hospital care.....	No fee	No fee
	Generic drugs.....	\$10	\$10
	Brand-name drugs.....	\$25, formulary. Non-formulary drugs: \$42, Riverside Co.; \$38, S.B. Co.	\$20
	Drug limits.....	\$450/quarter, all drugs, Riverside Co. \$450/quarter, brand-name, S.B. Co.	\$2,500/year brand-name
	Other.....	Not offered in Coachella Valley	
Kaiser Permanente (51,868) (800) 443-0815 www.kaiserpermanente.org	Monthly premium.....	\$57	\$30
	Office visit.....	\$10	\$10
	Inpatient hospital care.....	\$200/stay, \$800 annual max	No fee
	Generic drugs.....	\$10	\$10
	Brand-name drugs.....	\$25	\$10
	Drug limits.....	\$2000 combined annual limit	Unlimited
SCAN (12,772) (800) 559-3500 www.scanhealthplan.com	Monthly premium.....	\$40	None
	Office visit.....	\$5	\$5
	Inpatient hospital care.....	No fee	No fee
	Generic drugs.....	\$7	\$5
	Brand-name drugs.....	\$25, formulary; \$40, non-formulary	\$20
	Drug limits.....	Unlimited	Unlimited
Secure Horizons (56,458) (800) 228-2144 www.securehorizons.com	Monthly premium.....	\$30	None
	Office visit.....	\$10	\$10
	Inpatient hospital care.....	\$275/stay	No fee
	Generic drugs.....	\$9	\$7
	Brand-name drugs.....	Not covered	\$20
	Drug limits.....	No limit on approved generics	\$2,000/all drugs combined

SOURCES: CENTERS FOR MEDICARE AND MEDICAID SERVICES AND HEALTH PLANS LISTED

Source:



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For more information contact Jennifer Resch-Silvestri at 8-250-5269

The Press-Enterprise
Page: A1
Tuesday, May 14, 2002

Health Insurance Rate Hikes Expected

Poll: UCLA survey finds more employers plan to shift the burden of rising premiums to workers.

By DON LEU
TIMES STAFF WRITER

In an early look at what health insurance will cost in 2003, a new national survey by UCLA shows that many employers are expecting rate hikes of 20% or more and are preparing to make substantial changes in health plans to shift more of the burden of rising premiums to workers.

Some employers already have begun to make changes such as raising co-payments and deduct-

ibles or reducing the level of health benefits. But the pace appears to be quickening, according to the UCLA survey, which is being released today.

"We're changing from an era where companies sucked up the increases to where they're going to pass [them] on to employees," said Chris Thornberg, a senior economist at the UCLA Anderson Forecast, which conducted the poll of 460 employers. They view this as just the beginning.

Just about all of the respondents to the survey said they were expecting health premiums to jump by double-digit percentages in the coming year. One out of four employers said it was bracing for an increase of 20% or more.

Please see **HEALTH, C13**

HEALTH: Premiums Expected to Rise 20%

Continued from C1

As a result, about 75% of the managers polled said they were somewhat or very likely to substantially revise their health plans when annual renewals come up.

UCLA's findings are consistent with other recent reports from consultants that suggest health care will be even more costly for employers than previously expected. This month, Hewitt Associates said insurance firms are demanding HMO premium increases of more than 20% for 2003, compared with an average rise of 15% for this year. Hewitt's survey noted that employees are being asked to pay more out of pocket for prescription drugs, which have been a major contributor to the inflation.

UCLA's survey included small and large employers across a broad spectrum of industries. Most big employers are now only beginning to negotiate with insurers and decide plan options for the upcoming year. But a lot of smaller businesses have already received their annual renewal rates.

Garry Angelotti, owner of VTS Inc., a medical equipment service firm in Santa Clarita, got his new company health insurance bill last month. It jumped 45% from a year ago, to \$2,325 a month. Angelotti has 10 employees and his company is unusual in that it pays 100% of employee insurance premiums.

But Angelotti said he can't keep that up for long. To pay for the higher premiums, he has raised prices for services and parts. But even that isn't enough. There's only so much money in the till, he

said.

Most businesses, however, can't raise prices because of the competition, and, tough economy, said Steve Richter, a senior health-care benefits consultant at Watson Wyatt Worldwide in Universal City. They've got to pass a lot of the costs to employees, he said.

Eva Wang, an insurance broker in San Gabriel who specializes in small-group policies, said her clients are seeing 10% to 30% premium increases. So far, she said, no one has dropped coverage. But some have boosted deductibles and switched from a regular HMO to a cheaper plan with fewer benefits. "I see downgrading," said Wang, who has more than 1,000 individual and small-business clients.

UCLA's Thornberg said such widespread action is a huge shift from the late 1980s and early 1990s, when employers largely absorbed the cost increases before HMOs took hold.

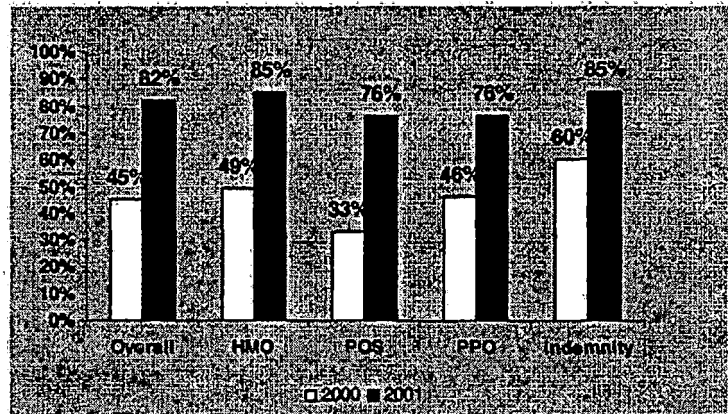
UCLA's survey, however, showed employers were in no rush to switch to so-called defined contribution plans, in which businesses give their employees a set amount of cash to buy health insurance themselves.

Some analysts had predicted these plans would proliferate soon, but only 15% of the respondents to UCLA's poll said they were likely to take that route. Analysts said employers are hesitant to offer these plans because of tax consequences and the uncertainties of leaving it up to employees to buy private medical coverage, which typically is more expensive.

Source: Los Angeles Times, June 18, 2001, Business Section C1, C13

APPENDIX G
DEFINED BENEFIT TO DEFINED
CONTRIBUTION

% of Purchasers Anticipating Annual Premium Rise of 10%+



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Deep Pressure Points

Health Care Cost Drivers

- Hospitalization
 - Reversal of 20-year downward trend
- Provider consolidation
 - 20-50% hospital rate increases not uncommon
- Retreat from managed care
- Pharmacy costs
 - 15-20% annual growth rate
 - Projected to overtake inpatient costs by 2010

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Source: The Permanente Executive Conference, The Permanente Federation LLC, May 5-7, 2002, "Sixty Years Later—Inventing the Future of Health Care, Jay Crosson, MD, pp 9-14

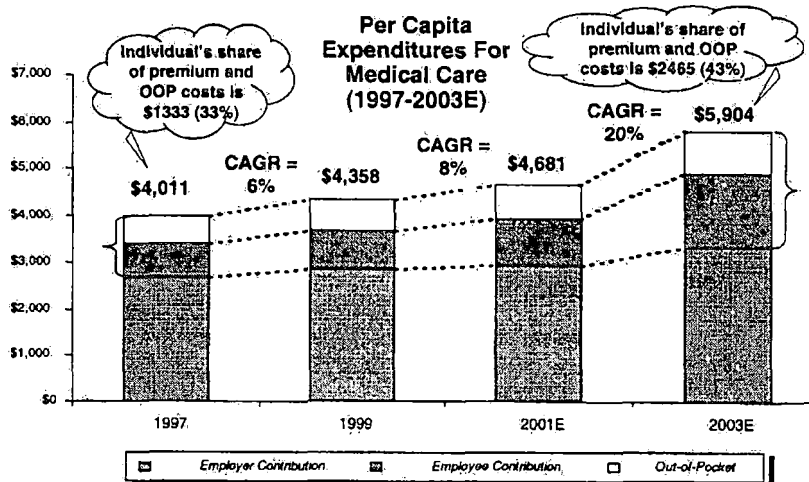


More Cost Drivers

- New technologies, therapies for an expanding range of health conditions
- Benefits mandates
- Demographics — Baby boomers needing more care
- Shortages of nurses, specialists, pharmacists
- Liability

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Who Gets Shaken?

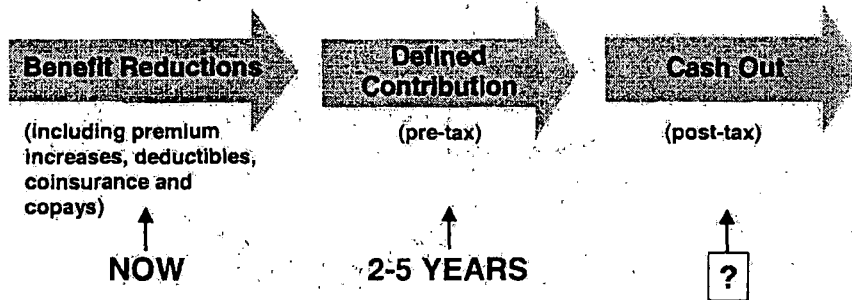


Source: Hewitt Associates 2000 data, HCFA, Goldman Sachs Managed Care Overview (9/10/00)
 Note: Increase in employee contribution to premium and OOP costs: '97-'99 (75 basis points), '99-'01 (250 basis points), '01-'03 (.800 basis points)

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Source: The Permanente Executive Conference, The Permanente Federation LLC, May 5-7, 2002, "Sixty Years Later—Inventing the Future of Health Care, Jay Crosson, MD, pp 9-14

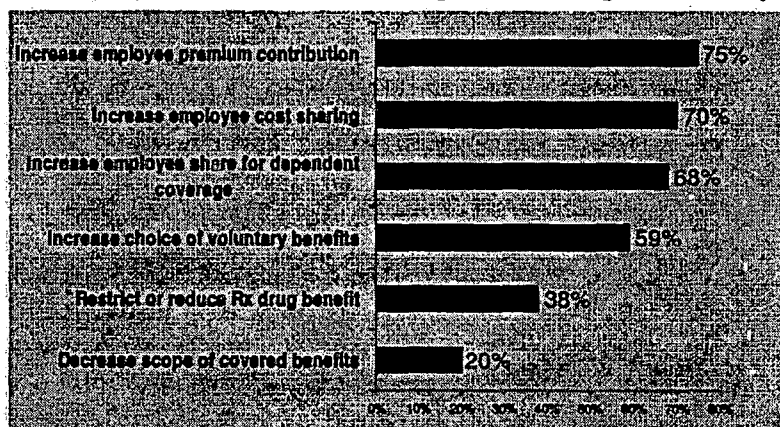
Purchaser Responses — Cost Shifting to Employees



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Purchaser Responses — Benefit Reductions

Share of employers likely to make following benefit changes in next 2 years.

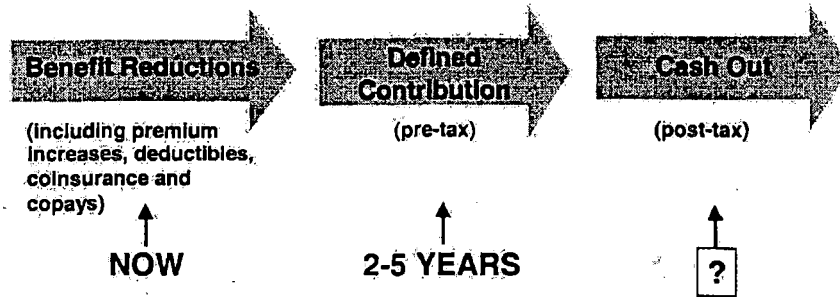


Source: Harris Interactive 2001

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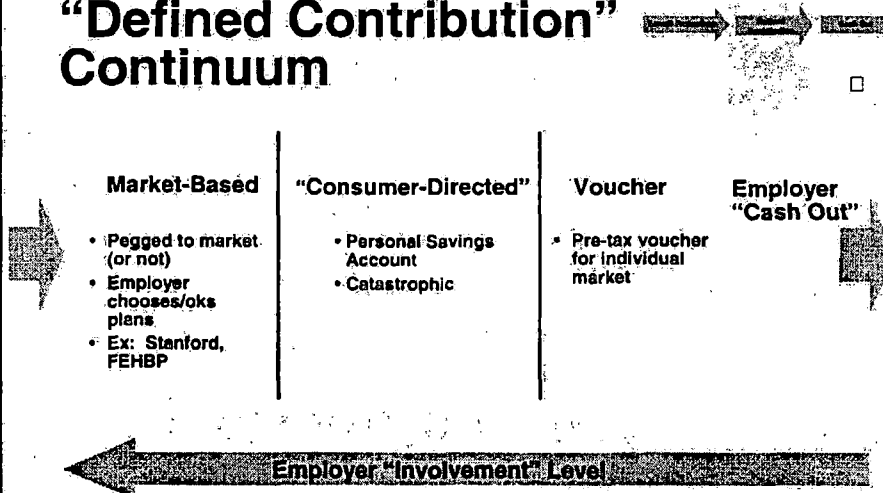
Source: The Permanente Executive Conference, The Permanente Federation LLC, May 5-7, 2002, "Sixty Years Later—Inventing the Future of Health Care, Jay Crosson, MD, pp 9-14

Purchaser Responses — Cost Shifting to Employees



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"Defined Contribution" Continuum



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Source: The Permanente Executive Conference, The Permanente Federation LLC, May 5-7, 2002, "Sixty Years Later—Inventing the Future of Health Care, Jay Crosson, MD, pp 9-14



A Typical "Consumer-Directed" Plan

Example:
Definity's
"Breakthrough
Plan" as offered
by PBGH

Catastrophic Coverage

- Covers all care above \$1500-5000 deductible, with copay

Unfunded Care

- Paid out of pocket
- Difference between PSA amount and deductible

Personal Savings Account

- \$1000-1500
- Paid by employer
- Annual rollover of unused balance
- Preventive care

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Cost Shifting in Medicare + Choice Program

- AAPCC Payment increase capped at 2% (BBA 1997)
- Premium increases, California

**On the
horizon...**
"Premium
Support"
program,
Defined
Contribution
for Medicare

	2000	2001	2002
San Francisco	\$0	\$30	\$80
Los Angeles	\$0	\$20	\$35
Sacramento	\$0	\$40	\$80
Ventura	\$0	\$30	\$75
Atlanta	\$0	\$40	\$40
Baltimore	\$19	\$79	\$79

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Competitor Health Plan Responses

Responding to employer demands for relief from double-digit health care cost increases, plans are offering a broad variety of new and traditional options that shift decision-making – and costs – to the employee/consumer.

- High deductibles, coinsurance, and copays
- Tiered benefit packages — Different copay levels for pharmacy, hospitals, and physician groups based on costs
- Carve-outs of covered services
- Self-Insurance

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Implications of Employer Cost Shifting

- Cost burden shift to chronically ill
- Barriers to care (high copays, coinsurance, deductibles)
- Risk pool fragmentation, adverse selection

One of the great ironies is that label placed on these things is consumer-driven – a clever label for it, but this isn't coming from consumers as far as I can tell."

—Elizabeth Imholtz, Consumers Union

May 5-7, 2002 Page 28

Source: The Permanente Executive Conference, The Permanente Federation LLC, May 5-7, 2002, "Sixty Years Later—Inventing the Future of Health Care, Jay Crosson, MD, pp 9-14



definity health



Pacific Business
Group on Health

Contact: Clark Miller (PBGH)
(415) 615-6302

Chris Delaney (Definity Health)
(952) 277-5603

**Pacific Business Group on Health Unveils
Groundbreaking Alternative to Managed Care**

*Developed in partnership with Definity Health, Breakthrough Plan
gives consumers control over health care decisions*

San Francisco, CA, Nov. 8, 2001—The Pacific Business Group on Health (PBGH) announced today that it will offer a new consumer-driven health care plan—the Breakthrough Plan—to its 44 member-companies.

PBGH becomes the largest purchaser coalition in the country to offer an innovative new type of health plan that gives more choice to consumers while spurring traditional health plans to give consumers both more control and more responsibility. Consumers will have access to quality information on hospitals and medical groups – and ultimately on individual physicians. The plan introduces greater flexibility in selection and use of providers. By providing powerful decision-making tools to participants, the Breakthrough Plan places consumers in control, with strong incentives to make health care decisions on the basis of quality and value.

"The Breakthrough Plan brings a fundamentally different approach to health care delivery. Ten years ago, large employers in California embraced the managed care model and helped make it today's national standard. Now, purchasers are announcing their desire to change the direction of care delivery in the state and usher in a new era of accountability for consumers and providers," said Peter Lee, President and CEO of PBGH.

"Over the coming months, we will work to integrate PBGH's quality measurement systems into Definity Health's consumer tools, and ultimately, we expect the Breakthrough Plan to take us to the next step in quality measurement—to the individual physician level. That's what consumers are most interested in," said Lee.

"In today's health care marketplace, we not only have substantial cost inflation, but also quality and service stagnation. We think the ingredients of this approach will engage and activate consumers to be involved in their own health care in exciting new ways, whether through a traditional health plan or the Definity Health plan," stated Michele

Source: Definity Health, "Pacific Business Group on Health Unveils
Groundbreaking Alternative to Managed Care," November 8, 2001

APPENDIX H
BALANCED SCORE CARD

French, Executive Director of Workforce Planning, University of California (a member of the PBGH board of directors and part of the review process for the Breakthrough Plan).

"We know consumers are interested in much greater flexibility and autonomy in making health care decisions for themselves and their families," suggests Ron Pollack, Executive Director of Families USA, a leading Washington-based consumer organization. "Until now, there has been insufficient information support to do this in a meaningful way. We believe PBGH is uniquely positioned to help develop a product anchored in quality performance information."

The plan has three core elements:

- **Personal Care Account (PCA)**—The PCA is an annual account established by employers for individual employees and their families. When covered employees require medical care, it's paid for from their PCAs—with no referrals, preauthorizations, or administrative burdens. Most expenses paid through the PCA apply toward an annual health coverage deductible. Any unused PCA benefit dollars "roll over" into the following year's account. To ensure that consumers aren't discouraged from getting needed care, the plan is designed to pay for 100% of preventive care, and these amounts are not deducted from an employee's PCA.
- **Health Coverage**— Employees tap health coverage when annual health care expenses exceed Personal Care Account funds and they have reached an annual deductible. Qualifying medical services covered with benefit dollars from the Personal Care Account apply towards the health coverage deductible. Employees are encouraged to use a plan-preferred provider, but are free to choose any provider they wish (although coinsurance may be higher outside the network).
- **Tools and Resources**—The Breakthrough Plan will offer participants easy-to-use and engaging information to help choose the best providers and manage their health care needs. For those with serious health issues and chronic illnesses, it will provide the best care management and self-care tools and resources available, as well as incentives to use them. Resources will be available by telephone and Internet and will include up-to-date medical information from leading research institutions, an audio health information library, and provider quality information and ratings from PBGH's Web site, HealthScope.org. The availability and accessibility of quality and cost information will allow consumers to more closely scrutinize their options and weigh trade-offs between competing decisions.

"Consumer-driven approaches increase customer satisfaction and raise employee awareness of the true cost of health care. We are pleased to partner with PBGH on this groundbreaking project," said Tony Miller, CEO of Definity Health.

The Breakthrough Plan is the product of an intensive two-year review by PBGH and its members of alternate health care models and vendors. The review was launched in response to purchasers' concerns about widespread consumer dissatisfaction with existing health care delivery systems, rising costs and few improvements in health care

Source: Definity Health, "Pacific Business Group on Health Unveils Groundbreaking Alternative to Managed Care," November 8, 2001

quality. PBGH assessed a wide range of products, including "traditional" managed care plans and products that identified themselves as "defined contribution," in which the employer limits financial risk by contributing a specific amount of money to each employee for the purchase of health care coverage. The selection of Definity Health was based on its consumer-driven model, strong array of support tools and willingness to work closely with PBGH to develop better tools to serve the consumer best.

The Breakthrough Plan is also expected to significantly influence the health care marketplace—not only by providing employers and employees another health benefit option, but also by sparking traditional health plans to improve quality and customer service.

As a service to purchasers, employer coalitions, small group purchasing pools, and other interested organizations, PBGH will make available the tools developed for plan evaluation on its Web site early next year. The Breakthrough Plan would most likely be customized by each employer and offered as an additional health benefit program. It could be available to consumers as early as 2002, though most purchasers are looking to make it available in 2003.

About the Pacific Business Group on Health

The Pacific Business Group on Health (PBGH) (www.pbgh.org), a major non-profit coalition of 44 purchasers, is dedicated to improving health care quality while moderating cost. Its members annually spend more than \$3 billion to provide health coverage to approximately 3 million employees, retirees and their families. PBGH seeks to promote health plan and provider accountability and to provide consumers with standardized, comparable data to make the best health care decisions at all levels of care. PBGH also operates PacAdvantage, the nation's largest small-group purchasing pool providing health insurance to 140,000 Californians employed by more than 10,000 small employers.

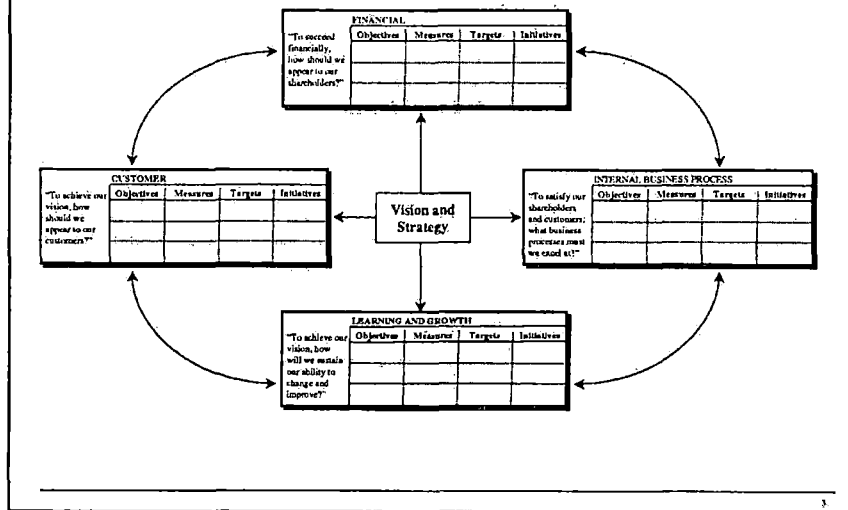
About Definity Health

Minneapolis-based Definity Health (www.definityhealth.com) began operations in 1998 with the goal of providing health benefit programs that give consumers greater choice and responsibility over their health care decisions. A broad range of industry-leading employers have announced their offering of Definity Health effective January 2002, including Medtronic, Aon, Charter Communications, Textron, Raytheon and the University of Minnesota. Financial backers include Kohlberg Kravis Roberts & Co., Merrill Lynch Ventures, Bain Capital, Aon Corporation, Alta Partners, Psilos Group Managers, Toronto Dominion Investments and Brightstone Capital. Strategic partners include Johns Hopkins University and Health System, Synertech, Unifi, Wells Fargo, and Merck-Medco.

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Source: Definity Health, "Pacific Business Group on Health Unveils Groundbreaking Alternative to Managed Care," November 8, 2001

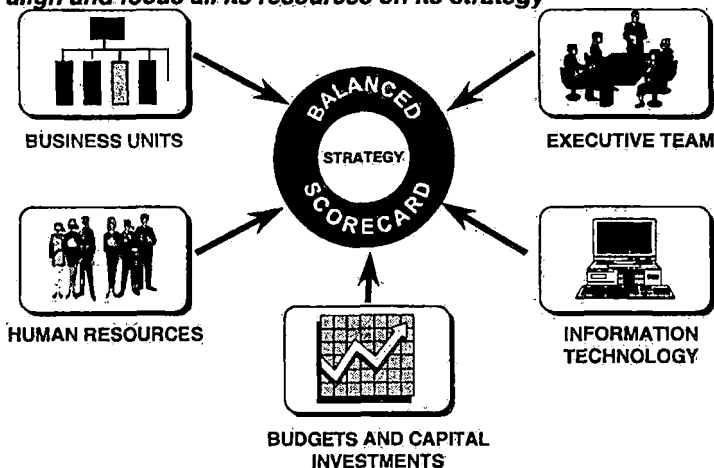
Translating Vision and Strategy: Four Perspectives



Question:
How can complex organizations achieve results like this in such short periods of time?

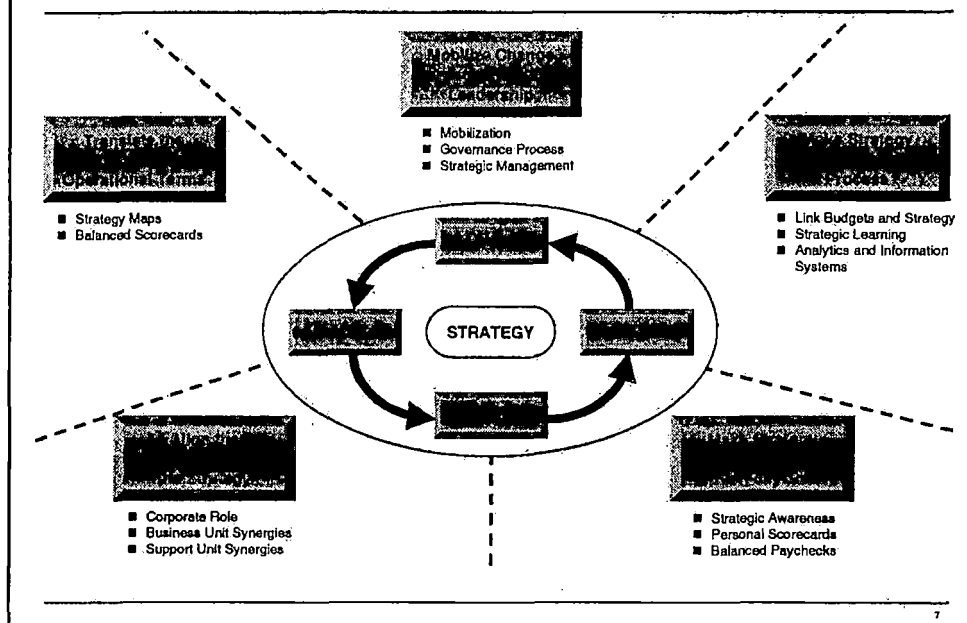
Answer:
Alignment!

The Balanced Scorecard process allows an organization to align and focus all its resources on its strategy



Source: "Building Strategy Focused Organizations with the Balanced Scorecard," Dr. Robert S. Kaplan, Marvin Bower Professor of Leadership Development, Harvard Business School

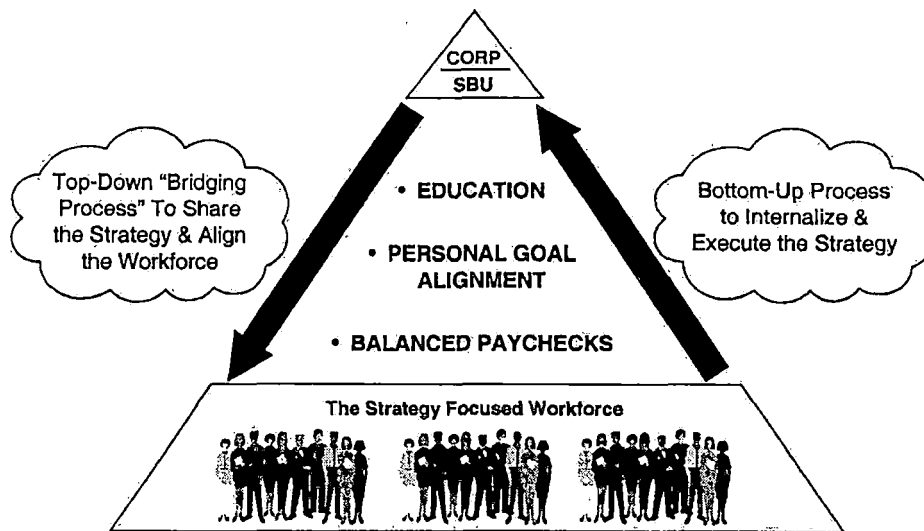
The Five Principles to Become a STRATEGY-FOCUSED ORGANIZATION



#4

Principles of the Strategy Focused Organization: **MAKE STRATEGY EVERYONE'S EVERYDAY JOB**

HR Processes Are Essential for Moving Strategy From the Top to the Bottom



Source: "Building Strategy Focused Organizations with the Balanced Scorecard," Dr. Robert S. Kaplan, Marvin Bower Professor of Leadership Development, Harvard Business School.

Example of Kaiser Permanente Balanced Score Card for Operating Unit

Category	Metric
Growth:	Member Monthly (Revenue)
Quality:	HEDIS (e.g. Mammo, Ped Immunization, and Pap % in Population Served)
Service:	Patient Satisfaction Survey Access and Personalized Care
Inpatient & Utilization	Bed Days/1000 Members (Admin Rate x Average Length of Stay) Total Plan Commercial/Medicare Breakdown (less than 65 years old)
Pharmacy	Per Member/Per Month Expenditure + Performance on Specific Initiatives
Financial	Overall Per Member/Per Month Health Plan/Medical Group Breakdown
Workforce Planning	#RN Vacancies - Overall - By Specialized Units
Regulatory Compliance	- Member Service/DMHC Issues - Sentinel Events

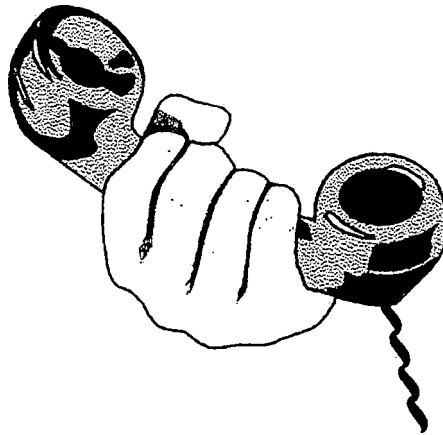
APPENDIX I
KAISER PERMANENTE TIMELINE

Kaiser Permanente 2001-2002 Defined Benefit to Defined Contribution Timeline

	2 nd Quarter 2001	3 rd Quarter 2001	4 th Quarter 2001	1 st Quarter 2002
Market Place Events 	<ul style="list-style-type: none"> CALPERS/PBGH Negotiations Medicare Rate Setting 	<ul style="list-style-type: none"> Benefit Design and Cost Sharing Medicare Submission re Product and Location 	<ul style="list-style-type: none"> Open Enrollment - Commercial - Medicare 	<ul style="list-style-type: none"> Implementation of New Benefit Design and Cost Sharing
	 April-June 2001	 July-Sept 2001	 Oct-Dec 2001	 Jan-March 2001
KP Response	<ul style="list-style-type: none"> Strategic Planning 	<ul style="list-style-type: none"> Tactical Planning 	<ul style="list-style-type: none"> Stakeholder Communication Systems Development Implementation Readiness 	<ul style="list-style-type: none"> Balanced Scorecard Monitoring Performance Feedback Loop

Year 2002 Benefit Changes

THE CHANGE	DESCRIPTION	IMPACT ON TRADITIONAL HMO MEMBERS	OPTIONAL BENEFIT?
CONTRACEPTION Certain contraceptives will be covered under the base benefit* at no charge in the medical office. <i>*supplemental drug coverage not required</i>	Effective 2002, as purchasers' contracts renew, emergency contraception (the "morning after" pill), injectable and implantable contraceptives, and intrauterine devices (IUDs) will be covered under the base benefit at no charge in the medical offices. Oral contraceptives and contraceptive devices other than IUDs (e.g., cervical caps, diaphragms) will continue to be covered under the supplemental drug plan benefit at the drug plan copayment and days supply.	Members who used to receive contraceptives under the supplemental drug plan benefit at the drug copayment, as well as members without any supplemental drug plan coverage at all, will begin to receive injectable, implantable, and emergency contraception, plus IUDs, under the base benefit at no charge in the medical offices. Injectable contraceptives (Depo Provera), implantable contraceptives (Norplant), and IUDs will be administered in the medical offices only and not dispensed in the pharmacy. Emergency contraception ("morning after" pills) may be dispensed in the medical office and the pharmacy upon prescription by a Plan physician.	No. (Except for religious groups as defined by Knox-Keene). Purchasers who meet California Health and Safety Code 1367.25 criteria for religious groups may elect to exclude contraceptives used for contraceptive purposes for Traditional Plan members.
BASE VISION Medically necessary therapeutic contact lenses will be covered for patients with anisidia.* <i>*Anisidia is the congenital absence of an iris.</i>	Effective 2002, as purchasers' contracts renew, medically necessary therapeutic contact lenses with or without refractive value will be covered under the base vision benefit for patients with anisidia. Coverage will be limited to up to 2 lenses per eye, per year. Additional lenses will be provided at the Member Rate.	Members in Northern and Southern California with anisidia will begin to receive therapeutic lenses with or without refractive value under the base vision benefit.	No.
SUPPLEMENTAL OPTICAL Up to five medically necessary replacement pediatric aphakic* contact lenses will be covered under the supplemental optical benefit. <i>*Aphakia is the absence of the crystalline lens of the eye.</i>	Effective 2002, as purchasers' contracts renew, the supplemental optical benefit will cover up to five medically necessary replacement pediatric aphakic contact lenses per eye for children up to the age of 10. Additional lens replacements will be provided only when there is a change of at least 0.5 Diopter.	To match the benefit in Southern California, Northern California members will be covered under the supplemental optical benefit for up to five medically necessary replacement pediatric aphakic contact lenses per eye, for children up to the age of 10.	No.
OPTICAL Supplemental optical exclusions	Effective 2002, as purchasers' contracts renew, the exclusions that apply to the supplemental optical benefit will include (but are not limited to): lens adornment, such as engraving, faceting, and jewelry; progressive multifocal lenses and high-index lenses; ultraviolet-inhibiting lenses; and tinted or other special-use lenses, such as polycarbonate, photochromic, or anti-reflective lenses, unless the lenses are medically required for the treatment of retinitis pigmentosa or macular degeneration.	The same exclusions will apply under the supplemental optical benefit to members in Northern and Southern California.	Only ultraviolet-inhibiting lenses.
PROSTHETICS AND ORTHOTICS Three post-mastectomy brassieres will be covered under the base prosthetics and orthotics (P&O) benefit.	Effective 2002, as purchasers' contracts renew, the California Division will cover 3 brassieres every 12 months under the base P&O benefit for members who require an external breast prosthesis after mastectomy. At the end of 12 months and every 12 months thereafter, up to three replacement post-mastectomy bras will be provided due to wear. No more than three bras will be provided within a 12-month period.	To match the benefit in Southern California, Northern California members will be covered for three brassieres after mastectomy.	No.
AMBULANCE A \$50 copayment will apply to covered medically necessary ground and air emergency ambulance transportation.	Effective 2002, as purchasers' contracts renew, a \$50 copayment will apply to covered medically necessary ground and air emergency ambulance transportation. Medically necessary non-emergency ambulance transportation will remain covered at no charge. Non-medically necessary ambulance transportation is still not covered. Transportation by any means other than a licensed ambulance, including wheelchair and gurney van, is also not covered.		Yes. Note: Purchasers with non-customized contracts will have the \$50 ambulance copayment as the default. Customized contracts will keep the current ambulance equipment, Strategic, National, and Large Group purchasers may elect to buy up the emergency ambulance copay to \$40 or \$25, or buy down the copay to \$75.
EMERGENCY DEPARTMENT VISITS A \$50 copayment will apply to covered Emergency Department (ED) visits.	Effective 2002, as purchasers' contracts renew, a \$50 copayment will apply to covered ED visits.	Members will be charged a \$50 copayment for covered ED visits. The copayment will be waived if the patient is admitted to the hospital.	Yes. Note: Purchasers that currently have the \$35 copayment will have the \$50 ED copayment as the default. Customized contracts will keep the current ED copayment. Strategic, National, and Large Group purchasers may elect to buy up the emergency copayment to the office visit copay, \$25, or \$35, or buy down the copay to \$75 or \$100.
DME AND P&O A 20% copayment will apply to base and supplemental outpatient durable medical equipment (DME) and prosthetics and orthotics (P&O) items dispensed in the medical office, in the pharmacy, or by a vendor.	Effective 2002, as purchasers' contracts renew, a 20% copayment will apply to outpatient base and supplemental DME and P&O items dispensed in the medical office, in the pharmacy, or by a vendor. DME and P&O provided during a covered inpatient or SNF stay will continue to be provided at no charge under the base benefit. Internally implanted devices covered under the base P&O benefit will also continue to be provided at no charge.	Members who used to pay \$0 for base and supplemental DME and P&O items dispensed in the medical office, pharmacy, or by a vendor will be charged a 20% copayment for these items.	Yes. Note: Purchasers with non-customized contracts will have the 20% DME and P&O copayment as the default. Customized contracts will keep the current DME and P&O copayment. Strategic, National, and Large Group purchasers may elect to buy up the 20% DME & P&O copayment to \$0.



MEDICAL FINANCIAL ASSISTANCE Program Information Hotline:

Procedure to follow if patient needs financial assistance:

- 1) deliver service
- 2) bill for service
- 3) advise patient that there may be assistance available,
and to please call the above number for more information
- 4) write the 800 number on the patient copy of the CPR

PLEASE POST THIS NOTICE AND USE THIS PROCEDURE UNTIL
YOU RECEIVE YOUR SUPPLY OF MFA REFERRAL FORMS AND
BROCHURES.

Questions?
Call Point-of-Service Support
At 8/250-7670.

Forms are expected to be delivered by mid-January or before.

Source: Internal Communication Kaiser Permanente, Fontana, California,
January 2002

KAISER PERMANENTE

For information about changes to
your 2002 benefits, please visit
your local Member Services
Department, or call the Member
Service Call Center at

1-800-464-4000 (English)

1-800-788-0616 (Spanish)

1-800-757-7585 (Cantonese and
Mandarin)

1-800-777-1370 (TTY)

California Member and Marketing Communications
5527-3005-01

KAISER PERMANENTE

Si desea información sobre los
cambios en sus beneficios del
2002, por favor llame al
Departamento de Servicios a los
Miembros en su localidad o llame
al Centro de Llamadas para
Servicios a los Miembros al

1-800-464-4000 (inglés)

1-800-788-0616 (español)

1-800-757-7585 (cantonés y
mandarín)

1-800-777-1370 (TTY)

California Member and Marketing Communications
5527-3005-01

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