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PAYERS & PROVIDERS

CALIFORNIA EDITION

Blue Shield's 2019 Mission Report Shows $21 Billion in Revenue and 2.7% Profit Margin

Blue Shield of California has just released its 2019 Mission Report, including financial statements for the year. The Mission Report shows the taxpaying, nonprofit health plan served nearly 4.4 million members as of Dec. 31, 2019, up about 10 percent over the past three years.

Blue Shield reported improved customer experience scores, receiving a Forrester Customer Index Score of 66.0, putting it in the top tier of the health insurance industry.

In the report, the company highlighted these initiatives:

- Real time claims: In October 2019, they launched a pilot program with OODA Health, Dignity Health, and Hill Physicians to make healthcare claims and payments happen more immediately after patients receive care.
- Partners in care: Blue Sheild Advocates put their Medi-Calmembers in touch with vital community and social services, such as nutrition and housing, that are essential for good health.
- Investing in next-generation care: Blue Shield was a founding investor in Altais, a new company that empowers doctors to focus on what they do best: connecting with and treating patients.
- Powering better health: Blue Shield's Wellvolution platform gives members 50+ digital tools for improving their health – as well as access to more than 30,000 brick & mortar locations. More than 27,000 members joined the Diabetes Reduction program and there was an average weight reduction of 5% and customer satisfaction rating of 92%.

The company paid more than $18 billion in health care costs, up 4.3% compared with 2018 expenses. More than 85 cents of every $1 collected in premiums went to cover healthcare expenses. The 85 cents is comprised of 40 cents to hospitals, 25 cents to physicians, 13 cents to pharmaceuticals and 7 cents for other medical services. Blue Shield also noted they have 67 provider ACO arrangements covering 692,000 members.

The company has reduced its general and administrative expenses by more than $80 million compared to a year ago, or 2.8%. The savings were generated by enterprise wide initiatives to help meet its affordability goals. This includes transforming its operational areas through automation and operational efficiencies.

Blue Shield's net income of $527 million, was 2.9% of revenues. As a nonprofit with a 2% cap on net income, this created the opportunity for the company to return more than $100 million to its members and the communities it serves in 2020, including various forms of premiums relief for members struggling to maintain their insurance during the coronavirus pandemic. Blue Shield also maintained a steady level of funding for Blue Shield of California Foundation, contributing $40 million at the end of 2019.

The report indicates at year end Blue Shield served 4,397,477 members, including 16.8% in government programs (Medicaid and Medicare) and 16.5% in Individual and Family plans. 458.376 of their government program members were served by the Blue Shield Promise Health Plan. Blue Shield had a 4-star rating for Medicare, and a 3.5-star rating for their Promise Health Plan.

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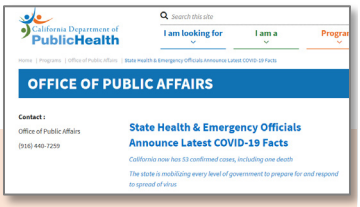
COVID-19 in California By The Numbers



(Source: CDPH – Data is as of the dates indicated)

June 9th	June 2nd	May 26th	May 19th	May 12th	April 28th	April 14th	March 31st	
136,191	117,687	98,980	84,057	71,141	46,500	24,424	8,155	Positive cases
18,504	18,707	14,923	12,916	12,326	11,104	7,467	5,620	New cases past week
6.5%	5.9%	5.2%	4.4%	3.8%	2.7%	1.6%	1.1%	% Age 0-17 cases*
53.5%	52.7%	51.6%	50.7%	50.1%	48.7%	48.1%	50.9%	% Age 18-49 cases*
22.7%	23.3%	23.9%	24.4%	24.9%	26.2%	27.3%	26.2%	% Age 50-64 cases*
17.3%	18.2%	19.3%	20.5%	21.2%	22.4%	23.0%	21.7%	% Age 65+ cases*
3,240	3,090	3,114	3,047	3,301	3,495	3,171	1,855	Confirmed Hospitalizations
33.6%	34.9%	35.2%	35.1%	32.6%	33.9%	37.1%	41.7%	Confirmed % ICU
1,479	1,368	1,430	1,634	1,244	1,516	1,894	3,168	Suspected Hospitalizations
4,776	4,361	3,884	3,436	2,934	1,887	821	171	Deaths
415	477	448	502	522	533	379	118	New Deaths Past Week

* excludes unknown age case

Additional COVID-19 Numbers

California: New York Times COVID-19 Database as of June 10, 2020

- 140,123 total cases
- 4.869 deaths
- Los Angeles County: 67,064 cases and 2,768 deaths
- Riverside: 9,911 cases and 372 deaths
- San Diego County: 8,900 cases and 312 deaths
- Orange County: 7,991 cases and 198 deaths
- San Bernardino County: 6,593 cases and 225 deaths
- Top Five Counties: 72% of cases and 80% of deaths. These counties comprise 54% of the state population.

Anthem Blue Cross Rolls Out Digital Kiosks

Anthem Blue Cross has deployed hundreds of digital solutions kiosks in health centers across the state to provide real-time video interpretation services and access to telehealth. The kiosks help clinicians overcome communication barriers and improve service to the growing number of non-English speaking residents in California. Anthem has deployed more than 200 of these digital kiosks inside 80 health centers in the past six months with plans to install hundreds more across California.

Anthem's kiosks include Wi-Fi enabled tablets that allow treating clinicians to engage certified interpreters without having to pre-schedule in-person interpreter appointments or wait with third-party call centers. More than 240 languages are accessible. The tablets can also be used to provide comprehensive, whole person care by enabling access to medical specialists via telehealth and information about free community resources to address non-medical needs.

In a statement, Dr. Demetria Malloy, Anthem Blue Cross Medical Director explained "effective communications between a clinician and patient is critical for safety and quality of care because this is how clinicians determine appropriate diagnosis and treatment plans. When language barriers exist, the risk of incorrect diagnosis, duplicative testing and inappropriate prescribing increases. Language barriers may make individuals less likely to seek care or build trusting relationships with their doctors and less likely to adhere to treatment programs."

Rapid Changes To Health System Spurred By COVID Might Be Here To Stay

By Julie Rovner, California Healthline

The U.S. health care system is famously resistant to government-imposed change. But the COVID-19 pandemic has done what no president or social movement or venture capitalist could have dreamed of: It forced sudden major changes to the nation's health care system that are unlikely to be reversed. "Health care is never going back to the way it was before," said Gail Wilensky, a health economist who ran the Medicare and Medicaid programs for President George H.W. Bush in the early 1990s. But experts warn that the breakthroughs may not all make the health system work better, or make it less expensive. That said, here are three trends that seem likely to continue.

Telehealth For All: Telehealth is not new. But even while technology has made video visits easier, it has failed to reach critical mass, largely because of political fights. Licensing has been one main obstacle – determining how a doctor in one state can legally treat a patient in a state where the doctor is not licensed. The other obstacle, not surprisingly, is payment. Should a video visit be reimbursed at the same rate as an in-person visit? Will making it easier for doctors and other medical professionals to use telehealth encourage unnecessary care, thus driving up the nation's $3.6 trillion health tab even more? Or could it replace care once provided free by phone? Still, the pandemic has pushed aside those sticking points. Almost overnight, by necessity, every health care provider who can is delivering telemedicine. A new survey from Gallup found the number of patients reporting "virtual" medical visits more than doubled, from 12% to 27%, from late March to mid-May. That is due, at least in part, to Medicare having made it easier for doctors to bill for virtual visits. It's easy to see why many patients like video visits — there's no parking to find and pay for, and it takes far less time out of a workday than going to an office. Doctors and other practitioners seem more ambivalent. On one hand, it can be harder to examine a patient over video and some services just can't be done via a digital connection. On the other hand, they can see more patients in the same amount of time and may need less support staff and possibly smaller offices if more visits are conducted virtually. Of course, telemedicine doesn't work for everyone. Many areas and patients don't have reliable or robust broadband connections that make video visits work. And some patients, particularly the oldest seniors, lack the technological skills needed to connect.

Primary Care Doctors In Peril: Another trend that has suddenly accelerated is worry over the nation's dwindling supply of primary care doctors. The exodus of practitioners performing primary care has been a concern over the past several years. Having faced a difficult financial crisis during the pandemic, more family physicians may move into retirement or seek other professional options. At the same time, fewer current medical students are choosing specialties in primary care. The American Academy of Family Physicians reports that 70% of PCPs are reporting declines in patient volume of 50% or more since March, and 40% have laid off or furloughed staff. The AAFP has joined other primary care and insurance groups in asking HHS for an infusion of cash. One easy way to help keep primary care doctors afloat would be to pay them not according to what they do, but in a lump sum to keep patients healthy. This move from fee-for-service to what's known as capitation or value-based care has unfolded gradually and was championed in the Affordable Care Act.

But some experts argue it needs to happen more quickly and they predict that the coronavirus pandemic could finally mark the beginning of the end for doctors who still charge for each service individually. Farzad Mostashari, a top Health and Human Services Department official in the Obama administration who runs Aledade, said in times like these, it would make more sense for primary care doctors to have "a steady monthly revenue stream, and [the doctor] can decide the best way to deliver that care. Unlimited texts, phone calls, video calls. The goal is to give you satisfactory outcomes and a great patient experience." Still, many physicians, particularly those in solo or small practices, worry about the potential financial risk — particularly the possibility of getting paid less if they don't meet certain benchmarks that the doctors may not be able to directly control. But with many practices now ground to a halt, or just starting to reopen, those physicians who get paid per patient rather than per service are in a much better position to stay afloat. That model may be gain traction as doctors ponder the next pandemic, or the next wave of this one.

Hospitals On The Decline?: The pandemic also might lead to less emphasis on hospital-based care. While hospitals in many parts of the country have obviously been full of very sick COVID patients, they have closed down other nonemergency services to preserve supplies and resources to fight the pandemic. People with other ailments have stayed away in droves even when services were available, for fear of catching something worse than what they already have. Many experts predict that care won't just snap back when the current emergency wanes. Dr. Mark Smith, former president of the California Health Care Foundation, said among consumers, a switch has been flipped. "Overnight it seems we've gone from high-touch to no-touch." Which is not great for hospitals that have spent millions trying to attract patients to their labor-and-delivery units, orthopedic centers and other parts of the facility that once generated lots of income. Even more concerning is that hospitals' ability to weather the current financial shock varies widely. Those most in danger of closing are in rural and underserved areas, where patients could wind up with even less access to care that is scarce already. All of which underscores the point that not all these changes will necessarily be good for the health system or society. Financial pressures could end up driving more consolidation, which could push up prices as large groups of hospitals and doctors gain more bargaining clout. But the changes are definitely happening at a pace few have ever seen. Said Wilensky, "When you're forced to find different ways of doing things and you find out they are easier and more efficient, it's going to be hard to go back to the old way."

This article is an excerpt of the full story appearing in California Healthline. This story was produced by Kaiser Health News, which publishes California Healthline, an editorially independent service of the California Health Care Foundation.

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Blue Shield's 2019 Mission Report Shows $21 Billion in Revenue and 2.7% Profit Margin …continued

BLUE SHIELD OF CALIFORNIA CONSOLIDATED FINANCIALS ($ IN MILLIONS)				
	2019	2018	2017	2016
Premiums, net, and other revenue	$21,086	$20,632	$17,684	$17,598
Less: medical expenses	$18,006	$17,249	$15,035	$15,085
Gross profit	**$3,080**	**$3,383**	**$2,650**	**$2,513**
Medical expenses as a percent of premiums	*85.4%*	*83.6%*	*85.0%*	*85.7%*
Marketing and selling	$649	$723	$685	$631
ACA taxes, premium taxes, and other fees	$273	$548	$261	$451
General and administrative	$1,884	$1,615	$1,541	$1,398
Total administrative expenses	**$2,806**	**$2,886**	**$2,487**	**$2,480**
Pre-tax operating income	$276	$497	$163	$33
Investment income	$426	$119	$142	$169
Income before taxes	**$702**	**$616**	**$304**	**$202**
Income taxes	$129	$203	$8	$135
Net income	**$573**	**$413**	**$296**	**$67**
Profit margin (net income as a % of premiums)	*2.7%**	*2.0%*	*1.7%*	*0.4%*

●● News Bullets ●●

- California Healthcare M&A Deals Could Be Facing Increased Regulatory Scrutiny
- UPS is growing the physical footprint of healthcare division with new or expanded facilities in California
- California tech CEO charged in coronavirus test fraud case
- O.C. health officer resigns after coronavirus controversy
- Santa Clara County orders hospitals to expand COVID-19 testing
- California hospitals suffer massive losses from fewer patients, major COVID-19 expenses
- HCA is looking for qualified nurses in the event of a job action against its facilities in Los Angeles
- IRA Capital Buys Another SoCal Medical Clinic for $40M

UnitedHealthcare of California
Enrollment and Utilization Table as of 3/31/2020

QUARTERLY STATEMENT AS OF March 31, 2020 - UHC of California dba UnitedHealthcare of California

ENROLLMENT AND UTILIZATION TABLE

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Source of Enrollr	Total Enrollees At End of Previous Period	Additions During Period	Terminations During Period	Total Enrollees at End of Period	Grandfathered Enrollees (also included in Column 5)	Cumulative Enrollee Months for Period	Total Member Ambulatory Encounters for Period - Physicians	Total Member Ambulatory Encounters for Period - Non-Physicians	Total Member Ambulatory Encounters for Period	Total Patient Days Incurred	Annualized Hospital Days/1000	Average Length of Stay
1.	Large Group Con	342,548	40,647	33,409	349,786		1,053,059	204,760		204,760	15,013	171	4.05
2.	Medicare Risk	366,474	43,092	34,950	374,616		1,126,997	432,919		432,919	91,998	980	4.80
3.	Medicare Supplement				0					0		0	
4.	Medi-Cal Risk				0					0		0	
5.	Individual	2	0	0	2		6	0		0	0	0	0.00
6.	Point of Service - Individual				0					0		0	
7.	Point of Service - Small Group				0					0		0	
8.	Point of Service - Large Group				0					0		0	
9.	Small Group Con	69,588	6,752	6,739	69,601		209,693	9,915		9,915	2,725	156	4.56
10.	Healthy Families				0					0		0	
11.	AIM				0					0		0	
12.	Medicare Cost				0					0		0	
13.	ASO				0		N/A	N/A	N/A	0	N/A	N/A	N/A
14.	PPO Individual				0					0		0	
15.	PPO Small Group				0					0		0	
16.	PPO Large Group				0					0		0	
17.	Aggregate Contracted from Other Plans	0	0	0	0		0	0	0	0	0	N/A	N/A
18.	Aggregate Other Source of Enrollment	0	0	0	0		0	0	0	0	0	N/A	N/A
19.	Total Membersh	778,612	90,491	75,098	794,005	0	2,389,755	647,594	0	647,594	109,736	N/A	N/A

Source: Quarterly Statement 3/31/2020 UnitedHealthcare of California, Enrollment and Utilization Table