

**PAYMENT LEVEL COMPARISON BETWEEN PUBLIC PROGRAMS AND COMMERCIAL
HEALTH PLANS FOR WASHINGTON STATE HOSPITALS**

At the request of Premera Blue Cross, Milliman, Inc. has prepared this comparison of healthcare provider payment levels between public programs and commercial health plans in Washington State. Separate comparisons are presented for hospitals and physicians. For hospitals, we have analyzed financial statements for fiscal years 1995 through 2004, and quantified the cost shift from Medicare and Medicaid to other payers. For physicians, we have compared current fee schedules and quantified the payment level differences between public and commercial payers. We understand that this paper will be shared with hospitals, physicians, employer groups, legislators and others to support a constructive dialogue between all stakeholders regarding provider payment rates paid by public programs.

FINDINGS

In recent years, Washington hospitals have incurred increasingly large losses on Medicare and Medicaid business. At the same time, margins on commercial business have increased. This phenomenon can be thought of as a cost shift from the public programs to commercial payers. That is, if Medicare and Medicaid had paid higher hospital rates, commercial payer rates could have been lower with hospitals still achieving the same net patient service operating margins.

Similarly, Medicare and Medicaid fee-for-service physician rates are significantly lower than market rates paid by commercial PPOs in Washington. While publicly available financial statements that would enable quantifying gains and losses by payer type are not available for physician services in total, as they are for hospitals, the payment rate differences suggest a subsidization of public payers by those who pay commercial rates.

HOSPITAL PAYMENT LEVEL COMPARISON

Our hospital findings are based on analysis of Washington State hospital financial statements for fiscal years 1995 through 2004, as reported by the Washington State Department of Health. We have reviewed the data for reasonableness, but have not audited or independently verified the data. If the data is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

The Department of Health reported financials are sufficient to separate Medicare, Medicaid, and all other payers into separate categories. The “all other” category is dominated by commercial insurance payers, but also includes payers such as self-pay, Workers’ Compensation, and other government programs. Throughout this paper, we refer to the “all other” segment as “Commercial.”

In order to focus on payment level differences by payer category, only patient related financial results are included in our analysis. Specifically, non-operating, tax, and other operating revenue and expense are excluded.

MILLIMAN, INC.

- 1 -

PAYMENT LEVEL COMPARISON BETWEEN PUBLIC PROGRAMS AND COMMERCIAL HEALTH PLANS FOR WASHINGTON STATE HOSPITALS

Charts 1 and 2 illustrate the cost shift from Medicare and Medicaid to Commercial payers in 2004.

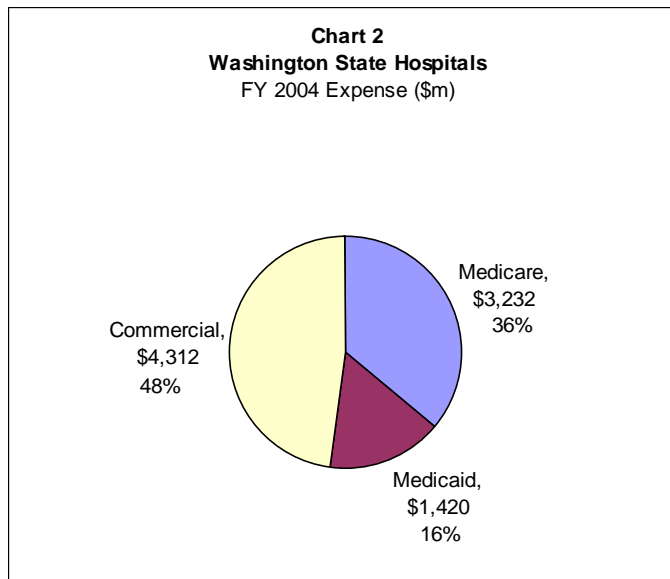
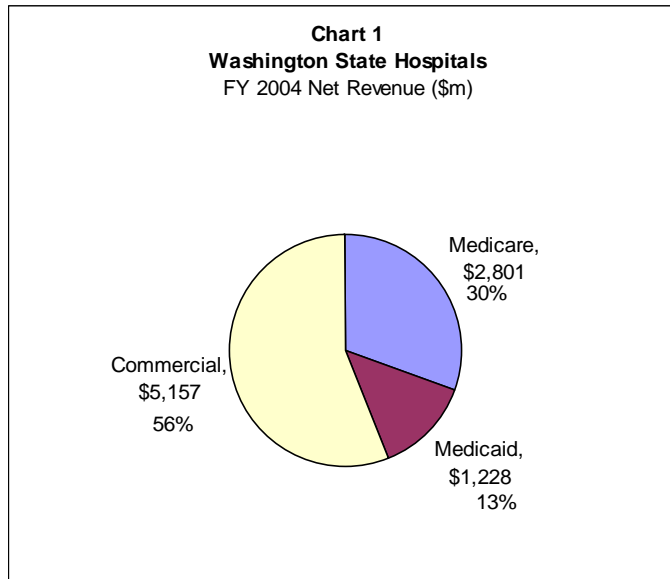


Chart 1 presents net patient service revenue by payer type in fiscal year 2004. Chart 2 presents expense by payer type. Notice that the Commercial segment generated 56% of revenue, but only 48% of expense. On the flip side, 30% of revenue was generated on the Medicare segment, but 36% of expenses were incurred. Likewise, Medicaid accounted for 13% of revenue, but 16% of expenses. If there were no cost shift, each segment's share of

MILLIMAN, INC.

- 2 -

**PAYMENT LEVEL COMPARISON BETWEEN PUBLIC PROGRAMS AND COMMERCIAL
HEALTH PLANS FOR WASHINGTON STATE HOSPITALS**

revenue would equal its share of expense. That is, the sizes of the pie pieces would not change between Chart 1 and Chart 2.

Attachment A, at the end of this paper, presents the detailed values underlying all charts presented in this paper.

Chart 3 presents the detail of the fiscal year 2004 cost shift.

Chart 3							
Washington State Hospitals							
Fiscal Year 2004 Cost Shift (\$m)							
Patient Related Services Only							
	<i>Net</i>					<i>Revenue</i>	<i>Margin</i>
	<u>Revenue</u>	<u>Expenses</u>	<u>Income</u>	<u>Margin</u>	<u>Cost Shift</u>	<u>Cost Shift</u>	<u>Cost Shift</u>
Medicare	\$2,801	\$3,232	(\$430)	-15.4%	(\$510)	\$3,312	2.4%
Medicaid	1,228	1,420	(192)	-15.6%	(227)	1,455	2.4%
Commercial	5,157	4,312	845	16.4%	738	4,419	2.4%
Total	\$9,186	\$8,964	\$222	2.4%	\$0		

Chart 3 shows that in 2004 Washington State hospitals, in aggregate, had a -15.4% margin on Medicare business, a -15.6% margin on Medicaid business, and a 16.4% margin on Commercial business, resulting in an overall patient related margin of 2.4%.

In terms of patient related operating income, Medicare resulted in a \$430 million loss, Medicaid a \$192 million loss, and Commercial an \$845 million gain, combining to an overall gain of \$222 million.

Chart 3 also shows that if each segment were to supply revenue in proportion to its expense, Medicare would have needed to supply an additional \$510 million in revenue, and Medicaid an additional \$227 million in revenue. The Commercial segment would have needed to supply \$738 million less in revenue. If this cost shift had not occurred, each segment would achieve the overall margin of 2.4%.

**PAYMENT LEVEL COMPARISON BETWEEN PUBLIC PROGRAMS AND COMMERCIAL
HEALTH PLANS FOR WASHINGTON STATE HOSPITALS**

Chart 4 presents the fiscal year 2004 cost shift by segment as a percentage of net revenue.

Chart 4			
Fiscal Year 2004 Cost Shift Percentages (\$m)			
	<i>Net</i>		<i>Cost Shift</i>
	<u>Revenue</u>	<u>Cost Shift</u>	<u>Percentage</u>
Medicare	\$2,801	(\$510)	-18.2%
Medicaid	1,228	(227)	-18.5%
Commercial	5,157	738	14.3%
Total	\$9,186	\$0	

Chart 4 can be interpreted to mean that Medicare revenue would need to increase by 18.2% in order to achieve the overall margin of 2.4%. Likewise, Medicaid revenue would need to increase by 18.5%. Commercial revenue could then decrease by 14.3% with hospitals still achieving the aggregate 2.4% margin.

Further, losses on the public programs were widespread among Washington hospitals. Chart 5 presents the percentage of hospitals in Washington State with negative patient related margins by payer segment in 2004.

Chart 5			
Hospitals with Negative Patient Related Margins			
FY 2004			
	<i>Hospitals</i>	<i>Hospitals with Negative Margin</i>	
	<u>Analyzed</u>	<u>#</u>	<u>%</u>
Medicare	92	74	80%
Medicaid	92	75	82%
Commercial	92	25	27%
Total	92	38	41%

Chart 5 shows that 80% of Washington State hospitals lost money on Medicare and 82% lost money on Medicaid in 2004, compared with 27% losing on the Commercial segment.

**PAYMENT LEVEL COMPARISON BETWEEN PUBLIC PROGRAMS AND COMMERCIAL
HEALTH PLANS FOR WASHINGTON STATE HOSPITALS**

◆.....◆

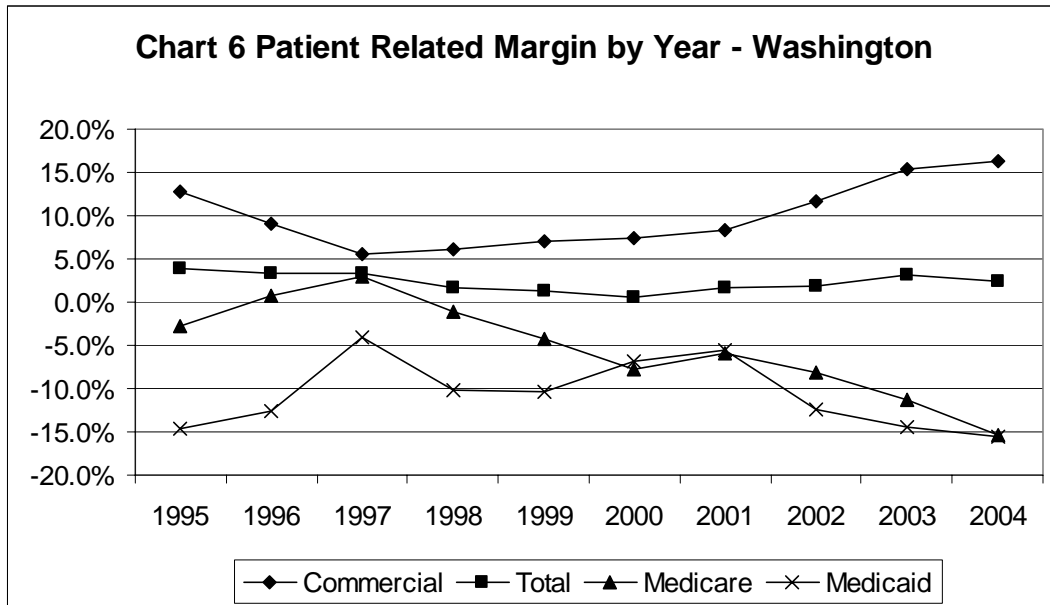
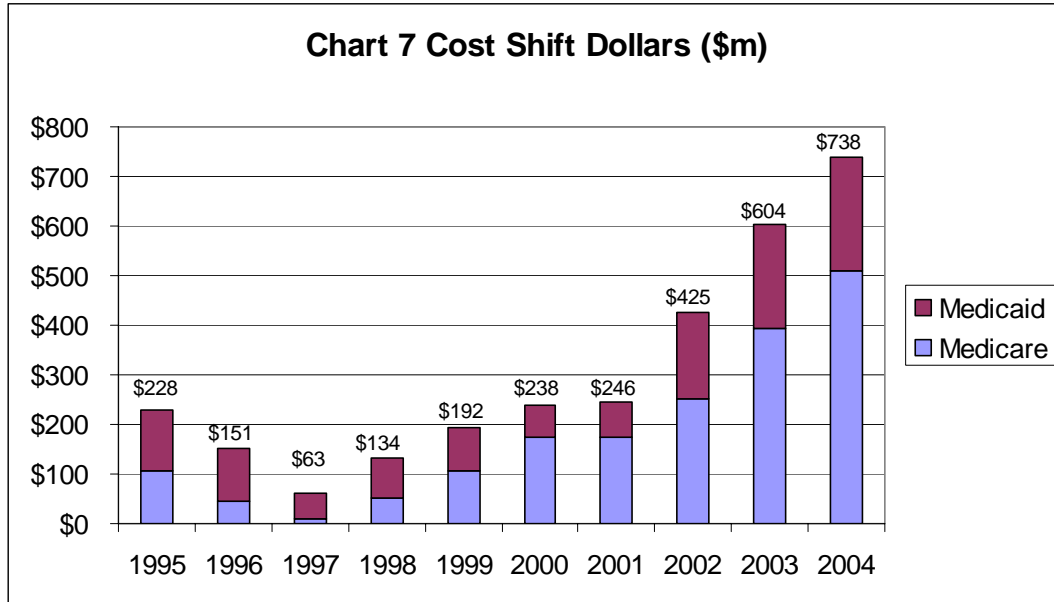


Chart 6 shows that while total patient related margin has remained in the 0% to 4% range from 1995 through 2004, it has been achieved through increasingly large margins on the Commercial segment in order to offset increasingly negative margins on the public segments. Public margins peaked in 1997 and have declined significantly since then. Commercial margins show a reverse mirror image of the public margins, bottoming in 1997 and growing since then.

PAYMENT LEVEL COMPARISON BETWEEN PUBLIC PROGRAMS AND COMMERCIAL HEALTH PLANS FOR WASHINGTON STATE HOSPITALS

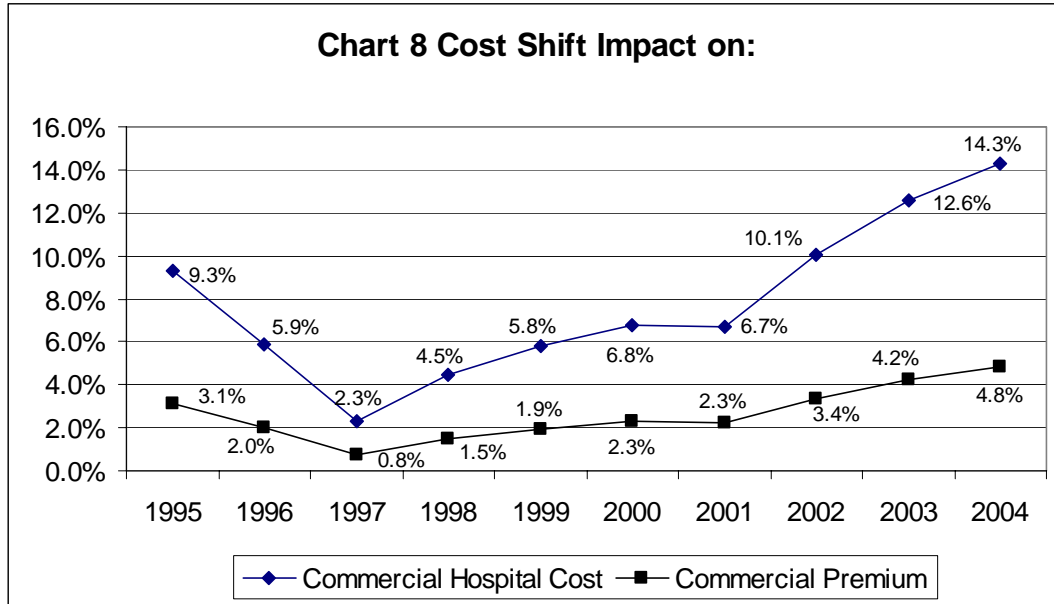
Chart 7 quantifies in dollar terms the trend in cost shift that was clear in Chart 6.



From a \$63 million dollar cost shift in 1997, the shift has grown to \$738 million in 2004. The cost shift escalated beginning in 2002, with average increases of \$164 million per year between 2002 and 2004.

PAYMENT LEVEL COMPARISON BETWEEN PUBLIC PROGRAMS AND COMMERCIAL HEALTH PLANS FOR WASHINGTON STATE HOSPITALS

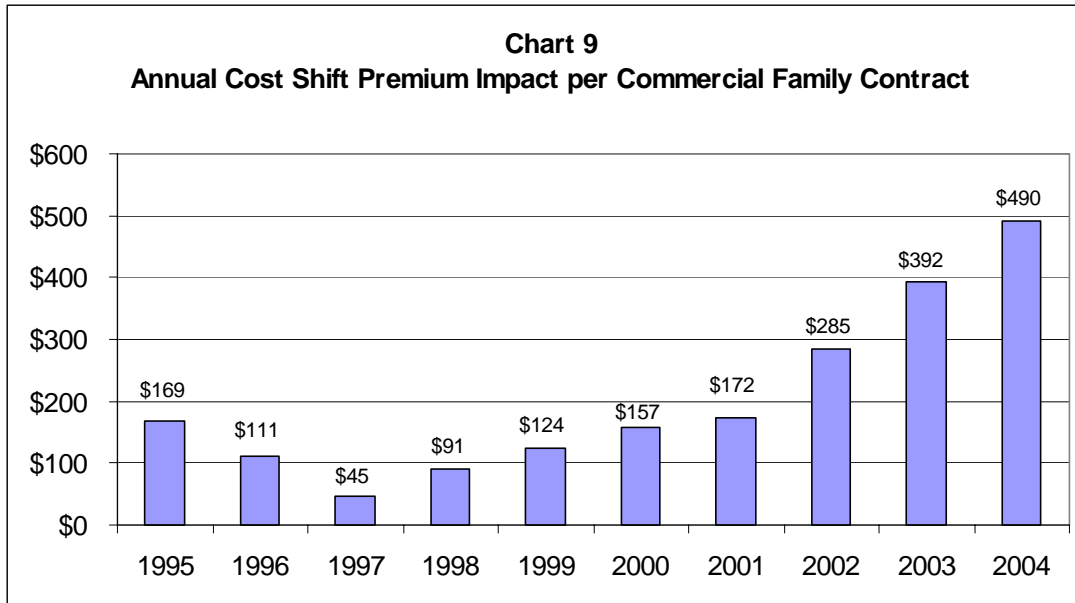
Chart 8 displays the impact of the cost shift on Commercial hospital costs and premium.



In 2004, the cost shift amounted to 14.3% of Commercial hospital cost. With the assumptions that hospital costs represent 40% of medical costs and an 84% loss ratio, the 2004 cost shift amounts to 4.8% of Commercial premium ($4.8\% = 14.3\% \times 40\% \times 84\%$).

PAYMENT LEVEL COMPARISON BETWEEN PUBLIC PROGRAMS AND COMMERCIAL HEALTH PLANS FOR WASHINGTON STATE HOSPITALS

Translating the premium impact into dollars, with typical commercial premium around \$850 per family contract per month in 2004, the cost shift amounts to an annual cost of \$490 per commercial family contract ($\$490 = \$850 \times 4.8\% \times 12 \text{ months}$). Chart 9 presents the annual premium impact of the cost shift per commercial family contract.



PAYMENT LEVEL COMPARISON BETWEEN PUBLIC PROGRAMS AND COMMERCIAL HEALTH PLANS FOR WASHINGTON STATE HOSPITALS

PHYSICIAN PAYMENT LEVEL COMPARISON

As with hospitals, commercial health plans in Washington pay considerably higher rates, on average, to physicians than do Medicare or Medicaid. In order to assess physician payment level differences, we have compared physician fee schedules in effect as of March 2006.

Chart 10 presents the schedules.

Chart 10			
Washington State Physician Fee Schedule Comparison			
Schedules in Effect March 2006			
	<u>Conversion Factor</u>	<u>RVU Basis</u>	<u>Geographic Adjustment</u>
Medicare	\$37.8975	2006 RBRVS	King & Rest of State
Medicaid	CF varies by service: \$44.99 Maternity \$34.56 E&M - Children \$24.82 E&M - Adult \$22.71 All Other	2005 RBRVS	Statewide
Commercial	Fee schedules vary by payer. Typical schedule: \$50.00 - \$54.00	2005 RBRVS	None (area differences accounted for in conversion factor range)

Physician allowable fees are typically calculated as a dollar conversion factor multiplied by a relative value unit (RVU) and perhaps further adjusted for geographic area. In practice, there are many variations on this theme. In order to compare fee schedules, each of these components should be considered.

The commercial schedule represents what we believe to be typical commercial payment levels for fee-for-service PPO payers. Commercial payment levels vary by payer, and further may vary by geographic area, physician specialty or other factors. We based this assessment on our market knowledge, information provided by Premera Blue Cross, and publicly available data.

**PAYMENT LEVEL COMPARISON BETWEEN PUBLIC PROGRAMS AND COMMERCIAL
HEALTH PLANS FOR WASHINGTON STATE HOSPITALS**

While conversion factors are easy to compare across the schedules listed in Chart 10, the comparison could be misleading because the schedules have different RVU bases and geographic adjustments applied. In order to facilitate an overall comparison, Chart 11 adjusts the conversion factors to a 2005 RBRVS with no geographic adjustment basis. That is, for each schedule, we have calculated an adjustment factor to shift from the actual RVU and geographic basis of the schedule to 2005 RBRVS with no geographic adjustment. Using Medicare King County as an example, we estimate that a \$37.90 conversion factor on 2006 RBRVS with a King County geographic adjustment (the actual schedule) would produce the same payment amount, in aggregate, as a \$40.19 conversion factor on 2005 RBRVS with no geographic adjustment.

Chart 11			
Physician Fee Schedules Expressed on Consistent Basis			
2005 RBRVS without Geographic Adjustment			
	<i>Unadjusted Conversion Factor</i>	<i>Adjustment to 2005 RBRVS w/o Geo. Adj.</i>	<i>Adjusted Conversion Factor</i>
Medicare			
King County	\$37.90	1.060	\$40.19
Rest of State	\$37.90	0.984	\$37.28
Medicaid			
Maternity*	\$44.99	0.985	\$44.31
E&M - Children	\$34.56	1.005	\$34.74
E&M - Adult	\$24.82	1.005	\$24.95
All Other	\$22.71	1.002	\$22.75
Commercial			
High Typical	\$54.00		\$54.00
Low Typical	\$50.00		\$50.00
*Medicaid has an add-on payment for high risk deliveries of \$282.81, which for the most common delivery procedure is worth an additional \$6.56 on the unadjusted conversion factor. On the other hand, Medicaid pays the normal delivery rate for cesarean deliveries (which have a higher RVU value), resulting in an unadjusted conversion factor for the most common cesarean delivery procedure of \$39.71. We have not made any adjustment for the additional payment or the policy of paying only for a normal delivery.			

The adjusted conversion factors are then directly comparable, as all are expressed on the same underlying schedule basis.

**PAYMENT LEVEL COMPARISON BETWEEN PUBLIC PROGRAMS AND COMMERCIAL
HEALTH PLANS FOR WASHINGTON STATE HOSPITALS**

◆-----◆

Chart 12 presents the commercial adjusted conversion factors as a percentage of Medicare and Medicaid.

Chart 12			
Physician Payment Level			
Commercial as a Percent of:			
		Range	
		<u>Low</u>	<u>High</u>
		to	
Medicare	King	124%	134%
	Rest of State	134%	145%
Medicaid	Maternity	113%	122%
	E&M Children	144%	155%
	E&M Adult	200%	216%
	All Other	220%	237%

Chart 12 shows that typical commercial payments range from 24% to 45% above Medicare and 13% to 137% above Medicaid.

**PAYMENT LEVEL COMPARISON BETWEEN PUBLIC PROGRAMS AND COMMERCIAL
HEALTH PLANS FOR WASHINGTON STATE HOSPITALS**

METHODOLOGY

Hospital

The hospital analyses presented in this paper are based on the Year End Hospital Summary Reports for Washington State hospitals reported by the Washington State Department of Health. We have relied upon this data. We have reviewed the data for reasonableness, and in some cases have made adjustments to the data.

The data adjustments that we made were based on more detailed year-end financials also reported by the Department of Health. In two cases, the reported financials were internally inconsistent, with the inconsistency materially affecting overall results, so the hospital was excluded (excluded only for the year of the inconsistency).

The Department of Health data is sufficient to split billed charges and net patient service revenue between Medicare, Medicaid, and all other. The all other category includes commercial insurance payers, self-pay, Workers' Compensation, and other government programs. Throughout this paper, we refer to the all other category as "Commercial." The reported financial data does not split expenses into these payer segments, however. We allocated expenses to payer segment as described below.

The financials include gross revenue (billed charges) by payer segment. Deductions from gross revenue are reported for contractual rate agreements by payer segment and for charity care/other deductions. We removed the charity care/other deductions from the Commercial segment's billed charges. Total operating expenses were then allocated to each payer segment (Medicare, Medicaid, and Commercial) in proportion to the segment's billed charges. This was performed at the hospital level. In actual practice, the cost to charge ratio will vary by service within a given hospital. Our use of a constant cost to billed charge ratio is an approximation of the actual expense distribution.

The split between Medicare, Medicaid, and Commercial is based on each hospital's reporting of the split. It is likely that some Medicare and Medicaid payments for beneficiaries in health plan managed care programs are reported by hospitals in the Commercial segment, rather than the Medicare or Medicaid segments. To the extent that these managed plans apply payment rates similar to the fee-for-service government programs, this reporting issue serves to lower the cost shift identified in this paper, as the low payment levels for these patients are combined with the higher payment levels for other patients in the Commercial segment. That is, if all payments for Medicare and Medicaid beneficiaries were reported in the Medicare and Medicaid segments, the cost shift would likely be larger than presented here.

The results in this paper present only patient related financial results. Specifically, non-operating, tax, and other operating revenue and expense are not included. As total expenses were available only at the operating and non-operating level, we allocated operating expenses associated with other (non-patient) operating revenue by assuming the same margin between

**PAYMENT LEVEL COMPARISON BETWEEN PUBLIC PROGRAMS AND COMMERCIAL
HEALTH PLANS FOR WASHINGTON STATE HOSPITALS**

patient revenue and other revenue. Further, we did not allocate any expenses to tax revenue. All allocations were performed at the hospital specific level.

Group Health Central and Eastside hospitals were excluded from the analyses because they primarily treated only their own members and their summarized financials were not reported in a consistent manner with other hospitals.

Physician

The physician fee schedule analyses are based on the 2006 Medicare fee schedule after revision for the Deficit Reduction Act of 2005 (which served to maintain the same conversion factor Medicare applied in 2005, rather than decreasing it), the Washington State Medicaid fee schedule effective 7/1/2005, and our assessment of typical commercial fee schedules as of March 2006.

The Statewide geographic adjustment applied in the Medicaid schedule is equal to 30% of the Medicare King County adjustment and 70% of the Medicare Rest of State adjustment.

The Medicare, Medicaid, and assumed commercial fee schedules all apply the RBRVS site-of-service payment methodology.

In addition to fee schedule levels, claims editing rules applied by payers also affect the total reimbursement received by physicians. We have not attempted to compare or quantify claims edit differences between commercial payers and Medicare or Medicaid.

Attachment A
Washington State Hospitals
Patient Related Financial Results

	<u>FY 95</u>	<u>FY 96</u>	<u>FY 97</u>	<u>FY 98</u>	<u>FY 99</u>	<u>FY 00</u>	<u>FY 01</u>	<u>FY 02</u>	<u>FY 03</u>	<u>FY 04</u>
<u>Medicare</u>										
Billed Charges	\$2,248,609,742	\$2,417,358,670	\$2,626,507,446	\$2,781,682,110	\$3,119,753,970	\$3,747,617,801	\$4,302,226,836	\$4,993,869,081	\$5,815,307,513	\$6,580,743,483
Net Patient Revenue	1,536,438,850	1,708,320,696	1,838,127,715	1,826,849,103	1,866,423,886	2,039,292,316	2,249,605,454	2,467,422,519	2,653,309,266	2,801,192,463
Allocated Expense	1,578,769,573	1,695,904,638	1,785,143,197	1,848,245,187	1,946,956,986	2,198,646,760	2,381,598,000	2,670,261,764	2,955,009,940	3,231,507,818
Operating Income	(42,330,723)	12,416,058	52,984,518	(21,396,084)	(80,533,100)	(159,354,444)	(131,992,546)	(202,839,245)	(301,700,674)	(430,315,355)
Margin (1)	-2.8%	0.7%	2.9%	-1.2%	-4.3%	-7.8%	-5.9%	-8.2%	-11.4%	-15.4%
<u>Medicaid</u>										
Billed Charges	\$1,010,354,460	\$997,751,086	\$1,041,651,054	\$1,092,855,314	\$1,239,434,718	\$1,526,721,157	\$1,791,219,748	\$2,335,673,061	\$2,492,688,331	\$2,782,712,122
Net Patient Revenue	633,890,955	629,871,946	701,309,988	671,885,554	727,242,497	869,991,688	984,415,659	1,184,696,251	1,163,504,550	1,227,773,606
Allocated Expense	726,288,304	709,469,891	729,721,483	739,876,995	803,099,804	929,049,613	1,039,273,573	1,331,517,814	1,330,685,702	1,419,726,087
Operating Income	(92,397,349)	(79,597,945)	(28,411,495)	(67,991,441)	(75,857,307)	(59,057,925)	(54,857,914)	(146,821,563)	(167,181,152)	(191,952,481)
Margin (1)	-14.6%	-12.6%	-4.1%	-10.1%	-10.4%	-6.8%	-5.6%	-12.4%	-14.4%	-15.6%
<u>Commercial</u>										
Billed Charges	\$3,002,818,266	\$3,276,586,033	\$3,729,107,839	\$4,218,867,148	\$4,947,174,016	\$5,526,701,075	\$6,012,154,396	\$6,950,924,890	\$7,961,867,297	\$8,679,514,563
Net Patient Revenue	2,443,586,857	2,548,908,059	2,709,892,133	2,990,102,561	3,319,610,865	3,519,184,802	3,659,672,836	4,217,157,009	4,792,023,366	5,156,917,356
Allocated Expense	2,129,205,709	2,317,649,788	2,558,262,861	2,808,695,623	3,087,530,760	3,260,567,265	3,356,043,279	3,722,407,231	4,059,317,482	4,312,338,637
Operating Income	314,381,148	231,258,271	151,629,272	181,406,938	232,080,105	258,617,537	303,629,557	494,749,778	732,705,884	844,578,719
Margin (1)	12.9%	9.1%	5.6%	6.1%	7.0%	7.3%	8.3%	11.7%	15.3%	16.4%
<u>Total</u>										
Billed Charges	\$6,261,782,468	\$6,691,695,789	\$7,397,266,339	\$8,093,404,572	\$9,306,362,704	\$10,801,040,033	\$12,105,600,980	\$14,280,467,032	\$16,269,863,141	\$18,042,970,168
Net Patient Revenue	4,613,916,662	4,887,100,701	5,249,329,836	5,488,837,218	5,913,277,248	6,428,468,806	6,893,693,949	7,869,275,779	8,608,837,182	9,185,883,425
Allocated Expense	4,434,263,586	4,723,024,317	5,073,127,541	5,396,817,805	5,837,587,550	6,388,263,638	6,776,914,852	7,724,186,809	8,345,013,124	8,963,572,541
Operating Income	179,653,076	164,076,384	176,202,295	92,019,413	75,689,698	40,205,168	116,779,097	145,088,970	263,824,058	222,310,884
Margin (1)	3.9%	3.4%	3.4%	1.7%	1.3%	0.6%	1.7%	1.8%	3.1%	2.4%
<u>Cost Shift</u>										
From Medicare to Commercial	\$106,294,176	\$46,499,138	\$9,017,930	\$52,909,921	\$105,777,190	\$173,191,845	\$173,031,997	\$252,996,697	\$395,122,063	\$510,461,899
From Medicaid to Commercial	121,822,737	104,244,706	53,756,531	80,606,847	86,270,235	64,904,990	72,766,569	171,832,422	209,250,217	227,163,951
Total	\$228,116,913	\$150,743,844	\$62,774,462	\$133,516,768	\$192,047,425	\$238,096,835	\$245,798,566	\$424,829,119	\$604,372,280	\$737,625,849
As a % of Comm. Hospital Cost	9.3%	5.9%	2.3%	4.5%	5.8%	6.8%	6.7%	10.1%	12.6%	14.3%
As a % of Comm. Premium Cost (2)	3.1%	2.0%	0.8%	1.5%	1.9%	2.3%	2.3%	3.4%	4.2%	4.8%
Annual Prem. Cost per Comm. Family (3)	\$169	\$111	\$45	\$91	\$124	\$157	\$172	\$285	\$392	\$490

Notes

- (1) Margins and other values are patient related only. Other operating, tax, and non-operating revenue and expense are excluded.
(2) Assumes hospital cost = 40% of medical cost and an 84% loss ratio
(3) Assumes 2004 premium PMPM of \$236 and family contract load of 3.6

MILLIMAN, INC.