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ORIGINAL

INVESTIGATORY HEARING REGARDING ACQUISITION OF CONTROL OF
PACIFICARE LIFE AND HEALTH INSURANCE COMPANY BY UNITED
HEALTH GROUP

Tuesday, November 1, 2005



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LOS ANGELES, CALIFORNIA
TUESDAY, NOVEMBER 1, 2005
9:00 A.M.

COMMISSIONER GARAMENDI: Good morning, all.
I thank you all for being here.

A couple of things before we get started on the schedule. There were several people that wanted to testify on the public side early in this proceeding in support of the merger, and I thought it fair that we also take a few folks at the beginning of this for those who may be concerned or opposed to the merger.

And so, we will do that. I am allotting about ten minutes for each of those two sides to have their moment here, and then we will move on to the panel, so we will do that.

Now that my general counsel has arrived, I can more formally begin.

Joining me here on our side representing the California Department of Insurances is Ramon M. Calderon who handles our financial side of things, my Chief Deputy, Rick Baum, both of them on my right.

On my left is my able counsel, Gary Cohen, and my deputy, Nettie Hoge.

1 Nettie has been largely responsible for making
2 sure this hearing went along smoothly, and I will take
3 all responsibility from this point on as to whether it is
4 smooth or not. Nettie, thank you very much for pulling
5 all this together.

6 Good morning all. This is an investigatory
7 hearing. The California Department of Insurance
8 regarding the acquisition of control of PacifiCare Life
9 and Health Company by the United Health Group file number
10 IH05048697. On July 19th, 2005, United HealthCare Group,
11 Inc. and Pacific HealthCare Systems Inc. announced that
12 they plan to merge.

13 The transaction is valued at roughly 8.2 billion
14 dollars, and the new entity would form the second largest
15 health insured in the United States with the combined
16 revenue of some 65 billion dollars and a combined net
17 income of 4.1 billion dollars.

18 United HealthCare Group plans to incur up to
19 \$2.1 billion dollars in debt to finance the merger
20 transaction.

21 My overwriting objective is to determine how
22 this change in control would impact California policy
23 holders present and future.

24 My department has been analyzing filings by the
25 applicant and conferring with other regulators on the

1 issues raised by this transaction since it was first
2 announced in August.

3 The purpose of today's event, is to hear the
4 applicant's presentation of their case and to give the
5 public an opportunity to consider it and comment upon its
6 impact.

7 Most are aware that I am deeply concerned about
8 the healthcare system in the state of California. I have
9 compared it to a badly broken machine.

10 It may function poorly for a while, but it will
11 inevitably break down if we do not pay attention to the
12 signs of failure.

13 I am concerned that the costs continued to out
14 run results, excuse me. I am concerned that costs
15 continue to run away resulting in more people being
16 priced out of a sound, comprehensive system of care.

17 I am concerned about the escalating premiums,
18 diminishing benefits, increasing costs sharing,
19 un-sustainable costs shifting, and the threat to
20 California's valuable system of managed care.

21 I am concerned about the deterioration of public
22 health, an increasing number of uninsured and under
23 insured. Like others, I see hope in the merging
24 initiatives relating to improvements of quality and
25 technological applications.

1 While it would not be fair to assume that the
2 companies before me can fix all these problems, since
3 they will be the second largest insureds in the United
4 States, I want to hear from them how the combined company
5 intends to address these challenges in a way that will
6 benefit California.

7 Of course it goes without saying that I am not
8 interested in approving a transaction that will make the
9 problem worse.

10 Today's analysis is pursuant to Insurance Code
11 Section 1215.2 D. In this regard we will examine the
12 structure of the transaction, financial considerations,
13 the operation of current companies, and their plan of
14 operation post merger.

15 The impact of this transaction on competition,
16 the company's history of claims handling and quality
17 assurance.

18 The continuity of products and services,
19 employment issues, and the commitment of the corporation
20 to the under-served in California.

21 As I have indicated, my over arching concern in
22 each of these areas is the impact of this merger on
23 policy holders in California.

24 I have invited the applicants to present their
25 case to us, but prior to that presentation, we will hear

1 from both pro and con in a limited fashion with further
2 comments from the general public following the
3 presentation made by the merged entities or the entities
4 that have applied to merge.

5 That being the case, let us hear from those
6 people who have offered to provide public testimony at
7 the outset.

8 The names are somewhere here before me. I am
9 told that John Cascell, Andy Gilmour and Dr. Robert
10 Margulis would like to testify. They said they would
11 take about ten minutes.

12 So there is the microphone if you gentlemen are
13 here, please come forward and present your testimony.

14 MR. MARGULIS: Good morning, Mr. Garamendi and
15 panel.

16 It is a pleasure to be here.

17 My name is Dr. Robert Margulis, and I am Chief
18 Executive Officer of HealthCare Partners Medical Group.

19 HealthCare Partners has been a large medical
20 group participant in healthcare in Southern California
21 and is the largest group serving the Los Angeles area,
22 the greater Los Angeles area for over 50 years.

23 We serve over 500,000 patients who are members
24 of ours through a relationship we have with various
25 insurance plans and health maintenance organizations that

1 are regulated both by the Department of insurance and The
2 Department of Managed Care.

3 This total includes over 130,000 members and
4 patients of ours who come through relationships with
5 PacifiCare and their senior program, Secure Horizons.

6 PacifiCare has a long history and commitment to
7 the support of decapitated, delegated delivery model in
8 California which you reference there.

9 The modo that we in PacifiCare and policy makers
10 believe provides a better quality care at a lower cost of
11 healthcare to millions of people state wide, to millions
12 of our consumers and fellow Californians.

13 We are and remain encouraged by statements that
14 United has made and PacifiCare has alluded to that they
15 intend to remain supportive of this modo of delegated
16 capitated management and well into the future.

17 I urge The Department of Insurance and The
18 Department of Managed Care to thoroughly satisfy
19 themselves that this state of intention is fulfilled
20 contractually in order to best serve the consumers of
21 healthcare in California.

22 We remain pleased that after this merger,
23 PacifiCare headquarters will remain in California. Many
24 of its leadership has committed that they will stay with
25 the company and continue to build on the more than

1 25-year history of strategic relationships between
2 patients, providers and health plan and maintain that
3 important relationship we all value, a relationship that
4 has enabled us for the last few decades to work together
5 to offer Californians, the quality and healthcare they
6 deserve in which I might add is the lowest cost
7 healthcare in the nation.

8 Ideally this merger will enable PacifiCare to
9 leverage the technology that United has developed to help
10 strengthen its relationship with members and providers
11 and simplify the healthcare administrative process that
12 takes much too much out of the healthcare dollar.

13 United offers on line support for claim
14 submission, tracking and processing and has the
15 technology to help support electronic medical records
16 which is an important element of healthcare improvement.

17 It's critically important to the doctors and
18 patients in California that the interfaces, the
19 technology that United brings to the table works within
20 the current delegated model.

21 Also, more than 18 million United Health plan
22 members have electronic I.D. cards to verify eligibility
23 which is a helpful edition.

24 These resources will, we believe, will be
25 clearly beneficial to PacifiCare in its efforts to

1 streamline its claims payment processes and help make
2 healthcare easier for members and providers.

3 It's technological advancements like these that
4 we can only hope will benefit providers and patients
5 because the administrative hassle should be less thus
6 allowing physicians to spend more time with their
7 patients. While United still has only a small market
8 presence in California, this therefore isn't really a
9 merger of two large California health plans trying to
10 gain leverage in the California marketplace.

11 We believe through this merger that a stronger
12 PacifiCare can emerge if it wishes, and only if it is
13 committed and combined company fulfills its commitment to
14 its strategic relationship with healthcare providers and
15 patients aimed at leveraging technology, supporting
16 ordinary systems of care and working with clinicians,
17 hospitals and other providers to assure the best health
18 and outcomes for consumers in California.

19 Thank you, sir.

20 COMMISSIONER GARAMENDI: Thank you, very much,
21 doctor.

22 John Cascell.

23 Or Andy Gilmour, you guys decide.

24 MR. CASCELL: Good morning.

25 Thank you for the time to come and speak before

1 the panel this morning. My name is John Cascell. I am
2 the Vice President for Memorial Health Services.

3 Memorial Health Services is a not for profit
4 hospital system that has five facilities in Los Angeles
5 and Orange counties.

6 Our facilities include acute care hospitals, a
7 children's hospital which is Miller Children's Hospital
8 in Long Beach, rehabilitation hospitals, skilled nursing
9 facilities, home health agencies, hospice agencies and
10 out-patient surgeries and out-patient diagnostic centers.

11 Currently Memorial contacts with almost all the
12 major health plans in California including PacifiCare
13 HealthNet, Aetna, Cigna, Scan, Bluecross and Blueshield.

14 We have a very strong long term relationship
15 with PacifiCare, that has been built over the years, and
16 we currently provide healthcare services to more than
17 100,000 PacifiCare and Secure Horizons members.

18 On any given day we have over 90 to almost 100
19 PacifiCare patients in our hospitals.

20 From Memorial's perspective, there are several
21 positive aspects to this merger.

22 First of all, it is very encouraging to hear
23 that after the merger is completed, PacifiCare will
24 maintain its local presence and leadership, and that is
25 United's intention, to offer a basic care in a manner

1 that is highly consistent with PacifiCare's current
 2 operations and its current procedures and also with
 3 United's enhanced resources.

4 I think this continuity will allow PacifiCare to
 5 maintain strong relationships that they have built in the
 6 provider community, and also I think their local presence
 7 allows us the opportunity to often times meet
 8 face-to-face with PacifiCare in dealing with issues
 9 instead of always having to do issues through the fax,
 10 phone or e-mail.

11 Second, I think it is pretty well known in the
 12 healthcare industry that United Health has spent
 13 significant money and invested and developed in
 14 technology that have fueled significant improvements in
 15 both clinical and administrative processes.

16 We think that this merger will enable PacifiCare
 17 to access that technology that United has developed to
 18 help strengthen its relationship with members and
 19 providers, and I think most importantly, help to
 20 streamline the healthcare administrative process which we
 21 all know we spend a lot of time and money on.

22 United offers electronic support for claims
 23 submission which is very important to the hospital.

24 It allows for on-line tracking and processing of
 25 claims, and it also has the technology to support

1 electronic medical records.

2 It is also my understanding that United will
3 assist PacifiCare in helping to provide PacifiCare's
4 members with electronic I.D. cards, which again helps
5 speed up the process for verifying eligibility and
6 obtaining authorization. All of these enhanced
7 technological resources we think will allow more time,
8 energy, and money to be spent where it should be, on
9 patient care instead of administrative process.

10 Lastly, and again I think probably more most
11 importantly from competitive standpoint, United at this
12 point has a very small market presence in California.

13 So we don't believe that this is a merger that
14 will give the combined companies the ability to unfairly
15 leverage providers.

16 In fact, we believe that this merger will create
17 a stronger PacifiCare that will allow it to more
18 effectively compete against larger national insurance
19 companies.

20 To conclude, we are aware that other hospitals
21 have voiced for support this merger, and Memorial also
22 believes this combination will create a better, stronger
23 PacifiCare for its members, its employers and its
24 provided partners.

25 Thank you.

1 COMMISSIONER GARAMENDI: Thank you, very much.
2 Mr. Gilmour.

3 MR. GILMOUR: Good morning, Commissioner.

4 Good morning. My name is Andy Gilmour, and I am
5 president of JD Gilmour company, Glendale, California.

6 I have been a licensed insurance broker since
7 1974, and my father started our agency in the 1960's. My
8 brothers and I now run a pretty successful brokerage in
9 Glendale.

10 My son is in the business. My daughter is
11 coming in two years when she graduates from USC. Really
12 the healthcare business is very important to me, and I
13 really believe in the future of our industries.

14 We have seen a lot of changes in our industry.
15 In the 1980's, 1990's we had small HMO plans like Take
16 Care, Universal Care, Care America, Health Plan of
17 America.

18 These were all good regional alternatives. Some
19 of you may remember those plans, FHP, Maxicare, all
20 compete on a state-wide basis.

21 And we also had traditional insurance companies
22 like Lincoln National, Prudential, New York Life, Pacific
23 Mutual.

24 They were all lined for the insurance dollar at
25 that time. This intense competition is good for our

1 clients. We had choices to offer in those days. In the
2 mid '90's to the early turn of this century we started
3 seeing mergers, bankruptcies, withdrawals from
4 California.

5 We lost all the small players to mergers.

6 Most of the traditional insurance companies
7 chose to leave the state.

8 By the turn of the century there were only seven
9 companies left on the state wide basis.

10 You know, seven carriers willing to do business
11 in California on a state wide basis. We are very
12 concerned about this, and we do business with all these
13 carriers right now as insurance brokers. We don't want
14 to lose any of these to our clients potential health
15 insurance markets.

16 We would be against any merger that decreases
17 the number of carriers in California. For this reason I
18 am very happy that United HealthCare is purchasing
19 PacifiCare. United HealthCare is really not a factor in
20 our marketplace.

21 We are not losing a market. PacifiCare is one
22 of the best plans available in California, and they will
23 continue to be available after the merger.

24 PacifiCare will be continued to run as it is
25 today.

1 My understanding is they will have local
2 accountability, local people, local relationships.
3 Relationships are the foundation of my business. A
4 relationship with a client and a relationship with the
5 carrier.

6 PacifiCare is number one with our agency.

7 Our relationship with PacifiCare and their sales
8 and service department could not be better. The merger
9 will give PacifiCare access to large national PDL
10 networks.

11 I have had trouble in the past insuring clients
12 of PacifiCare if they were in more than one state. The
13 dental programs work very well, but PacifiCare's medical
14 network was lacking outside of California.

15 This merger will also give PacifiCare the access
16 to discounted contracts for people in California
17 traveling out of the state if they are injured or ill.

18 Our economy is changing. I have many more and
19 more clients who do business outside of California.

20 These clients have limited access, and they
21 usually have to go to one of the national carriers. This
22 merger will give me another market for their benefits.

23 PacifiCare is one of the companies to pioneer
24 decapitated HMO model. Southern California is our main
25 territory, and Southern California area capitation has

1 been the most efficient care model for many years.

2 We also have the best rates as we know in the
3 country because of our capitated model. This model has
4 worked very well for our manufacturing based clients here
5 in Los Angeles.

6 I would not want to lose this type of plans and
7 options PacifiCare is committed to the model.

8 I know there are economies of scale, financing
9 advantages, technological advantages and other back
10 office improvements that will go with this merger.

11 I am sure those are very important to everyone
12 here and very important to Wall Street.

13 However, my main point is that this merger keeps
14 PacifiCare in the California marketplace, and that is
15 good for my agencies. It is good for my clients, and it
16 is good for their employees.

17 Thank you, very much.

18 COMMISSIONER GARAMENDI: Thank you, very much.

19 In keeping with, having had some balance here, I
20 note the President, state Senator Alarcon, would you like
21 to make a statement?

22 SENATOR ALARCON: Sure.

23 Well, thank you, Mr. Garamendi and panelists
24 both from the proposed merger side as well as those who
25 are considering the ramifications of this merger and have

1 a critical decision to make.

2 First, let me say that I don't think that the
3 criticality of your decision can be understated. There
4 is no greater challenge to California indeed the United
5 States than providing access to healthcare.

6 As we have seen, the healthcare system has been
7 diminishing on every front in terms of the urban sector,
8 the rural sector, in terms of seniors having more or less
9 access, children having more or less access and
10 notwithstanding some major endeavors in the state of
11 California over the course of the last seven or eight
12 years, we have never the less seen that our
13 infrastructure in terms of providing health services is
14 dwindling, and we must restore it.

15 So clearly the critical question regarding this
16 merger is will this merger contribute to expanding access
17 to healthcare or will it deplete resources.

18 Will it mean that more Californians will be
19 cared for adequately or will it mean that less will.

20 Will it address the issues that come forward in
21 the past and will it contribute in a way that is positive
22 to the overall needs of our healthcare system.

23 So, with that I would like to sort of formalize
24 my comments by following an outline prepared by my staff.

25 But first let me say that why is it that we

1 scrutinize mergers for tele-communications industry and
2 energy, but we do not scrutinize mergers when it relates
3 to healthcare?

4 Why is it that we define a telephone which
5 reminds me I should turn this thing on something other
6 than loud.

7 Why is it that we call this an essential
8 service, and yet we do not define many health services as
9 essential?

10 Clearly healthcare is essential to our quality
11 of life, and indeed in many circumstances simply under
12 traumatic circumstances, it is essential to life.

13 And so, I believe that the first thing we ought
14 to be exploring is whether or not we need to raise the
15 standard of scrutiny relative to the health insurance
16 industry and these kinds of mergers so that we are
17 ensuring that the same kind of process is in place that
18 we allow for energy and telecommunications industry.

19 I believe that in doing so we will ensure the
20 integrity of the process, but more importantly we will
21 prevent the loss of services.

22 We will ensure a better treatment, a better
23 provision of services and access to healthcare moving
24 forward.

25 This is a quality of life issue. California has

1 declared all these energy, and tele-communication, and
 2 water are essential services.

3 We simply don't understand why health services
 4 are not, why health insurance industry is not considered
 5 an essential industry, and that must be scrutinized by
 6 the public.

7 We also need greater oversight, greater
 8 oversight over the merger of these healthcare companies
 9 as we did in the SBC, ATT, merger. There were public
 10 hearings up and down the state to determine if the merger
 11 was in the public interest.

12 It seems to me we ought to do the same thing
 13 when it comes to health insurance company mergers to
 14 ensure that the merger benefits not only the corporations
 15 but also the public.

16 The other -- another point that I would like to
 17 emphasize is what has happened in the past?

18 What has been the result of the mergers in the
 19 past? We know that there have been some benefits clearly
 20 that came out.

21 Commissioner Garamendi, I want to commend you
 22 for negotiating the 35 million dollar deal on the Well
 23 Point merger that we were able to dedicate, and the
 24 governor signed, and my legislation with Gil Savillo to
 25 allow that money to go to the primary care clinic fund

1 which will mean literally that those primary care clinics
2 will provide services to typically indigent in our
3 population, will be able to expand the units of service
4 provided, the visits to the doctor, units of service
5 provided by over one million units of service a year.

6 That is a good benefit, but is it the complete
7 picture?

8 We need to look at those previous mergers, and I
9 believe we need to have a formal report on what the
10 ramifications of those mergers has been.

11 We need to look at the track record of the
12 previous mergers to see if indeed it was in the public
13 interest.

14 The 2004 Well Point merger shows us anecdotally
15 that corporate executives and shareholders made a ton of
16 money.

17 The stock nearly doubled, and large severance
18 packages were given out to executives. Was that in the
19 public interest?

20 Could we have struck a deal? Rates for health
21 insurance went up for Blue Cross of California
22 subscribers almost 20 percent.

23 Did that mean that more people had access to
24 healthcare or did fewer Californians have access to
25 healthcare as a result of the higher costs of that

1 company's services?

2 Thousands of people literally lost healthcare
3 due to the higher health insurance rates.

4 As a result we have no reports that the quality
5 of healthcare improved. I would like to know about that
6 before we decide on future mergers.

7 This is not -- my statement is really not about
8 PacifiCare and United HealthCare.

9 I have no specific research on this subject. I
10 am speaking to the integrity of the process of
11 consideration of all mergers related to health.

12 And that is why I think it is important that we
13 improve the standards and the considerations so that we
14 can ensure greater access.

15 These are some of the questions that I believe
16 need to be asked very specifically.

17 What is the cost of the merger to the public?

18 How much is the public going to have to pay for
19 higher premiums as a result?

20 Do we know in this particular merger, for
21 example, that the costs of the rates, the premiums, will
22 not go up?

23 I doubt that question has been asked. I doubt
24 that the answers will be forthcoming.

25 Will the quality of healthcare improve or

1 worsen? Will there be more or less access to the care?
2 Is anyone going to be cut from insurance because of the
3 merger?

4 Can PacifiCare United Health guarantee that
5 nobody will lose healthcare as a result of this merger?
6 Will the merger improve the healthcare infrastructure.
7 For merger to be in the public interest, it needs to help
8 Californians.

9 A lot of Californians do not have access to
10 healthcare already. Will more Californians have
11 healthcare or less?

12 I think it is a legitimate question to ask. A
13 lot of Californians rely on the public infrastructure for
14 their healthcare.

15 Will the merger put more resources into that
16 safety net or will it deplete those resources?
17 California emergency and trauma safety net protects
18 everyone, but it is falling apart.

19 Los Angeles, in Los Angeles County nine of our
20 emergency rooms and trauma centers have closed in a very
21 short period of time. The San Fernando Valley with over
22 1.3 million people where my 100 percent of my district
23 is.

24 They do not have a single trauma center for
25 children. I introduced SB-57 because I know as a father

1 who lost a son in a traumatic car accident, and perhaps
 2 you know, in hindsight as I reflect on that, instead of
 3 having to be flown to Kaiser in Hollywood, if he had had
 4 a trauma care center within a mile or two of North
 5 Hollywood, perhaps my son would be going to college right
 6 now.

7 So, does this merger have an impact on our
 8 trauma care system? I would like to know, and I think
 9 most Californians would like to think that when we do
 10 these mergers, we take advantage of them as opportunities
 11 to expand services, to ensure the integrity of not just
 12 our trauma care system, but our primary care system as
 13 well.

14 We should expand services for the indigent
 15 because when they do not get services instead of going to
 16 the primary care clinic and getting tested for a cold, we
 17 see them ending up in our county facilities with full
 18 blown tuberculosis.

19 We didn't have tuberculosis 20 years ago. We
 20 are seeing it again.

21 When we talk about HIV, when you talk about
 22 hepatitis C, all these things we thought we beat for a
 23 while, not HIV but hepatitis C certainly, and yet there
 24 is a resurgence.

25 If we do not capture these things quicker, it

1 doesn't matter whether you are rich or poor, you will be
2 in jeopardy.

3 All of these things, I believe, are pertinent to
4 the PacifiCare United Health merger.

5 I think they are within the realm of your
6 authority to be considered.

7 I would like to see the process more formally
8 delineated, and I would encourage Commissioner Garamendi
9 to further delineate that process so that we can ensure
10 the integrity of these mergers. So my recommendations
11 are basically three.

12 Before the merger goes through, there must be
13 assurances that rates will not go up, that the quality of
14 care will improve, that the infrastructure of the
15 healthcare industry will be positively impacted.

16 Two there must be additional oversight. There
17 must be a system in place to more closely oversee the
18 merger if it goes through, and there should be more
19 coordination between DMAC and the CEI.

20 In terms of long term, the health insurance
21 should be declared as an essential service and the same
22 amount of oversight and attention to the public benefits
23 seen in the public utilities will be seen in the health
24 insurance industry.

25 I want to commend PacifiCare and United Health

1 for being in the health business.

2 We need you, but we also need to ensure that you
3 can provide services in a way that expands our
4 healthcare system that it provides more services to
5 people. In fact, how could that be bad for your industry
6 if you have more customers?

7 I think it would be good, and we don't also want
8 to put the burden on this merger to the exclusion of all
9 the other things that are going out there, but I think we
10 have the opportunity here to send a powerful message to
11 the people of California that where these mergers occur,
12 we will guarantee that there will be an expansion of
13 access to care that we will cover some of the
14 infrastructure losses that we have seen.

15 We will protect our trauma care system, for
16 example, but we will also delineate a process that will
17 be more complete and more holistic in terms of the kinds
18 of things we ought to be looking at when these mergers
19 occur.

20 Commissioner Garamendi, I want to thank you for
21 your work in this area particularly the \$35 million that
22 will go to Californians in the form of millions of units
23 of service.

24 The last time we dedicated 50 million to the
25 exact same cause, it resulted in over one million units

1 of service per year.

2 I believe this 35 million will have the same
3 effect, and if you multiply that times the number of
4 years, we are talking about families being more
5 protected.

6 This is a critical time for us. It is an
7 opportunity for us as well.

8 I think you can make a positive statement for
9 California, and I believe you will.

10 So thank you so much for your work.

11 COMMISSIONER GARAMENDI: Senator, thank you very
12 much.

13 Also, thank you for your legislation, the
14 Alarcon Savila legislation.

15 It does provide original money and a mechanism
16 to provide additional services through the community
17 clinics a very good piece of legislation which was used
18 in the Well Point and the merger.

19 SENATOR ALARCON: Unfortunately SB-57 the trauma
20 care bill was not signed by the Governor, and I fear that
21 our trauma care system is going to be reduced more than
22 increased.

23 COMMISSIONER GARAMENDI: I share your concerns.

24 The issues that you raised are all subject
25 matters for this hearing.

1 The panel has been presented with six pages of
2 questions all of which you went through, so if you or
3 your staff either want the text from this hearing or you
4 want to stick around for the hearing, you will perhaps
5 see answers to those questions, and if not, later on.

6 Thank you very much, Senator.

7 SENATOR ALARCON: Thank you.

8 We will continue to follow up and work with you.

9 COMMISSIONER GARAMENDI: Thank you.

10 I believe I have one more public participant and
11 then remaining public comments will be following the
12 panel's testimony.

13 Carl Coan from the Kaiser Pediatric and Family
14 Medical Center representing the California clinics, Carl.

15 MR. COAN: Good morning.

16 My name is Carl Coan.

17 I am the President and Chief Executive Officer
18 of the Kaiser pediatric and family medical center, the
19 federally funded community health center located in
20 central Los Angeles.

21 I also serve on the board of California primary
22 care association which represents over 600 of
23 Californians not for profit community clinics and health
24 centers.

25 I am speaking at this hearing in this board

1 capacity and on behalf of CPCA. Not for profit community
 2 clinics and health centers share a common mission to
 3 serve everybody who walks through our doors regardless of
 4 their ability to pay.

5 Because of this mission, we frequently are the
 6 only place to turn for people who face obstacles to
 7 utilizing main stream healthcare services such as the
 8 lack of ability to pay for services, fear of
 9 repercussions on immigration status, language and
 10 cultural barriers and a lack of knowledge about or
 11 comfort with traditional health services and providers.

12 With over six million uninsured Californians,
 13 the community clinics role within the safety net and
 14 healthcare delivery system is expanding and becoming
 15 increasingly vital.

16 Last year over 3.2 million patients were treated
 17 at our clinics with ten million visits provided. Over
 18 one third were uninsured. Another third are dependent on
 19 some form of state or federal assistance program, and
 20 more than half are non-English speaking, and these
 21 numbers continue to grow.

22 Community clinics and health centers are in the
 23 forefront in responding to Californians needs growing
 24 needs of Californians medically uninsured communities.

25 As the needs of these communities continue to

1 grow and change, clinics and health centers have
2 responded.

3 We are the back bone of the healthcare safety
4 net. The merger of PacifiCare and United Health will
5 result in United Health becoming one of the two largest
6 health insurance companies in the United States.

7 PacifiCare is the largest market in California
8 with over one and a half million commercial and a
9 significant number of Medi-Care members.

10 Through acquiring PacifiCare and United Health
11 will gain the ability to operate in California with a
12 significant presence in the Medi-Care market, a highly
13 desirable market because of the revenues enhancements and
14 other changes brought about by the Medi-Care
15 modernization act.

16 This merger in and of itself will not fix or
17 alleviate the under current of health problems in
18 California.

19 We believe, however, this merger provides an
20 important opportunity for both companies to be good
21 corporate citizens in addressing health issues at the
22 community level through the safety net.

23 Today one of the greatest needs of safety net
24 clinics is health information technology. As in all
25 businesses today, technology is essential to effective

1 and efficient operations in healthcare research effective
2 use in data collected and managed through technology
3 increasing patient health outcomes.

4 Therefore it is critical to support the use of
5 technology and safety net providers not only to enhance
6 business operations but to improve health outcomes for
7 California's low income patients.

8 The federal government has made clear its goal
9 to accelerate the adoption of health information
10 technology and to secure portability of health
11 information across the United States.

12 According to a Tides Foundation analysis in
13 2000, one third of safety net clinics had no information
14 technology system at all, 25 percent of clinics had
15 information systems that were more than five years old,
16 and two thirds of clinics with remote sites had locations
17 that could not access the practice management system.

18 These are just a few examples of many of the
19 reflecting increasing disparity within the means and
20 needs of clinics pertaining to information technology.

21 The benefits that are being incurred by the
22 merging companies through this pending merger are
23 substantial and again begs the question where can these
24 benefits be extended to the community and safety net?

25 On behalf of CPCA, California Primary Care

1 Association, I want to thank you for this opportunity to
2 address this important issue.

3 We look forward to working with you in the
4 future.

5 COMMISSIONER GARAMENDI: Excuse me, Carl, before
6 you leave, do the clinics have a plan to combine, to
7 develop the technology system or to use the technology
8 system that might be available?

9 MR. COEN: Yes, we do.

10 We have worked on that plan for a while, and we
11 have it available, yes. We would be glad to provide it
12 to you.

13 COMMISSIONER GARAMENDI: And the approximate
14 cost.

15 MR. COEN: Unfortunately I don't have that off
16 the top of my head.

17 COMMISSIONER GARAMENDI: But you do have a
18 written plan?

19 MR. COEN: Yes, sir.

20 COMMISSIONER GARAMENDI: Thank you very much.

21 Okay let's, move on.

22 Now I know there are other public people from
23 the public that want to testify, but we really need to
24 move to the panel and hear from the applicants. To that
25 end, they are all there.

1 I am not sure that we have a specific order of
2 participation, so do you want to flip coins?

3 Do you want to toss?

4 Who wants to go first?

5 MR. FREY: Good morning. My name is James Frey.
6 I am President of PacifiCare of California.

7 I would like to introduce the folks up here this
8 morning.

9 To my right is Mr. Bob Sheehy who is Chief
10 Executive Officer of United HealthCare.

11 To his right is Dr. Reed Tuckson, who is Senior
12 Vice President of consumer health and Medi-Care
13 advancements, United Health Group.

14 On my left is Nancy Monk our Vice President of
15 public affairs PacifiCare and at the end of the table is
16 Dr. Sam Ho our Chief Medical Officer at PacifiCare.

17 The department has given us specific questions
18 and issues that it would like us to address this morning.
19 If I may, I would like to make a few brief opening
20 comments before addressing the specific agenda items.

21 I want to thank the commissioner and the
22 department one for putting on this public hearing.

23 This is a significant issue I think as the five
24 speakers already this morning have articulated, and I
25 also appreciate the clarity that the department has

1 provided in terms of expectations that any transaction in
2 the state of California needs to provide value for
3 Californians.

4 And so if I may just highlight a few of the
5 reasons I believe this transaction will help make
6 healthcare more affordable in California, help provide
7 better products and better services for Californians,
8 give California employers more choice and add stability
9 in healthcare marketplace.

10 And I will start with the last one, and that is
11 stability.

12 First of all, we believe this will add to the
13 financial stability of PacifiCare. United Health Group
14 has the highest debt rating in this industry.

15 Their company generates three to four billion
16 dollars of cash flow a year from operating activities,
17 and that provides a strong financial back bone, and as
18 Mr. Gilmour presented, we need as many options as
19 possible here in California.

20 With that strong financial back bone it makes
21 PacifiCare a continued viable player in this marketplace.

22 Secondly, there is stability in leadership and
23 several of the speakers this morning talked about the
24 importance of local leadership and the importance of
25 continuity in that leadership.

1 And as we have stated publicly in this
 2 transaction the leadership team that is currently placed
 3 in California for PacifiCare which includes myself and
 4 Nancy Monk and Dr. Sam Ho, we are all staying on in the
 5 new organization. Our chief financial officer is staying
 6 on in the organization.

7 Our head of provider relations is staying on, so
 8 there is continuity of leadership which provides
 9 stability, and that also helps make sure that the
 10 integration of these two companies is thoughtful.

11 So that while we bring the benefits that United
 12 brings to PacifiCare, we keep many of the benefits that
 13 we currently have in place, and we don't lose that to
 14 local leadership.

15 The department and the commissioner have been
 16 very specific that we need to have -- we need to make
 17 healthcare in California more affordable, and I
 18 completely agree.

19 We believe there are ways that this transaction
 20 will help that. Number one, as was mentioned by one of
 21 the speakers, there will be lower out of network costs.

22 United has a delivery system across the country
 23 with over 460,000 physicians contracted in over 4,000
 24 hospitals. That is much more robust than what PacifiCare
 25 has today and at a much better price point than

1 PacifiCare has today.

2 We have estimated savings for PacifiCare
 3 somewhere between 45 and 65 million dollars a year in out
 4 of network costs, and our members who are on a
 5 co-insurance based benefit design. There will be savings
 6 for themselves because they pay a percent of those
 7 charges, and the charges will be lower than we currently
 8 have when a member goes out of state.

9 We will also see lower administrative costs
 10 through higher rates of member self service and employer
 11 self service.

12 Today 92 percent of United's small groups verify
 13 their eligibility up-date their eligibility on line.

14 PacifiCare currently doesn't have that
 15 capability, so it creates more accurate eligibility more
 16 accurate billing, better administration at the
 17 physician's office, and it actually is lower cost because
 18 it is done on line by the employer themselves and does
 19 require an individual at PacifiCare.

20 We will see higher rates of claims
 21 auto-adjudication with this transaction. That is not
 22 something that happens on day one because that involves
 23 the integration of the core transaction system, and that
 24 may take 12 to 24 months because that is a major
 25 undertaking, but at the end of the day, today United

1 auto-adjudicates 81 to 84 percent of their claims today.

2 Pacific-Care auto-adjudicates about 48 percent
 3 of our claims. As we move to their claims system we will
 4 see clearly more auto-adjudication and less
 5 administrative expense.

6 I think we will also see lower IT costs at
 7 PacifiCare. PacifiCare our core transaction system is
 8 built on an antiquated technological platform.

9 It costs us over 200 million dollars a year just
 10 to maintain our IT infrastructure. That doesn't include
 11 any amounts for new programs, new technology. That is
 12 just to keep the old system running.

13 So the ability to migrate off that system to a
 14 more efficient, better system that United will bring to
 15 us is a benefit.

16 There is also the benefit of better products,
 17 better services.

18 We have heard some discussion this morning
 19 procedures from the speakers about helpful technology.

20 Today after we spend about 200 million for the
 21 maintenance of our system, we have about 50 to 70 million
 22 left over each year that we put into new system
 23 development for new programs, better services for our
 24 members, that is good, but it is not nearly as good as
 25 what United is able to spend.

1 They spend somewhere between 300 to 400 million
 2 dollars a year on new technology and new systems. They
 3 have spent, I believe, in excess of two billion dollars
 4 in the last five years on new systems.

5 It has been mentioned this morning the
 6 electronic I.D. card today that 18 million United members
 7 have, and that today allows for a instantaneous
 8 verification of eligibility.

9 Next year will allow access to an automatic up
 10 dating of that patient's personal health record. That is
 11 technology that California through PacifiCare will have
 12 years ahead if we were on our own.

13 They are probably five years away from being
 14 able to develop that own technology given our current
 15 infrastructure constraints. So that is a benefit for our
 16 members.

17 You have talked about commitment to under served
 18 populations.

19 I think PacifiCare being one of the first health
 20 plans in the country to offer the Medi-Care HMO program
 21 and stayed with that program through the lean years of
 22 funding is very committed and again having the financial
 23 stability of United just allows us to weather the ups and
 24 downs of federal reimbursement.

25 And we are also looking forward to increasing

1 our involvement with our secure gold product which is a
 2 product for low income seniors here in the state of
 3 California, increasing our involvement with our Latino
 4 health solutions program, our African American health
 5 solutions program and Asian American health solutions
 6 program which provides better benefit and greater access
 7 to the under-served population.

8 Lastly, we heard this morning about more choice
 9 for California employers.

10 And Mr. Gilmour mentioned his clients that are
 11 headquartered here in California, but have employees in
 12 other states.

13 To this point they have very few options. Quite
 14 frankly especially if they wanted the benefits of the
 15 capitated delegated model that I think is one of the
 16 superior delivery systems in this country.

17 But, if you wanted a national player that also
 18 add the HMO and a co-pay based benefit down here in
 19 California, you didn't have many options.

20 This would now give those employers a new option
 21 with the PacifiCare United combination.

22 Before we move to the specific questions and
 23 issues, I would like to ask Mr. Sheehy to add any of his
 24 opening comments this morning.

25 MR. SHEEHY: Bob Sheehy.

1 Commissioner, thank you, James, I want to
2 express my gratitude for having the hearing.

3 I think it is a great opportunity to have a
4 dialogue about the proposed transaction and present our
5 views on this important issue.

6 I think you have teed up effectively.

7 We have tremendous challenges in this country in
8 this state and of providing high quality affordable
9 accessible healthcare, and we at United Health Group
10 believe that we are part of that solution.

11 And I would like to explain, try to explain
12 anyway why we believe that the combination of United
13 Health Group and our assets and our positions with
14 PacifiCare's assets and positions really make for a
15 better healthcare system.

16 Let me first give you a little background. I
17 started with United almost 20 years ago.

18 And I actually came in through an acquisition, a
19 company that was purchased by United, so I have got quite
20 a bit of first hand experience in terms of the whole
21 integration process and the benefits that a broader,
22 national organization can bring to a local market or a
23 regional market organization.

24 I think PacifiCare has terrific assets.

25 One of those assets is the local market

1 expertise really understanding and operating in the
2 California marketplace, in a way that national companies
3 can't really understand or deliver on.

4 I think the integrated delivery system and
5 coordinated care model is a terrific strength.

6 California is relatively unique in the country
7 in terms of having the access of the integrated delivery
8 system where you really have physicians working together
9 as part of an organized group to improve the quality and
10 cost of care.

11 That is something we are very excited about
12 learning from and hopefully building on.

13 And lastly, I think PacifiCare has got terrific
14 relationships and strategies for California, and I think
15 those are things that we are very excited about
16 supporting.

17 United Health Group is really built around three
18 key assets. First is our network and care delivery
19 system that we have been building on over the years.

20 Secondly, are the information capabilities that
21 we use, and the third key asset that we use is technology
22 that James touched on.

23 If I can just quickly run through maybe a few
24 facts on each of those things.

25 James talked about the network. It is the only

1 real national network on a single system.

2 If your kids are traveling across the country or
3 you have employees in different parts of the country,
4 they can still receive the same benefits and services on
5 the single system.

6 It is an important competitive advantage from a
7 choice and aspect for consumers, but also what is
8 important with that network is that we collect
9 information and data on the physicians across the
10 country.

11 One of the real opportunities I think we have
12 nationally is improving the variation and healthcare that
13 happens in communities and across the country.

14 And we see that national network combined with
15 our second asset, the information capabilities is really
16 keyed at doing that.

17 That information gives us the ability to compare
18 doctor practices to other doctors in the community, other
19 doctors across the country or evidence based standards
20 and work with those physicians in a constructive
21 proactive way, I think very similar to the way PacifiCare
22 has worked with physicians to help improve the quality
23 and performance of healthcare system.

24 So we think the information is really a key
25 asset to bring the healthcare system to a more efficient

1 level by using comparative data.

2 We also use that same information increasingly
3 now with consumers giving consumers information on the
4 relative quality of physicians in certain areas, the
5 relative cost effectiveness in certain areas, and we have
6 put that in a way that consumers can access it easily
7 through the internet, through direct interaction with
8 nurses and really trying to give consumers better
9 information so they can be better patients in the
10 healthcare system. Our vision on technology is I think
11 makes this different.

12 I think it can really help us bring more value
13 to PacifiCare. We view the healthcare system as having a
14 tremendous opportunity for improvement by using end to
15 end technology and really getting rid of the paperwork.

16 So our view when somebody enrolls in a
17 PacifiCare United healthcare product they will fill out a
18 healthcare assessment or do it on line which will be a
19 paperless system.

20 They will get their enrollment materials on
21 line, get an I.D. card.

22 James mentioned it was a swipe card that doctors
23 can use in their offices through a Mastercard terminal.

24 There isn't any special equipment they need.

25 We have worked with Mastercard to see the

1 eligibility for that individual network consumers can go
 2 on line check on status of their claims, check on the
 3 status of basic health information.

4 We are also in the beginning of the next year,
 5 commissioner, we will be pulling together the claims
 6 information we have through pharmacy lab physician claims
 7 hospital claims, and we will be able to give people
 8 access to a personal health record.

9 It won't be an electronic medical record that
 10 you were limited to before because we won't have all the
 11 clinical information, but consumers will be able to go on
 12 line and see for themselves and the family the healthcare
 13 they have received over the past year or a specified
 14 period of time through the claims system and the clinical
 15 database that we have built.

16 We will be pulling in more artificial
 17 intelligence so there may be certain things if you had a
 18 high cholesterol level, you can go to on line.

19 It may say you need a follow-up check for this
 20 because the time is due.

21 We think this will be helpful if people are
 22 traveling they go to an emergency room, there are no
 23 medical records, physicians will be able to access that
 24 personal health record and get a better understanding of
 25 the historical health treatments that that person has

1 received.

2 So we think our view on technology is not just
3 about claims processing.

4 It is really making it more of a seamless easier
5 to use healthcare system for consumers.

6 Just a couple closing comments. We are very
7 committed to serving all segments of the marketplace, the
8 individual marketplace, small business.

9 We are the largest small business carrier in the
10 country. It is a very important marketplace for us.

11 One of the dynamics that has been touched on a
12 couple times is that the marketplace has changed, and
13 more employers of different sizes have employees spread
14 out over a broader geographic areas, and it is a
15 significant competitive issue in the marketplace because
16 the Bluecross association has formed a blue card product
17 that really has enabled them to grow relatively
18 significantly by offering that national access by
19 combining those Bluecross networks across the country.

20 So we think we can add a lot of value to
21 PacifiCare and a lot of value to PacifiCare customers by
22 offering an alternative by offering the United
23 HealthCare National network which we think has superior
24 access and cost.

25 So, we think it is a positive enhancement to the

1 healthcare system in California for consumers.

2 We think financially it is a very strong
3 proposition for a few reasons. As James mentioned, we
4 have the highest rating in the industry, United Health
5 Group.

6 We expect to retire a lot of PacifiCare's debt
7 as part of this transaction. It will diversify
8 PacifiCare's revenue extreme because United Health is
9 diverse across customer segments and across geographies,
10 and PacifiCare is relatively concentrated in certain
11 geographies particularly the Medi-Care marketplace.

12 We think it will help in a stability perspective
13 to have a broader base to operate off of.

14 I want to emphasize that PacifiCare policy
15 holders will not be paying any of the cost of this
16 transaction, and this is something we can assure you that
17 is not the case.

18 This will be borne by United Health Group and
19 not by the policy holders.

20 I want to close on the same comments that James
21 talked about.

22 We think this will give consumers more choice,
23 give consumers and doctors more information, better
24 information and will result in a simpler, more easier to
25 use healthcare system by combining our technology

1 platforms.

2 COMMISSIONER GARAMENDI: Thank you.

3 I will go to a series of questions some six
4 pages so we will work our way through these.

5 Several months ago in this very same auditorium
6 we had the Anthem WellPoint hearing on their merger.

7 The result of that hearing and subsequent
8 process was a set of undertakings contractual
9 relationships between the state of California and the
10 company.

11 That series of undertakings is what I call a
12 template that I intend to apply to any healthcare merger
13 that comes before me during my tenure in this office.

14 This is not news to any five of you at the table
15 since I have made it very clear to you and to others
16 about this.

17 So the questions that I am going to pose to you
18 really go to that template and to the issues that were
19 raised in the previous merger.

20 There is one set of issues that is new and
21 applies now to you, and I will come to that in a few
22 moments that one dealing with claims and claims
23 management.

24 So let's begin with the financial side of this.

25 You have pretty well explained the structure and

1 I thank you for that so you won't go into that with
2 further detail.

3 On the financial side, we will just say that
4 this department is satisfied that going forward the
5 company will be financially strong.

6 We are concerned about that, but our concerns
7 have been satisfied. But however, there are financial
8 implications to providers as well as consumers, and I
9 want to deal with that specifically.

10 There is a cash cost in this transaction. This
11 merger some \$21.50 per share transferred.

12 How do you propose to pay that cash cost?

13 Where does the cash come from, and what
14 assurances are you providing to this department and the
15 department of managed healthcare that those costs will
16 not be borne by either providers or policy holders?

17 MR. SHEEHY: The cash portion, the \$21.50 per
18 share that you mentioned will be borne through a
19 combination of United Health Group cash flows and
20 additional debt that will take on.

21 That debt will be serviced at United Health
22 Group level not at the PacifiCare level, so the cash
23 requirements to service that debt will not impact the
24 rates and the premiums that consumers in California pay.

25 COMMISSIONER GARAMENDI: I am sure you read the

1 transcript of the previous hearing I held on with Anthem
2 and Well Point, and I said I don't believe you. You will
3 have to show me that is the case.

4 What is the total cash cost here, 21.50 times
5 what number of shares do you quote?

6 MR. SHEEHY: It is roughly 2.1 billion dollars.

7 MR. GARAMENDI: Money is fungible.

8 It moves from here to there, and I am sure you
9 have a way of allocating those costs.

10 I want to make it clear to you that before this
11 deal is approved by this department me, and my signature
12 goes on the deal, that we must have assurances that no
13 portion of that 2.1 billion dollars is going to come out
14 of either the pockets of providers or consumers in
15 California.

16 And we must have a mechanism in place that
17 provides up front a review process and actuarial
18 accounting process and assurances that that is not going
19 to be paid for by Californians, either consumers or
20 providers.

21 Are you prepared to provide such assurances?

22 MR. SHEEHY: Yes, sir. I believe we are.

23 COMMISSIONER GARAMENDI: The other part of it is
24 the dividend ing.

25 There is a certain amount of cash currently in

1 the coiffeurs of PacifiCare, some over 300 million.

2 What is your intention with regard to that
3 surplus?

4 MR. SHEEHY: Commissioner, the way that United
5 Health Group typically operates, and maybe I will let
6 James jump in in terms of California specific issues, but
7 generally we have a capital level in the regulated
8 entities, and all the states we operate in that is in
9 surplus of the statutory required limits, any dividends
10 that would go to a parent company go through approval
11 process through the regulated bodies, and if that is
12 approved, then we would move forward with a dividend. If
13 not we don't.

14 COMMISSIONER GARAMENDI: The 350 million or so
15 of additional of surplus that is in the current
16 PacifiCare coiffeurs, where does it go?

17 MR. SHEEHY: (No response.)

18 COMMISSIONER GARAMENDI: What is going to happen
19 to it?

20 MR. SHEEHY: Well, I think for my expectation
21 for the time being it will stay at PacifiCare regulated
22 entity.

23 COMMISSIONER GARAMENDI: What does time being
24 mean?

25 MR. SHEEHY: Well, if there is say a point in

1 time when we wanted to dividend that up to the group, we
2 would make an application to your office and --

3 COMMISSIONER GARAMENDI: And DMHC.

4 MR. SHEEHY: For approval of the dividend.

5 COMMISSIONER GARAMENDI: I fully anticipate such
6 a request.

7 And you can have some expectation of being
8 denied that money. That came from Californians. It is
9 going to stay here.

10 With regard to the question of premium
11 increases, issues that were raised earlier by the
12 witnesses, public witnesses, what is your anticipation of
13 premium increases for California?

14 MR. SHEEHY: Commissioner, it is, as you know,
15 premium rate increases are determined by projected costs
16 and utilization and administrative costs in the future.

17 We believe we will be able to improve the
18 administrative cost ratios at PacifiCare by providing
19 much of the technology that James touched on.

20 So I don't have a specific number in terms of
21 what the rate increases will be for PacifiCare next year
22 or United healthcare next year, but I thought maybe I
23 would give you some context in terms of what happened
24 with a couple recent acquisitions.

25 COMMISSIONER GARAMENDI: Excuse me, Mr. Frey.

1 You went through a litany of potential savings.
2 I assume they are not potential. They are real
3 savings?

4 MR. FREY: Correct.

5 COMMISSIONER GARAMENDI: What is the summation
6 of those?

7 I have 45 to 60 million because United has a
8 more advantageous payment schedule for providers. You
9 have talked about auto-adjudicating claims and some
10 savings there and some administrative.

11 What is the total?

12 MR. FREY: I think some of those come at
13 different times.

14 I think we have estimated 75 to 100 million
15 dollars of savings in the first year, and our intention
16 would be to -- that shows up as lower premiums because
17 our administrative costs would be lower, and therefore we
18 are able to -- the administrative portion of our premium
19 is able to be lower. That is our intention.

20 That clearly the overwhelming driver of premiums
21 in California and every state is the underlying cost of
22 healthcare.

23 And clearly we will use all the resources of
24 United to try to keep the underlying cost of healthcare
25 in terms of services as low as possible.

1 I think United, on a national basis, has shown
2 an ability to have cost trends lower than the national
3 average and not working at United by my assumption is a
4 lot of that comes from their superior technology and our
5 ability to help keep cost trends moderate in California
6 is important.

7 MR. GARAMENDI: Did I hear you say then that the
8 savings in this particular category of administrative
9 costs and the broad general nature of it are going to be
10 passed on to the consumers?

11 MR. FREY: I think our expectation, and I think
12 we have stated publicly, that we would expect our
13 administrative cost ratio to go down over time which
14 would mean that we would be passing it on.

15 COMMISSIONER GARAMENDI: Do you have a schedule
16 of reduction of administrative cost ratios you are
17 presently working with?

18 MR. FREY: No.

19 MR. GARAMENDI: Would you like to develop one
20 and deliver it to us?

21 MR. FREY: Absolutely.

22 COMMISSIONER GARAMENDI: Thank you, and then be
23 held accountable?

24 MR. FREY: Absolutely.

25 COMMISSIONER GARAMENDI: Good.

1 That brings me to the question of I think I want
2 to go a different way here.

3 Hang on just a second.

4 Where are you with your current medical loss
5 ratio for the HMO products that you have?

6 MR. FREY: Our, let me just make sure I get the
7 right number.

8 Year-to-date through the second quarter, based
9 on our DMAC filings, our MLR is at 85.7 percent on the
10 HMO product.

11 COMMISSIONER GARAMENDI: When we discussed the,
12 a moment ago the administrative costs and the potential
13 reduction of those costs, I assume then the medical cost
14 ratio you would anticipate it to increase or excuse me to
15 yeah to decrease actually. You will spend less money on
16 administration more money on medical care; is that
17 correct?

18 In other words, go from 85 to 87, 88, 90 some
19 other number?

20 MR. FREY: That is a potential.

21 Much of what happens with your MLR is driven by
22 your member mix.

23 We have a significant percentage of our
24 businesses are Medi-Care business which runs at a higher
25 MLR than our commercial business.

1 And so as the mix of business changes so it is
2 not a pure -- it is hard to say right now here is where
3 our MLR is going to go.

4 Clearly our intention is to provide the
5 healthcare that is needed and necessary for our members
6 and the mix of business will often times drive what the
7 over MLR in the marketplace is.

8 COMMISSIONER GARAMENDI: Apparently from your
9 testimony that the current mix of business is in the
10 85 percent range?

11 MR. FREY: That's correct.

12 COMMISSIONER GARAMENDI: What has been the trend
13 over the last three years?

14 MR. FREY: On our HMO business, that number has
15 moved from a high of 90 in 2001 to a low of 83 in 2003.

16 So it trends in that range. For us in
17 California and that in large extent as our membership has
18 shifted in that timeframe.

19 COMMISSIONER GARAMENDI: 90 to 83?

20 MR. FREY: Correct.

21 COMMISSIONER GARAMENDI: And describe your
22 membership shifts over that three-year period.

23 MR. FREY: We have seen at times less Medi-Care
24 membership as a percent of our overall membership, and at
25 other times we have seen that number go up.

1 COMMISSIONER GARAMENDI: Which way is it going
2 from 90 to 83?

3 MR. FREY: Right now 85 is our historical
4 five-year average.

5 So we are right in line with our average over
6 the last five years.

7 I think right now we are seeing our commercial
8 business and our Medi-Care business grow about the same
9 rate.

10 So we would expect it, if that is consistent, to
11 stay pretty much in that range it is today. If we grow
12 our business basically at the same rate that we are
13 growing this year.

14 COMMISSIONER GARAMENDI: You have had detailed
15 discussions with my staff concerning this medical loss
16 rate, and we have not yet completed that process.

17 But this issue is central to the determination
18 of and your success or failure at achieving the goals
19 that you have set out.

20 We would be very distraught to see the medical
21 loss ratio decline unless there is a clear indication
22 that you are taking on far more risky business which has
23 not been the trend in the insurance health insurance
24 industry which has been quite the opposite that is to
25 shed risk of business, to shed risky business.

1 Before I approve this merger we will nail this
2 down, and we will only approve the merger if it is clear
3 and capable of determining that the medical loss ratio
4 given a specific population, that is community at risk,
5 is improving not declining.

6 I am going to hold your company accountable for
7 improving medical loss ratio without accounting tricks.

8 So, be prepared in the days ahead to work with
9 us to figure out exactly how you are going to do that.

10 And yes we will take into account the changing
11 population okay.

12 MR. FREY: I think that is clearly our
13 expectation. I think your department has been very clear
14 about that. I also think PacifiCare has had from your
15 perception one of the best MLR's in this state for a long
16 period of time.

17 COMMISSIONER GARAMENDI: Certainly better than
18 Bluecross which is the worst or near the worst.

19 MR. FREY: I would agree.

20 COMMISSIONER GARAMENDI: Okay. I want to now go
21 to the issue of your operations in the state of
22 California.

23 You have said in your opening statement that
24 your operations would essentially would stay in
25 California. Apparently the medical community operations

1 would stay in California. Aside from opening statements
2 testimony, what assurances are you willing to provide or
3 will you provide to the people of California and this
4 department that that is in fact going to happen?

5 MR. FREY: I will make some comments and see if
6 Mr. Sheehy or others would like to add.

7 Yes. We both PacifiCare believe local
8 accountability is critical.

9 I have mentioned the leadership team in
10 California staying the same.

11 We believe the vast majority of our employees in
12 California will remain with the company.

13 In fact, we currently have about 500 open
14 positions which is not uncommon when you have 10,000
15 employees.

16 And we are actively recruiting to fill those
17 positions now.

18 There will be some positions in the corporation
19 that will be eliminated as part of the cost savings we
20 have talked about earlier.

21 Clearly public company positions, investment
22 relations, things like that, but I think we have
23 estimated those in our filings at about 200 individuals.

24 We have about 5,600 individuals that work in
25 California about 10,000 across our whole company so we do

1 expect the overall employee population for PacifiCare in
2 California to remain relatively constant where it is at
3 today, and our goal is to grow as a company and to grow
4 our employee base in California specifically a couple
5 things.

6 I will mention that I believe we are committing
7 to maintaining in California, that is our medical
8 director, our clinical decision making and clinical
9 policy, our prior authorization and referral process as
10 appropriate, our grievance process, our administration of
11 provider disputes. We will certainly maintain our
12 provider relations, organization in this state.

13 So as we have said much of what we do today and
14 who does it for PacifiCare will remain in the new
15 organization in California.

16 Bob, do you have anything?

17 MR. SHEEHY: A couple comments from a business
18 sense perspective.

19 It makes sense to keep strong operations in
20 California.

21 California is a unique market in the country,
22 and you can't manage, and I don't believe you can manage
23 California business outside the state.

24 So the other point is that one of the nicest
25 things about this proposed merger is we don't have a

1 strong presence.

2 We don't have a presence in California at all.

3 So it is not like we have got to get rid of some
4 jobs and keep other jobs.

5 It is really just from United's perspective of
6 greenfield, so it is our expectation is that this will be
7 a hub not just for California and the office where James
8 is but for the western part of the country. So we are
9 very committed to that premise.

10 COMMISSIONER GARAMENDI: I don't think it is
11 appropriate for this department to place a demand that
12 certain number of employees remain in California.

13 However, services to California consumers and
14 providers are specifically by law under one of the
15 obligations that I have to account to.

16 And so I would like not -- would like, I will
17 simply, demand that there be assurances that those
18 functions that are specifically related to customer
19 service and provider service remain in the state of
20 California whether it be ready and easy access for both
21 customers and providers. So be prepared to write that
22 one also and to agree to it.

23 I want to back up for a second or more than a
24 second.

25 We had a discussion on the medical loss ratio

1 issues. It is exceedingly important to us that we have a
2 very clear definition of the factors that are involved in
3 determining the medical loss ratio, factors such as
4 administrative costs, which we have discussed, the
5 provider costs, and also profit and other related items.

6 So, just be aware that I have learned from the
7 past that this will be defined clearly, not subject to
8 future debate but debate prior to this hearing or this
9 merger being approved.

10 So if you have any debate with my staff about
11 those definitions, you better get it on the table. We
12 will want that defined and clarified, but just a general
13 question.

14 Why is it in the benefit of consumers and
15 providers that United going forward has a four billion
16 dollar annual profit?

17 MR. SHEEHY: Well, that is a broader question in
18 terms of how does the country fund the national
19 healthcare system, and we use our earnings from
20 operation, our operating cash flows to reinvest in the
21 business, to build new technology, to expand our
22 marketplace and without that type of performance, we
23 would be the inability would be unable to do much of
24 that.

25 COMMISSIONER GARAMENDI: What portion of the

1 four billion dollars do you intend to invest in those
2 specific things that you just stated technology etcetera?

3 MR. SHEEHY: Just to give you a historic
4 perspective, we spent about \$2.2 billion over the past
5 five years in technology spending. We expect that to
6 continue to increase at about that level.

7 COMMISSIONER GARAMENDI: Some 500 million a
8 year?

9 MR. SHEEHY: I don't have a breakdown of every
10 specific category in terms of re-investment in the
11 business, but we could provide a forecast for you on
12 that.

13 COMMISSIONER GARAMENDI: So, the profit is used
14 to enhance technology and what else?

15 MR. SHEEHY: Our profit, our operating cash
16 flows which are generated from the company are used to
17 invest in the business, expand the business, acquire new
18 businesses, not just in the insurance area, but other
19 areas of healthcare whether that is technology.

20 COMMISSIONER GARAMENDI: Let's be specific here.
21 Your operating cash flow is used for what
22 purpose?

23 What have you used it for over the last three
24 years?

25 MR. SHEEHY: Technology investment.

1 COMMISSIONER GARAMENDI: To some 500 million a
2 year?

3 MR. SHEEHY: We have acquired other health
4 plans, regional health plans, Oxford Health Plan in New
5 York, Mamcy HealthCare.

6 COMMISSIONER GARAMENDI: What portion of it goes
7 to acquisition?

8 MR. SHEEHY: I don't have those numbers on my
9 head. I don't know, Bob.

10 Do you have, our treasurer would probably do a
11 better job in answering that than I could.

12 COMMISSIONER GARAMENDI: What are your plans for
13 future acquisition?

14 What are you telling Wall Street?

15 MR. SHEEHY: United Health Group is a
16 diversified company that provides services in the
17 insurance healthcare insurance area but also in the
18 information areas specialty company areas.

19 So we are always looking for a fix whether it is
20 geographic fix there may be an area of the country that
21 we don't cover.

22 There may be a certain marketplace we need to be
23 in.

24 So we are looking for those types of
25 opportunities if they come up, and it seems like it makes

1 sense for the company and our customers we move forward
2 on those.

3 COMMISSIONER GARAMENDI: That four billion that
4 is profit that is not your operating cash flow, correct?

5 What is your operating cash flow?

6 MR. SHEEHY: I think about three billion
7 operating cash flow over three billion dollars operating
8 cash flow, Bob.

9 COMMISSIONER GARAMENDI: Introduce yourself and
10 enlighten me, please.

11 MR. OBERRENDER: Bob Oberrender, I am the Vice
12 President and Treasurer of United Health Group. The four
13 billion dollars we are referring to here is expected cash
14 flow operations for 2000 and 2005 net income for United
15 Health Group is expected to be around three 3 billion
16 dollars this year.

17 But perhaps I could go back.

18 COMMISSIONER GARAMENDI: Prior to or with the
19 merger?

20 MR. OBERRENDER: Prior to.

21 COMMISSIONER GARAMENDI: You have about four
22 billion dollars operating cash flow, EBIT.

23 MR. OBERRENDER: Before depreciation
24 amortization it would be a similar measure.

25 Maybe I can address a couple previous questions,

1 commissioner, with regard to the use of cash flow from
2 operations we have got a very disciplined process at
3 United, and it is a similar process we know in our
4 discussions with PacifiCare.

5 The first step we do when we look at your cash
6 flow from operations is obviously, we are paying all the
7 expenses related to providing healthcare services.

8 We then look at each regulated entity to make
9 sure it is appropriately capitalized.

10 PacifiCare has a similar process, and PacifiCare
11 has been targeting to run its regulated entities about
12 300 percent of authorized control level which is
13 substantially in excess of the scheme requirements on the
14 managed care side, and United Health is also run at
15 levels that are at least 300 percent of authorized
16 control level.

17 The next step we look at is making sure we meet
18 all of our obligations for indebtedness. And again our
19 coverage ratios are very, very high in terms of being
20 able to meet all of our debt obligations.

21 So we do nothing in terms of technology
22 investments until we make sure the regulated entities are
23 appropriately capitalized.

24 COMMISSIONER GARAMENDI: So what portion is used
25 for those regulatory deficiencies?

1 MR. OBERRENDER: Well, if you look at the cash
2 flows, the cash flows are basically retained in the
3 regulated entities again about a billion four of our cash
4 flow is generated by our database management businesses,
5 other non-regulated businesses.

6 So if you look at the 2.4 billion, that is all
7 retained in the regulated entity and profit that is
8 generated each annual year.

9 We go to the various regulators and assuring
10 after we work through with the regulators and show that
11 we are running the businesses with adequate capital, and
12 in excess of the minimum requirements, we request
13 approval for those ordinary dividends if it is needed to
14 be approved, and then it is up streamed to the holding
15 company, and PacifiCare as well had very similar process.
16 So in order to support the business, many of those cash
17 flows stay in the business and --

18 COMMISSIONER GARAMENDI: Isn't the major portion
19 of your cash flow actually used for acquisitions?

20 MR. OBERRENDER: Once the regulatory
21 requirements we have in the past two years when all the
22 regulated entities that we have over 50 across the
23 country, we do up stream the dividends up to holding
24 company, and after that requirement is done we then
25 re-invest in our business through technology and other

1 improvements in terms of our operations.

2 Then the final step if there is excess cash flow
3 to that we will look at making acquisitions of other
4 companies to provide improved services, improved
5 technology that may be more efficient for us to purchase
6 rather than develop in-house.

7 So over the last two years.

8 COMMISSIONER GARAMENDI: Isn't a major portion
9 of your cash flow used for acquisitions?

10 MR. OBERRENDER: Over the past two years, about
11 50 percent of the cash flow from operations has been used
12 for acquisitions.

13 The -- another large portion is used to
14 re-purchase stock in the opening market at United Health
15 Group, again the last use of the free cash flow.

16 Again, when we make these acquisitions of the
17 companies and the proposed transaction with PacifiCare,
18 we are also taking very prudent approach by issuing
19 significant amounts of equity.

20 We will issue six billion dollars of common
21 stock to the PacifiCare holders so that we keep the debt
22 level low relative to the overall capital structure.

23 MR. GARAMENDI: What you are basically doing is
24 you are taking money out of the healthcare system and
25 transferring it to other entities, investment whatever.

1 That is a lot of money that is being taken out
2 of the system for acquisition or for the pre-purchase of
3 stock or whatever else you are doing.

4 I think the only way that we can get at this and
5 listen this is not a surprise to you or to anybody on
6 this panel or anybody that has been paying attention to
7 what I have been saying for the last several years is
8 that I am very, very concerned about your medical loss
9 ratios.

10 And I don't know any other way for this
11 department to get at the issue of the money that you are
12 taking out of the pockets of the citizens of this state
13 and the nation and using it for purposes other than
14 medical services.

15 You basically have been taking billions of
16 dollars out of the pockets of citizens, consumers, and
17 arguably providers and using that money for investment
18 purposes.

19 The question is have those investments been to
20 the benefit of consumers and providers, big argument.
21 The only way I will answer this is with the medical loss
22 ratio.

23 And I will not approve this merger until I am
24 convinced that the medical loss ratio will improve from
25 the point of view of providers, not Wall Street, cause I

1 think Wall Street has the exact opposite view of medical
2 loss ratios and consumers and providers.

3 Enough said I don't think I will get the
4 specific answers although you will get a written inquiry
5 on this issue.

6 MR. OBERRENDER: We will be happy to meet with
7 your staff and go through that and work through the
8 trends both on the legacies of PacifiCare business and
9 United Health business.

10 COMMISSIONER GARAMENDI: I must tell you I don't
11 like the concept of using consumers premiums to do a roll
12 up.

13 And that is what I think you guys have been
14 doing.

15 I think that is WellPoint and Anthem have been
16 doing.

17 I don't like it.

18 I think it is wrong. I think you want to do a
19 financial play, you get your money someplace else, but
20 not out of the healthcare of citizens.

21 MR. OBERRENDER: Again, commissioner, we do not
22 dividend, request dividends of any regulated entity until
23 we have more than adequately capitalized their business.

24 COMMISSIONER GARAMENDI: We are sophisticated
25 enough to know that is not the heart of the matter.

1 That is a piece of it. That is not the heart of
2 the matter.

3 Let's move on here. There are questions about
4 product.

5 United, by all information that I have received
6 has decided over the last decade or five years to move
7 away from HMO, managed care operations to what are now by
8 your company called consumer driven health plans.

9 Is that the case could you describe where United
10 is with regard to consumer driven health plans and its
11 relationship to managed care systems?

12 MR. SHEEHY: Sure, commissioner.

13 We have consumer activation in our products and
14 consumer directed health plans.

15 I think people have different interpretations of
16 what they are.

17 If it is a high deductible plan you are talking
18 about that has a high deductible, that is a very -- we
19 offer those products as a very small percent of our
20 overall business.

21 It is about three percent. Our approach in the
22 marketplace is to give the tools that people can use to
23 make better decisions in their healthcare or work with
24 their doctors to come up with a collective better
25 decision, give them the information they need so we can

1 help empower consumers in the healthcare system.

2 That is something that United really started
 3 several years ago. Bill our chairman pioneered the
 4 concept of giving consumers and physicians more
 5 information to help empower the consumer getting rid of a
 6 lot of the administrative requirements that typically had
 7 burdened HMO's.

8 Our business is more PPO than HMO but not so
 9 much of a philosophical reason we think one product is
 10 better than the other.

11 It is more of a market dynamic. Market dynamic,
 12 employers have offered a basic plan in their benefit plan
 13 the use across the country five or six years ago used to
 14 offer an HMO plan and a PPO plan.

15 We want one plan for all employees because of
 16 those state by state regulatory requirements regarding
 17 HMO's that product was typically a PPO.

18 And it gives consumers the choice to go out of
 19 network or stay in network, and that is why it is that is
 20 why we have again in the PPO more than HMO product.

21 COMMISSIONER GARAMENDI: Is that why you forced
 22 41,000 employees into a consumer driven health plan and
 23 eliminated the managed care program they previously had?

24 MR. SHEEHY: I wouldn't say we eliminated the
 25 managed care program.

1 COMMISSIONER GARAMENDI: Is it not true that
2 your 41,000 employees now have only a consumer driven
3 health plan available to them?

4 MR. SHEEHY: Did they have three products two
5 HRA products and one HSA product that we all.

6 COMMISSIONER GARAMENDI: I didn't hear you.

7 MR. SHEEHY: We have three products we can
8 choose from as employees two HRA products health resource
9 accounts which the company continues to, and they are
10 able to carry those dollars over every year and then a
11 high deductible HSA plan that is available.

12 COMMISSIONER GARAMENDI: And no more HMO
13 product?

14 MR. SHEEHY: No.

15 We don't offer HMO product for our own
16 employees.

17 COMMISSIONER GARAMENDI: Did you previously?

18 MR. SHEEHY: You know, I am sure I have been
19 with the company for 20 years. I am sure I had an HMO
20 offered to me.

21 COMMISSIONER GARAMENDI: So the answer is "yes."
22 You previously did, but you no longer do?

23 MR. SHEEHY: And the reason for that is the
24 issue of having a common benefit plan across the country
25 as we grew more nationally, we wanted to offer a common

1 benefit plan, and a PPO allows us to do it, and HMO is
2 more difficult.

3 COMMISSIONER GARAMENDI: I understand the
4 rationalization, but I am not buying the reason.

5 I think there are other reasons that are driving
6 you to do that.

7 With regard to your -- describe your HRA benefit
8 package and your HSA benefit package that you are
9 providing for your employees.

10 MR. SHEEHY: Well, let me start at the HSA
11 benefit package.

12 HSA benefit is really has to comply with federal
13 requirements on the high -- health plan.

14 It is a deductible of, I think, \$1,000
15 \$2,000 deductible, and my colleagues here, and then the
16 employees can contribute to a health savings account that
17 can be used to fund healthcare expenses.

18 Preventative care is covered. There is
19 preventative care benefit in all the plans so we
20 encourage people to get the preventative care they need
21 so it is not an obstacle.

22 The HRA's we have two health resource accounts
23 with a company contributes to an account with the
24 consumer the employee to use for their healthcare needs,
25 and those deductibles are lower, the lowest deductible

1 you have.

2 COMMISSIONER GARAMENDI: I am familiar with all
3 of that.

4 What I wanted to find out from you is what is
5 the benefit package?

6 What are you covering?

7 Not the deductible here not the HSA portion or
8 the HRA portion, but what services are you covering?

9 MR. SHEEHY: We cover preventative care, we
10 cover the typical major medical benefits that insurance
11 covers maternity coverage, mental health coverage,
12 ancillary coverages.

13 COMMISSIONER GARAMENDI: Is it or is it not
14 similar to the HMO benefit package?

15 MR. SHEEHY: It is with the exception of the
16 deductible. Most HMO packages can't off a deductible,
17 but there is a deductible with our benefit plan.

18 COMMISSIONER GARAMENDI: Thank you.

19 MR. FREY: Can I make one point because I think
20 it is important to point out California is unique.

21 We have talked about that.

22 We have a coordinated delivery system. Dr.
23 Margulis is an example of that where we have physicians
24 in this state that have standed together, and they work
25 extremely well in a capitated delegated environment.

1 There are very few places in this country that
2 operate that way.

3 It allows us in California to have co-pay based
4 plans that offer predictable costs versus a company
5 insurance where you are paying 20 or 30 percent of an
6 unknown figure, and I really -- and United's national
7 delivery system is really mirrors what is happening in
8 other states.

9 I think one of the benefits for Californians is
10 because of PacifiCare's commitment to the HMO the
11 capitated delivery system in California now with some of
12 the technology and the financial back bone of United, I
13 think it strengthens groups like Dr. Margulis' and the
14 California Association of the Health Physicians.

15 And I think it will help give a longer term life
16 to the HMO in California so that we don't see California
17 go the way the rest of the country has.

18 COMMISSIONER GARAMENDI: Thank you for bringing
19 that up.

20 Dr. Margulis tried to listen carefully to him,
21 and he said that I should not approve this merger until
22 there is a contractual commitment by PacifiCare to
23 maintain the delegated model and capitation.

24 What do you think of that, sir?

25 MR. FREY: Well, I, because PacifiCare is long

1 and the management team at PacifiCare has long been a
2 supporter of that type of delivery system, and I think we
3 believe it provides higher quality and lower cost in
4 California, we are certainly -- we are very supportive
5 today, and I imagine we will be very supportive in the
6 future.

7 And there would only be changes in the
8 environment that would change that type of support.

9 So I think we would certainly be willing to
10 discuss an undertaking of that type that Dr. Margulis
11 brought up.

12 MR. GARAMENDI: That is good news.

13 What was the word assess?

14 MR. FREY: Discuss at the end of the day.

15 I mean PacifiCare we have 1.8 million commercial
16 members in California. I take that back. Let me just
17 make sure I get the right numbers here.

18 I apologize.

19 We have 1.4 million members on any commercial
20 plans; 1.3 of those are in HMO's.

21 It is core to what we are, and it will be core
22 to our future.

23 COMMISSIONER GARAMENDI: Let me get to my
24 concern.

25 If you have not figured it out yet, let me be

1 very specific.

2 United has a history, recent history that is
3 ancient history was very much an HMO model.

4 Its recent history is to move away from that
5 into a PPO non-capitated is my assumption.

6 PacifiCare, you are quite correct, the testimony
7 we heard today, and all of the other information
8 available indicates that California was a leader and
9 remains a leader in a managed care mechanism or model in
10 which you just stated.

11 So PacifiCare, by your statement, has been and
12 would continue to be dedicated to a managed care model.

13 And I assume that means capitated.

14 If that is not correct, let me know.

15 MR. FREY: That's correct.

16 COMMISSIONER GARAMENDI: However, your new owner
17 is going the other direction, and I don't quite see how
18 these two things are going to exist simultaneously in the
19 future.

20 So let's talk about that.

21 MR. SHEEHY: Commissioner, maybe I would say
22 that the difference is really more of a market issue.

23 The integrated delivery system here in
24 California is not really replicated across the country
25 with the exception of maybe Harvard Community Health Plan

1 and a couple of other spots which we actually have a
2 contract with Harvard Community Health Plan in
3 Massachusetts to offer those products to our consumers.

4 You really can't find the closely, highly
5 effective integrated medical groups across the country
6 that you have here in California.

7 COMMISSIONER GARAMENDI: Yeah, yeah, yeah, yeah
8 okay.

9 MR. SHEEHY: It is not a philosophical issue.
10 It is a marketplace issue.

11 You can't replicate that, we think.

12 COMMISSIONER GARAMENDI: My concern obviously I
13 am concerned about America for many, many reasons, but my
14 concern is California specifically here.

15 United's policy, strategic direction has been
16 away from capitation.

17 You are acquiring a company in the state of
18 California that has a long history of providing managed
19 care, HMO capitated services to its consumers. And I
20 want to know which direction you intend to take
21 PacifiCare.

22 Are you taking it towards your national model?
23 Or are you going to maintain what exists in California?
24 What is your intention?

25 MR. SHEEHY: Well, we absolutely expect to

1 maintain and build upon what exists in California. That
 2 is the, I think, the core benefit that PacifiCare brings
 3 to consumers.

4 We think, Commissioner, that we can increase the
 5 marketability of that, that model by offering that
 6 managed care coordinated care model to national customers
 7 who historically have not been able to get it because we
 8 haven't offered it. We haven't offered it here in
 9 California.

10 COMMISSIONER GARAMENDI: There is an
 11 inconsistency here, and I will accept the inconsistency,
 12 but I want to nail it down.

13 You said a moment ago, several moments ago, that
 14 you were using HMO. You were using the HSA, HRA programs
 15 to create national consistency.

16 And you just, I think, said you are looking to
 17 create an inconsistency. Now, I am all for it. I am all
 18 for the inconsistency here, but I want to be absolutely
 19 sure that we do not lose, in California, an extremely
 20 valuable asset which is the managed care system.

21 And you are a major player, and you will not be
 22 approved until I have absolute assurance that you're not
 23 going to take California the way you have taken the rest
 24 of the nation.

25 MR. SHEEHY: Commissioner, I can assure you we

1 are not going to.

2 COMMISSIONER GARAMENDI: It will be a writing
3 and it will be a contract. Okay.

4 Now, how do you propose to do this?

5 How does the HSA, HRA fit into that commitment
6 for California?

7 Will it be a different product that you will be
8 offering and simply let the managed care system wither
9 and disappear as you create the PPO, HSA, HRA product?

10 MR. SHEEHY: Well, I think, you know, we haven't
11 gotten to the point of actually putting the products
12 together given this stage in the discussion.

13 I would expect that the advantages of the
14 integrated delivery system, the managed care model that
15 you touched on in California are significant to the
16 marketplace.

17 If you look at the utilization patterns, the
18 hospital utilization, California has some of the
19 particularly Southern California here has some of the
20 lowest hospital utilization in the country because of
21 coordinated care system, having that as an option for
22 individuals if they are choosing between a PPO product or
23 even an HSA product and a cost effective comprehensive
24 managed care program that we think that could be a
25 compelling market proposition.

1 COMMISSIONER GARAMENDI: I suspect, you, your
2 staff, has been monitoring very carefully what I have
3 been saying in recent months including publications that
4 we have put out.

5 I am very, very concerned that the insurance
6 industry is engaging in cherry picking and moving away
7 from community rating programs.

8 I would like to have your comments on my
9 concern. Tell me I have no reason to be concerned that
10 United and Pacific together will price their products,
11 HMO products, in such a manner as to reduce the
12 participation and simultaneously offer a PPO product that
13 is lower priced for certain segments of the population
14 that are not likely to be expensive.

15 Tell me I shouldn't be concerned about this.

16 MR. SHEEHY: Commissioner, I am not sure why we
17 would have any economic benefit to do something like that
18 if in fact we have got, if we have got those products,
19 why would we disadvantage one against the other?

20 COMMISSIONER GARAMENDI: Profit, profitability
21 of the product. You only need to look to your competitor
22 your major competitor to see the example of what I am
23 concerned about.

24 It is the slicing and dicing of the population,
25 and by offering a consumer driven health plan that is

1 priced lower for a certain segment of the population, for
2 example, 19 to 29 years olds.

3 I don't believe the HMO model can survive when
4 the insurance industry is slicing and dicing the
5 population in a manner that provides a low cost product
6 for the healthy portion of the population, and a higher
7 priced product for those who are less healthy or who
8 might get pregnant.

9 So tell me I have no reason to be concerned that
10 your company is going to follow your principle
11 competitor.

12 MR. SHEEHY: I don't know the managed care
13 market as well as James does, but I would think that
14 highly effective coordinated managed care program through
15 an organized delivery model can compete on both a cost
16 and quality perspective against PPO products in the
17 marketplace.

18 COMMISSIONER GARAMENDI: As long as they both
19 have the same population base, the same community to
20 which they are serving.

21 If they don't, it won't work, and you will
22 destroy the HMO, the managed care model by taking from
23 that model those portions of the population or those
24 segments of the population that are not expensive.

25 MR. SHEEHY: If it seems to me if we go through

1 with this proposed acquisition with the resources we are
2 putting into it, we would be foolhardy to buy it and then
3 destroy it on the back end.

4 We think it is an opportunity to build that
5 model to give more people the option to purchase the
6 organized delivery system and also, Commissioner, we
7 think there is a lot that can be learned from this
8 organization, healthcare system in California.

9 We can apply to other parts of the country
10 getting physicians to work together which I think is a
11 tremendous application. Whether it is here in California
12 or exported to other places, we think it is a very
13 positive thing.

14 MR. FREY: Commissioner, I think your concerns
15 on a global basis are well founded.

16 I think if you asked Dr. Margulis or the
17 California Association of Provider Groups are they
18 concerned about the HMO losing healthy members to high
19 deductible health plans, I think there is a legitimate
20 concern. The bottom line for PacifiCare is it is who we
21 are. Our competitive advantage in this state is how we
22 work with those medical groups.

23 I think United is smart enough in terms of
24 moving into this state and this merger with PacifiCare,
25 they are going to bring their resources, their technology

1 to bear on the delivery system to continue to make it
2 competitive with skimpy benefit PPO's.

3 That is a challenge. Right now we have got the
4 benefit designs and technology limitations that allow
5 other competitors in this state to put very skinny
6 benefit plans on the street, that even with the benefits
7 and the lower priced point of a capitated delivery system
8 can't match because the benefits are so skinny.

9 COMMISSIONER GARAMENDI: We use the word
10 skeletal.

11 MR. FREY: And I wouldn't disagree with that.
12 So for us, for PacifiCare, and I think for United after
13 these two companies get together, we, in working with Cap
14 G and groups like Dr. Margulis' we have got to come up
15 with fixing some of the technology limitations that we
16 have, we have trouble today tracking.

17 COMMISSIONER GARAMENDI: Excuse me for
18 interrupting.

19 I will take you at your word, and I will let you
20 ride it, and I will ask you to maintain that, and I
21 appreciate the discussion, and we will see to it that
22 that is in the undertakings okay.

23 You said a couple of words. You just launched
24 into it, and it is technology, and I want to deal with
25 that now.

1 So, I don't think there is any doubt at least in
2 my mind and doubt of others who observed this that United
3 has been one of the leaders in technology.

4 My concern on this is that more be done by you
5 and by others, but also that it be done in a way that is
6 sensible and integrated with others.

7 There is a federal effort to achieve a
8 standardization for technology. There is also a state
9 effort. I would like to have your comments on those
10 efforts and how you either differ or the same as both the
11 state and the federal efforts.

12 My concern here is that there be a standard, and
13 that everyone adhere to that standard. The normal
14 American process is that we have a gazillion different
15 standards, and therefore we make no progress. So let's
16 talk about this.

17 MR. TUCKSON: I have had a chance to share some
18 of our thoughts on this issue with you before. We are
19 completely committed to the --

20 COMMISSIONER GARAMENDI: I think you best
21 introduce yourself.

22 MR. TUCKSON: Reed Tuckson.

23 COMMISSIONER GARAMENDI: Excuse me, I just
24 looked at our wonderful court reporter and realized I am
25 about to get a worker's comp claim.

1 We will take a ten-minute break for a technology
2 issue.

3 (Brief Recess)

4 COMMISSIONER GARAMENDI: It is time for us to
5 reconvene. I believe we were talking about technology.

6 MR. FREY: Yes, sir.

7 COMMISSIONER GARAMENDI: And we avoided a
8 worker's comp claim. This is good.

9 Let's go into technology.

10 In your opening comments you had discussed
11 technology that your company is a leader in technology,
12 and that certainly by all appearances is correct.

13 My question that I put to you as we were
14 breaking or just before we broke was how does this
15 technology, how does your technology integrate or not
16 integrate with the standardization mechanisms both at the
17 federal and state level?

18 MR. TUCKSON: Let me begin at the national
19 level. We are, as a company, committed to not only
20 achieving but to be part of the achieving of a national
21 standard for technology.

22 We are able to observe these fairly closely,
23 these activities. I am fortunate my company makes
24 available for me to sit as, give me time to sit on the
25 certification commission for health information

1 technology.

2 This is a forum of the software manufacturers
3 purchasers, physicians.

4 I sit beside the CEO's of the American Academy
5 of Family Physicians and the American College of
6 Physicians among many interested groups, and we have just
7 received thankfully the contract from the federal
8 government from Dr. Bailor's, office to be the standard
9 setting organization for health information technology
10 for the electronic medical record.

11 So we are able to observe these issues quite
12 closely, and we absolutely agree with, I think with the
13 premise of your question which is we really do need to
14 see those occur.

15 Furthermore, we are committed that our
16 electronic health information products as those standards
17 are clarified, will fit into those standards because we
18 absolutely understand the imperative for
19 interoperability.

20 At the state level here in California, let me
21 turn to my colleague, Sam Ho, who also is sitting in a
22 leadership position here.

23 MR. HO: Thank you, Reed.

24 Just to clarify, we are following the national
25 health information network discussion around policies and

1 programs very intently and look forward to further
 2 collaboration with Dr. Tuckson in particular but also the
 3 United in general in terms of making sure that we adhere
 4 to the evolving standards and specificity that are coming
 5 out of that type of discussion.

6 At the state level we have been invited to sit
 7 on the leadership group of the Cal Rio Commission which I
 8 know you are very familiar with, so I won't belabor that.

9 We are looking forward to the same type of
 10 standardization both at the state level, but also its
 11 compatibility as we go forward and invoke those
 12 specifications with the national commission that occurs.

13 So I think in general the idea of intra
 14 operability, standardization, common investment and
 15 hardware software approaches and language definitions
 16 quite frankly are all being followed closely, and I
 17 think, you know, my -- with your general direction.

18 MR. TUCKSON: I would also add that we are very
 19 involved through our Ingenics company one of United
 20 healthcare family of companies.

21 We are sitting as recently as this week with the
 22 federal CMS to look again as how they will behave because
 23 clearly the CMS role will be critical in all of this, and
 24 we are sharing together how we might be able to help in
 25 synergies to be able to fast forward some of the national

1 organization of this effort.

2 COMMISSIONER GARAMENDI: I will, well let me
3 just express my concern, and it is both to United Pacific
4 as well as to anybody else that cares to listen here. I
5 have about 30 years history in this whole business of
6 technology or lack of it both in medical records as well
7 as in the welfare systems.

8 And what I have observed over those many years
9 is that every interested party that is in governmental
10 entities at all levels and various providers of the
11 services all fight fiercely for their particular plan.

12 The result is that very little uniformity and
13 progress is achieved.

14 So I am not sure how I intend to force you to be
15 a good participant, but I want you to be aware of my
16 concerns, and I think there is also a clear possibility
17 that the Cal Rio program may go a different direction
18 than the federal program, and that would be a very sad
19 situation.

20 But, let's just be specific about what we can be
21 specific about, and that is what I would like a
22 commitment that you work diligently with the Cal Rio
23 program as you have, continue to do so, keeping in mind
24 the federal effort and your best efforts to see that they
25 are coordinated. I would like to say standardized, but

1 that is more than I could possibly hope for. Rick, you
2 had a question.

3 MR. BAUM: I had one question on your
4 observation that technology will, from your perspective,
5 be a consumer benefit.

6 And then I think when you were describing it
7 Jim, you were talking about this being a way of reaching
8 out to your consumers, to your policy holders.

9 You referenced it in content of the internet or
10 being able to go on line, and I, while it would be nice
11 to think that most of the world is on line, most of the
12 world is not.

13 And I am curious as to whether you have made
14 financial commitments, whether your program budgeting
15 includes thinking through how you give access to those
16 systems to those people who don't have computers at home
17 or on line.

18 MR. SHEEHY: Maybe I will, you know, one of the,
19 you are absolutely right.

20 People, some people use the internet to receive
21 information. We have had good success in getting
22 increased adoption and use of the internet, but there is
23 a large segment of our population that don't use the
24 internet.

25 So we provide through our net healthcare

1 community all United HealthCare customers have 27-7
2 access to a nurse who has the same capabilities over the
3 phone to relay that information to people in terms of
4 treatment alternatives or relative quality measurements.

5 So I think you really have to go about it in
6 different ways to reach different consumer groups with
7 the right information, and we -- that is the approach we
8 take.

9 MR. TUCKSON: I would amplify the thesis of your
10 question is very important. The encouraging news is the
11 uptake in the number of people who are connected to us by
12 internet, but also the number of them who are transacting
13 their administrative relationships with us on line.

14 That number is now well over 100 million
15 transactions annually which is in the scope of that curve
16 is fairly dramatic, but I think also the point that Bob
17 makes is important.

18 Our investment in information technology what is
19 sort of hidden, and what people don't often see is the
20 ability for those nurses to be connected across the
21 company and across all different product companies by one
22 computer system so that by telephone if you contact one
23 of those care coordination nurses, you are in touch with
24 all the other assets of all of our different products,
25 and that is the kind of benefit that we are seeing

1 through this investment and information technology.

2 COMMISSIONER GARAMENDI: I want to pick up the
3 issue of patient medical records and where United and
4 PacifiCare with regard to the technology, the application
5 of technology of patient medical records.

6 MR. TUCKSON: We have actually been very excited
7 by this element of it, and as Bob made the distinction
8 and as you are the electronic medical record will move
9 forward, but we can do something immediately around
10 giving consumers access to their medical records today.

11 Every single person who is insured by United
12 healthcare today, can go on-line and pull off and their
13 on-line their entire record of their personal health
14 record as we know it, their conditions, their allergies
15 their medications, their laboratory tests and diagnostic
16 interventions.

17 They can pull all that off, and if they want,
18 they can print it today so that that information is
19 pre-populated, and if someone calls in to or does a
20 health risk assessment, all of that information is being
21 migrated into that pre-populated database.

22 COMMISSIONER GARAMENDI: I am curious here. My
23 apologies for interrupting, but how do you get that
24 information?

25 MR. TUCKSON: We are able to integrate the

1 claims history, the pharmacy data, the laboratory data
2 and the personal health record information.

3 COMMISSIONER GARAMENDI: These are the, when you
4 pay a claim?

5 MR. TUCKSON: Or order a medicine or prescribe a
6 medicine is prescribed or a laboratory test is
7 prescribed.

8 COMMISSIONER GARAMENDI: The information on that
9 screen or in that file is information that is directly
10 related to a claim payment?

11 MR. TUCKSON: Yes.

12 COMMISSIONER GARAMENDI: You do not have the
13 physician or the hospital's records.

14 MR. TUCKSON: No, we do not have that part. But
15 it is a longitudinal record that goes forward and is
16 constantly re-updated.

17 COMMISSIONER GARAMENDI: What is longitudinal?

18 MR. TUCKSON: As new things happen, we
19 automatically update it and pre-populate it.

20 What happens is this gives us the opportunity
21 for the person to be able to augment that record
22 themselves also, but today, we at least are able to
23 pre-populate that and give it to them to print off.

24 What we are then describing is that in '06, the
25 eligibility swipe card that Bob talked about will now

1 then enable with the patient's permission at the point of
2 access of care when this is swiped for eligibility
3 determination with patient permission will also allow the
4 physician or hospital to have access to that same record.

5 So if you are portable, if you are traveling
6 somewhere, if you are, you know, a person who has been
7 relocated or dislocated for some reason, you can have it
8 swiped at the point of care, and then that physician will
9 know that same information.

10 COMMISSIONER GARAMENDI: The information that is
11 there would be the pharmacy issues?

12 MR. TUCKSON: It would tell you what
13 pharmaceuticals you have been prescribed, what allergies
14 you have.

15 COMMISSIONER GARAMENDI: Blood type major
16 medical issues.

17 MR. TUCKSON: It would say the major medical
18 issues. I don't think blood type would be on it unless
19 the patient took steps to add that to it.

20 COMMISSIONER GARAMENDI: Okay.

21 MR. TUCKSON: And this is where we are today,
22 and of course this is continuing to evolve as we go
23 forward, but at least these are capabilities that exist
24 that we are administering today.

25 COMMISSIONER GARAMENDI: Okay. An issue of

1 technology that may arise, Carl, from the Kaiser
2 Pediatric Clinics talked about a technology program for
3 clinics?

4 MR. TUCKSON: Yes.

5 MR. GARAMENDI: Do you have any familiarity with
6 that?

7 MR. TUCKSON: I am not familiar with his
8 particular program, but we work very collaboratively with
9 the National Association of Community and Migrant Health
10 Centers, the national organization that runs community
11 based health centers.

12 We have a very intense relationship with three
13 of those communities, migrant health centers around the
14 country, and what we have been helping them to do is to
15 redesign their health information technology systems
16 primarily around another interest of yours that you have
17 taken leadership on is in the area of quality perform and
18 assessment.

19 So what we have been trying to help them to do
20 is to create information systems that will allow them to
21 report on industry standard quality measures, and so I
22 would say that I would be very interested in following up
23 with them to see what system they have, but I think it
24 comes back to your larger issue, sir, and that is I hope
25 that we would find that community based health centers

1 would have the same industry standard information system
2 as non-community based health centers.

3 There may be some special information that needs
4 to be augmented that is special to that population, but
5 by and large I think that we need to see interoperable
6 systems there because as you well know the people going
7 to community health based centers are going to emergency
8 rooms and being seen by experts outside of those
9 environments, so it has to be consistent.

10 COMMISSIONER GARAMENDI: Before you leave today,
11 you will have an opportunity to discuss off line the
12 issue with representative of the clinics who are here in
13 the audience.

14 So don't leave without that discussion.

15 Please, thank you. You provided me with a segue
16 that I needed for the next and that begins with a Q,
17 quality, so let's go into quality.

18 United has boasted with perhaps appropriate
19 pride its ongoing effort to improve quality for its
20 members.

21 You mentioned this at the outset during your
22 open discussion. Let's go into it in a little more
23 detail about the quality issues and an overview on how
24 you assess quality, the way in which you relate this to
25 your membership and how this would apply in the pacific

1 -- in California through PacifiCare.

2 MR. TUCKSON: Let me just start it on at least a
3 high level and let you drill through to it.

4 I think we see first and foremost as we have
5 described first the backbone of our quality initiatives
6 are certainly the ability to accumulate and analyze and
7 very sophisticated of analytics the data the information
8 about clinical care, what was delivered, was it the right
9 care, for the right person what were the gaps and what
10 was missing so that is key.

11 Secondly for us quality depends ultimately on
12 consistency with defined evidence based clinical
13 standards.

14 And we are very committed and very involved in
15 our quality initiative in working with not only the best
16 scientific literature, but also with expert physician
17 professional societies who we believe really are the most
18 important players and have to be in determining the best
19 standards and the best criteria for clinical care
20 delivery, so we marry those two together best scientific
21 evidence and expertise with data.

22 We then sort of see, and I had just describe as
23 a high level three major domains of activity that we
24 think are important here. First of course is the
25 dissemination of the best information to clinicians.

1 We believe that physicians ought to have
 2 available to them at the point of care the best
 3 scientific evidence upon which to practice.

4 We devote seven million dollars a year in
 5 providing to every almost every practicing physician in
 6 this country regardless of our network we use the AMA
 7 mailing list twice a year, the definitive journal on best
 8 evidence for science called clinical evidence.

9 Secondly, we, through United HealthCare on line
 10 make products available for physicians in an integrated
 11 way with our other offerings on the website.

12 Secondly is the quality, evaluation and that is
 13 clearly where so much activity is really going today.

14 By the way I would want to mention one other
 15 thing in terms of helping physicians have the right
 16 information. We do recognize, as Mr. Baum did, that
 17 there are a number of not only patients but also
 18 physicians who do not have the internet, and one of the
 19 things we have been pirating is a registering function in
 20 physicians office called the bridging care registry which
 21 allows us to take our data pre-populated and put it onto
 22 a physician's office so they will know which patients
 23 they have who have what chronic diseases.

24 Therefore allowing them to not have to go
 25 through those files, those paper charts but to focus in

1 on those folks who we know have United HealthCare who
 2 have special issues that require special attentiveness so
 3 those are the kinds of things that we think make sense
 4 but secondly this quality issue.

5 And when evaluating quality, we have a number of
 6 activities. We have something called clinical profiles,
 7 takes the data gives the physician back their performance
 8 based on evidence based standard and compared to their
 9 market norms and their geography.

10 How are you doing compared to other people who
 11 are in your geography. Physicians are competitive people
 12 we learned.

13 They didn't go to medical school to be last in
 14 their class. If you give physicians the information, we
 15 are seeing they will act on it. There are some who don't
 16 so we have another augmentation.

17 COMMISSIONER GARAMENDI: Mostly in the St. Louis
 18 area.

19 MR. TUCKSON: No, sir. St. Louis is a fine city
 20 with great physicians, almost as good as California.

21 We see some do not act, so we have medical
 22 directors in all our geographical regions who sit down
 23 with the physicians and hospitals and discuss and try to
 24 learn.

25 Sometimes there are good reasons why there may

1 be outliers. Often they are not.

2 Third, we have created something called the
 3 premium program which builds upon the philosophy that is
 4 now taking over our companies, and that is a belief in
 5 the right care for the right person at the right time to
 6 meet from the right physician in the right hospital to
 7 meet their individual needs.

8 Being very specific, we know that there are many
 9 great hospitals in the country, but very rarely is there
 10 a hospital that is best for everything across the board.

11 If a person has heart problems, they need to go
 12 to the best heart facilities.

13 A place may be great at gallbladder, but the
 14 individual needs heart. So we want to match people with
 15 the best institutions. So we have been defining based on
 16 industry standard medical specialty derived guidelines
 17 around best performers in a variety of disciplines
 18 whether it is for very advanced complex care transplants,
 19 advanced cancer, congenital heart disease or less rare
 20 but also important things like musculoskeletal cardiac
 21 care and then for primary and ambulatory care,
 22 identifying the best we can, giving that information not
 23 only to the physician and the hospital but to the
 24 consumer so that they can make choices about where they
 25 go.

1 And then finally the last category in this would
 2 be operating programs to provide incentives for
 3 reimbursement that tries to align performance with
 4 reimbursement.

5 The third and last category, high level for this
 6 for us is to promote coordination of care because quality
 7 really also depends on, as I have mentioned, on getting
 8 the right care to the right person.

9 We have talked at length already about the
 10 number of nurses and other touch points. Whenever we can
 11 touch a person to be able to say to them it is important
 12 that you think about quality. It is important that you
 13 think about your needs. It is important that you try to
 14 match that.

15 It is important for us to know when there is a
 16 gap in care when a person who has hypertension,
 17 congestive heart care and diabetes and she is 65 years
 18 old did she get the immunization she is supposed to get.

19 If we see, through our data, that she didn't,
 20 then we want to contact the physician and contact her to
 21 try to close that gap in care, and that is a major part
 22 of our quality based initiatives.

23 Those are some of the things that we try to do.
 24 There are others but let me let you ask questions.

25 COMMISSIONER GARAMENDI: How do you propose to

1 integrate all of that with PacifiCare's current programs?

2 MR. TUCKSON: First, we will have a lot to learn
3 about that as we, and hopefully we will get the
4 opportunity to spend a lot more time with PacifiCare. I
5 think that where the challenges are.

6 COMMISSIONER GARAMENDI: You will have the
7 opportunity if certain requirements are met.

8 MR. TUCKSON: Then we will have the opportunity.

9 COMMISSIONER GARAMENDI: Just be positive.

10 MR. TUCKSON: I think the challenge will be, and
11 there is not a concern, but it is realistic is marrying
12 the databases.

13 We have a lot of data to integrate. We are not
14 anxious about that. We know how to do it. It takes time
15 and effort, but we can do it.

16 I think the second thing though comes back to
17 the questions that you asked before the break.

18 We believe, and we will find ways to convince
19 you of that, that the integrated care delivery model is
20 special and important.

21 That means that educating consumers about the
22 value of that will give us a new opportunity to refine
23 our consumer-oriented messages and our decision support
24 coaching that we do so that you can start to help people
25 to understand what their expectations ought to be.

1 We are not concerned, sir, about this
 2 integration in terms of expanding being difficult to
 3 expand our centers of excellence, our premium programs
 4 because we know that there are such a variety of those
 5 already here in the state. We would look forward to
 6 expanding that, and we think, finally, that what we are
 7 looking forward to is being able to also have people
 8 outside of the state take advantage of the centers of
 9 excellence that are here in California, and that is an
 10 important opportunity as well.

11 COMMISSIONER GARAMENDI: Pacific comment?

12 MR. HO: We are looking forward to, quite
 13 frankly, this integration of quality programs because as
 14 you may know, the PacifiCare has prided itself over the
 15 last 25 years in its programs around quality improvement
 16 in California.

17 We were the first plan in the state to achieve
 18 clear accreditation from National Committee for Quality
 19 Assurance.

20 We have had, over the last 12 years, since he
 21 just has been introduced year after year continuous
 22 improvement in our discourse. We have some distinguished
 23 disease management programs I think you are well aware of
 24 coronary disease, renal failure so forth, what and of
 25 course though we were one of the pioneers in developing

1 consumer directive report cards of physician performance
 2 at the medical group level.

3 And in the last two years of hospital
 4 performance across several quality metrics all of which
 5 taken together the DM programs and the accreditation
 6 programs, the Hideous program and so forth along with the
 7 quality index report card have shown to have been shown
 8 and demonstrated and proved quality year after year in
 9 the care delivered to our members.

10 What we are lacking, however, is the investment
 11 in the technology that Dr. Tuckson has enumerated in
 12 terms of his directing the personal health record
 13 approaches, the on-line capabilities to search and to
 14 develop patients specific files, if you will, based on
 15 claims data and integrating those claims data.

16 So I think we are quite frankly looking forward
 17 to the fact of how we could actually take the best of
 18 both worlds in the areas of profiling and disease
 19 management, high performance networks which we would be
 20 lucky enough to pioneer and develop in high quality low
 21 cost networks so that insurance could be more affordable
 22 to consumers and customers in California and marry that,
 23 if you will, with the technology and the advanced
 24 programs that have been developed over time with United.

25 So I think there is a consistency in an

1 alignment of not just philosophy and purpose, but in
 2 terms of programatic goals and results, that should be
 3 very beneficial for California customers as well as
 4 consumers.

5 COMMISSIONER GARAMENDI: I am a very firm
 6 believer in the whole quality issue direction you are
 7 going, so that is not an issue, but I need to raise the
 8 question of how your providers view your report cards.

9 MR. HO: Can I speak to the California
 10 experience first and then maybe we can learn from each
 11 other.

12 As you know, our report card in California came
 13 out in 1998. We began planning it in 1996, and it is
 14 again won quite a few distinctions about being the first
 15 consumer oriented report card of provider performance in
 16 the country.

17 It also has gone on to be proven by some
 18 academic researchers in the medical literature to
 19 actually have improved been associated correlated with
 20 improving quality and has had significant recognition by
 21 California physicians, the California Medical Association
 22 has recommended cat G mentioned before Dr. Margulis
 23 himself and many of the leaders in the California medical
 24 community have actually recognized the role that
 25 PacifiCare's quality index profile has helped them

1 develop their internal quality improvement program within
2 each provider entity.

3 So I think what we have been missing, however,
4 is the ability to develop the profile at the individual
5 physician level.

6 And that is where I think we can learn a
7 tremendous amount from the experiences at United.

8 COMMISSIONER GARAMENDI: Let me short circuit
9 this a little bit.

10 United and PacifiCare to have an undertaking
11 that nails down the commitment to achieve this
12 advancement what you just talked about with regard to
13 individual provider and the other three or four issues
14 that have been brought up here?

15 MR. TUCKSON: Absolutely. It is core to what we
16 are.

17 COMMISSIONER GARAMENDI: Talking about,
18 conversation. I am talking about a conversation I had
19 with you maybe an hour and a half ago, about where all
20 that cash goes.

21 Is it going to go into this kind of work, and if
22 so how much and what does it take and how much will be
23 available?

24 MR. TUCKSON: I certainly can't at this second
25 from the table give you the economics of it, but what I

1 can say to you is that this is fundamental to how we
2 operate the business.

3 This is the core of what we are, and so
4 commitment on this part is easy for us, trying to dissect
5 down the actual numbers and how and what things go into
6 that is something we would love to sit down and do, but
7 this is the core of how we run the business.

8 COMMISSIONER GARAMENDI: I intend to make you
9 happy in your love of doing that.

10 MR. TUCKSON: Great.

11 COMMISSIONER GARAMENDI: Let's move on, the
12 quality issue is out there.

13 There are several other pieces that the staff
14 will talk to you about some of the details, and we will
15 move forward to make sure you have every opportunity to
16 achieve your goal of doing what you love.

17 I want to pick up an issue that is of
18 considerable concern to my department, and it is not
19 specific to United at this moment. We have a new law
20 that requires this department to review and literally
21 adjudicate complaints from providers.

22 This is a new and extraordinarily taxing task
23 for this department.

24 United across the nation has had a history of
25 complaints about its claims handling specifically from

1 providers and to some extent consumers.

2 I, if that history is replicated in California,
 3 then this department is going to be inundated with
 4 complaints and a work load that will be beyond the
 5 capacity of the department.

6 And I, from everything I know about the
 7 legislature beyond their willingness to give us the
 8 personnel to deal with the complaints from thousands or
 9 hundreds of thousands of providers. I would like to
 10 avoid that.

11 And I would like to, I would like to I will
 12 demand that in this merger that there be a mechanism so
 13 that California is not going to have provider complaints
 14 beyond a minimum level.

15 Otherwise this department is going to be totally
 16 engaged in dealing with complaints, and it is not just
 17 your company but other companies but you're here, and
 18 they are not.

19 So, there is this what if we had a threshold,
 20 let's say, where Pacific presently is with regard to
 21 verified complaints?

22 And any increase above that threshold or that
 23 hurdle is dealt with in a way that provides incentive for
 24 that threshold not to be exceeded.

25 Let's have a discussion.

1 MR. SHEEHY: Well, Commissioner, I think maybe
 2 to address the broad base provider complaint issue, about
 3 a year ago I was in front of the sub group of the
 4 National Association of Insurance Companies addressing
 5 this issue in specific states, and really what I was not
 6 happy with that performance in certain states, not happy
 7 with the performance, and what we have done over the past
 8 year is significantly improve our ability to deal with
 9 issues that would escalate. That was, I think, the real
 10 problem that we were having was the physician's office
 11 would have an operator issue.

12 We were not resolving that particular issue in a
 13 timely basis, and then it would wind up in departments of
 14 insurance office itself, so we have built around the
 15 country dedicated units of people that are more highly
 16 trained, highly specialized and have all the tools to
 17 resolve the issues.

18 And over the past year we have seen significant
 19 improvement in our ability to deal with that, so I think
 20 we are in a very strong position to deal with that
 21 proposal and really resolve issues that the physicians
 22 may have quickly and fairly and keep them out of your
 23 office.

24 MR. TUCKSON: Part of it, sir, also is that to
 25 take away is to prevent the problem in the first place so

1 one of the things we have meticulously done over the last
 2 two years is to redo our reimbursement policies to make
 3 sure that we are working with the individual specialty
 4 society so we are on the same page, and everybody
 5 understands the interpretation of reimbursement policy,
 6 and we are as aligned as we can be with CMS as well as
 7 with the special societies. We have done that.

8 The other thing that since you frame this as a
 9 discussion, I think that we would agree that physicians
 10 deserve to have their to have their administrative issues
 11 handled quickly and efficiently, and there is no question
 12 as Bob said, we want to do and can do and will do a
 13 better job.

14 One of the things I would wonder as part of the
 15 discussion though we would enjoy is the ways in which you
 16 could help to encourage that physicians in their
 17 administrative relationship with companies like ours did
 18 it on line because really the issue on line is so much of
 19 the we almost have no difficulty in administering any of
 20 our issues when we have these claims and others submit it
 21 on line.

22 We don't charge for any of that. Everything is
 23 given away free.

24 We don't make that in any way a financial or
 25 economic hurdle, and that would sure go a long way. So

1 since you raised it as a discussion, I want to see
2 whether that has any interest to you at all. If it
3 doesn't, we will still do the things we need to do.

4 COMMISSIONER GARAMENDI: It does. The providers
5 are not asking me for my approval, so I have no leverage
6 to be perfectly blunt.

7 I am sure that hasn't escaped any of you at that
8 panel.

9 But it goes both ways here, and I certainly
10 understand that.

11 I want to put a proposal out, and that is that
12 there be established a baseline so many complaints per
13 thousand or tens of thousands of customers, and that if
14 the complaint level rises above that threshold, that
15 would be like historic threshold that there be a
16 financial penalty incurred by the new company.

17 That basically is what, I don't know what, but I
18 know we will incur some significant expenses on our side,
19 and these are justified complaints.

20 There is, I understand the difference I have
21 been in this business long enough to know complaints or
22 justified complaints.

23 MS. MONK: If I can make a point.

24 Your staff has also communicated your concern on
25 this, and we have begun to develop the data records to

1 solidify that kind of a commitment too, so not only are
2 we willing to implement it but are actively working that
3 data.

4 COMMISSIONER GARAMENDI: I focused principally
5 here on the provider side. There are consumer complaints
6 also that arise, and you have had for many years
7 responsibility of picking those up and being with those.
8 We may or may not choose to include those in this as we
9 need to do some analysis on our side with regard to that.

10 Gary.

11 MR. COHEN: One of the things that when we have
12 talked about this before it seemed to be an issue is that
13 there were an extraordinary number of complaints from a
14 relatively few providers who for one are or another had a
15 contract or arrangement with United Health Group that was
16 problematic in one way or another, and I guess my
17 question is:

18 Are those kinds of problems things that we are
19 likely to see here in California or were those unique to
20 the places where those problems arose?

21 MR. SHEEHY: Dr. Tuckson, I will mention as you
22 look at what is really causing a claim problem, often
23 times we find out that it is was in the contract set up
24 itself. There may be misunderstanding between a hospital
25 and a health plan or physician health plan, so what we

1 have done as an organization is developed a broad set of
 2 standard contracts that we know can be administered for
 3 hospital systems will run a set of dummy claims through
 4 those contracts, have a hospital sign off to say yeah,
 5 that is the way it should be paid.

6 And we found that has had a tremendous impact on
 7 reducing those small number of providers who have a lot
 8 of claims.

9 It is really getting back to kind of the input
 10 making sure the input is effective making sure everybody
 11 understands how the contract is supposed to be and is
 12 moving ahead with that.

13 Gary, how would that be integrated into
 14 California? Would you expect to take those standard
 15 contracts and report them to California or are you going
 16 to leave what PacifiCare is doing now in place or what is
 17 your - what are your thoughts about that?

18 MR. SHEEHY: It is really a longer term
 19 integration issue. The claims that PacifiCare place now
 20 often are contracts pay reasonably well.

21 I think their performance is good. As we look
 22 at down the road making a system conversion then we would
 23 have to evaluate whether or not those contracts can pay
 24 on the United system, and you do one of two things,
 25 change the contract or change the system to pay those

1 claims.

2 MR. FREY: I would also add one of the
 3 commitments we have made and one of the things that
 4 United has historically done is to keep provider
 5 relations, and network management very local, and so our
 6 team that is in place today in California will remain,
 7 and so any integration issues in future years would be
 8 handled by the same folks that work with those hospitals
 9 and providers today.

10 COMMISSIONER GARAMENDI: I will back up a little
 11 bit to back to the quality issue.

12 In the HMO product that PacifiCare currently
 13 offers, if a person presents themselves at an emergency
 14 room that is not in your hospital network, how do you
 15 deal with that?

16 MR. FREY: Ask Dr. Ho to answer that.

17 MR. HO: So, someone goes to an out of network
 18 hospital or emergency room and get treated, and they get
 19 care, and if that, based on the, we apply the prudent lay
 20 person criteria to whether or not an emergency was
 21 warranted or not and based on that prudent lay person
 22 review or criteria, the coverage is provided. Payment is
 23 made.

24 If there is a hospitalization after that
 25 emergency room visit, then we, after we notify which is

1 part of the contract with the subscriber enrollee, then
2 we apply case management resources and nursing resources
3 to assess that the appropriate care is being given at the
4 right time and place, and if they would benefit from
5 being transferred in network, then we facilitate those
6 programs and the services as well.

7 COMMISSIONER GARAMENDI: Transfer them to the in
8 network?

9 MR. HO: Back to the in network provider.

10 COMMISSIONER GARAMENDI: With regard to quality
11 issues, United had different program different policy
12 that would change from that or stay the same?

13 MR. SHEEHY: Still the same.

14 MR. BAUM: If that same individual under the
15 United structure which you have been talking about now
16 has that emergency in Minnesota, will that then no longer
17 be considered out of network?

18 MR. HO: The HMO probably still be out of
19 network. For PPO it would be part of a participating
20 assuming it is a contracted provider it would be a
21 participating provider.

22 MR. BAUM: But when you were talking about
23 trying to expand the HMO concept or product doubling
24 conceivably if you were to expand it into Minnesota, then
25 would you have the similar approach that you are taking

1 with the PPO?

2 MR. SHEEHY: That is mainly a state-by-state
3 issue cause depending on how the state regulatory defines
4 the service area of the HMO. I think that is the issue
5 that determines whether it is in network or out of
6 network. The PPO doesn't have that geographic
7 constraint, so we can cover those services as in network.

8 MR. HO: To further clarify in general emergency
9 room services are not usually the best example of that
10 type of disparity because usually we apply, I am sure
11 United does, apply prudent labor.

12 It is when somebody is seeking elective out of
13 network that is when the distinction in terms of product
14 and in network would be more easily exemplified.

15 COMMISSIONER GARAMENDI: I will pivot on you,
16 but I am not leaving this issue.

17 I will go to quality and the issues that,
18 doctor, you were discussing about quality.

19 Talk to me about stroke, strokes, and the
20 quality issues surrounding stroke treatment.

21 MR. TUCKSON: So, I, if I understand where you
22 are here for us in terms of how we would think about that
23 is first and foremost we would want to be, and we are
24 very attentive to trying to prevent this problem, and so
25 we want to make sure that we are doing, and we are doing

1 those things that are necessary to help people to keep
2 their blood pressure under control and to understand
3 about early symptomatology and those things, and so our
4 consumer website and other educational activities by mail
5 we try to work hard there.

6 Second, of course, for us it would mean to make
7 sure that there were affordable access to the
8 pharmaceuticals necessary for a person once diagnosis was
9 made if they had hypertension and that sort of thing, so
10 making sure we are doing as we have the lowest pharmacy
11 trends in the industry continuing to do that so that
12 people can get access to what they need.

13 Third is then looking at a facility that a
14 person would go to making sure that the quality of the
15 institution was the finest that we would ensure making
16 sure it is a safe place.

17 Therefore implementing the leap frog criteria
18 and the national quality forum criteria for safety, and
19 then as we work our way down to the actual care that is
20 delivered, we want to be able to and stroke is maybe you
21 picked that as an example because here is a case where it
22 is not so much an elective admission which is different
23 from the things that I have talked about before, but
24 something that a place that a person goes for on an a
25 emergent basis.

1 So then we may not there we would of course
2 through our care coordination activities be able to
3 follow the care that is delivered, but there we would be
4 very attentive to the post discharge instructions to make
5 sure that that person is discharged with the therapeutic
6 interventions that are appropriate for that case.

7 COMMISSIONER GARAMENDI: Let me basically two
8 different kinds of stroke; one is a blockage, and the
9 other is an aneurism.

10 MR. TUCKSON: Yes, one certainly because of not
11 getting enough blood to the brain tissue and the other
12 being those concerns when in fact there are blood vessel
13 blows out, and they are bleeding and again no blood to
14 the brain.

15 COMMISSIONER GARAMENDI: Are you familiar with
16 what is taking place in Santa Clara County with regard to
17 stroke issues?

18 MR. TUCKSON: I am not.

19 COMMISSIONER GARAMENDI: I thought not.

20 That is why I brought this issue up. We are
21 talking about quality. We are talking price.

22 We are talking cost to the system. In Santa
23 Clara County they have instituted a situation, a system
24 in which hospitals are designated as stroke certified
25 hospitals.

1 I think half a dozen that are now meeting that
 2 criteria which brings us to the quality issue.

3 They have a system set up with the emergency
 4 responders that goes into effect either the end of this,
 5 I think it is the end of November, in which an emergency
 6 case that's thought to be a stroke is sent to one of
 7 those five hospitals, not to the closest hospital, but
 8 the closest emergency room with trauma center but rather
 9 to the center that is certified for stroke.

10 And the appropriate diagnosis is then made as to
 11 whether it is a blockage or an aneurism.

12 Obviously if it is the latter, you don't give a
 13 certain drug TPA. If it is the former, you do. It is
 14 thought that the system will save 400 million dollars in
 15 Santa Clara County alone not in the treatment, which
 16 might be somewhat the immediate treatment, but in the
 17 long term care.

18 Now, the issue I want to present to you is how
 19 are you going to make this a state wide system using the
 20 quality issue, using the payment mechanisms that had
 21 discussion with Dr. Ho about and particularly of interest
 22 is the relationship between those two and PPO and the HMO
 23 payment mechanism.

24 My concern is very simple. If the insurance
 25 system requires treatment going or requires a patient to

1 go to the panel, this system of prevention care and cost
2 reduction won't work.

3 So let's have some comments.

4 MR. TUCKSON: Sam, as you start as you think
5 through that, the first key keeps coming back to this
6 issue of the, I think you are right on in terms of the
7 standards for evaluating centers.

8 And what that says is that the health plans have
9 to, and along with other entities in the physician
10 organizations in the state and so forth, have to agree on
11 the criteria for designating these stroke certified
12 hospitals.

13 COMMISSIONER GARAMENDI: It has been done
14 nationally.

15 MR. TUCKSON: Once you have those kinds of
16 things in place, then we all should be and can be
17 incorporating those in what we do and Sam.

18 MR. HO: It is a great modo and would like to
19 learn more about it.

20 We, just in terms of in general, we have started
21 about ten years ago centers of excellence programs of
22 prefer where we had an agreed upon criteria for
23 transplants in terms of higher quality, and we have
24 developed a network throughout the country along that
25 same modo so to expand a concept of stroke.

1 COMMISSIONER GARAMENDI: We will be obviously I
2 did this for a reason.

3 Sam, you and excuse me, Dr. Ho, I apologize for
4 being less formal, you are going to go, you, and I will
5 have a discussion about the specifics, and then you will
6 comment, and you will tell me how you are going to get
7 this integrated in California. Okay?

8 MR. HO: Thank you.

9 COMMISSIONER GARAMENDI: We are all for reducing
10 the price of the system.

11 I think I have got a couple more issues that I
12 need to bring up.

13 One, we will undoubtedly hear about when I go to
14 the public comments in just a few moments, and that is
15 executive comments issue.

16 Much concern about this much discussion about
17 it, certainly I discussed this at length with the
18 WellPoint Anthem.

19 What do we have here I have got calipers
20 document somewhere in this pile that says you ought to
21 unwind the executive compensation that the \$315 million
22 or so that is involved here is unconscionable.

23 That is money that can provide services to
24 100,000 Californians for a year.

25 Tell me why the executives should be benefiting

1 at the expense of the providers and consumers to the tune
 2 of over a quarter of a billion dollars?

3 MR. SHEEHY: Commissioner, I would first state
 4 that that the payment to the, payments to the executives
 5 are not at the detriment of policy holders and the
 6 consumers.

7 Those are payments that are made through United
 8 Health Group, the parent company.

9 Historically, just the content of those payments
 10 is that PacifiCare is a struggling organization several
 11 years ago, in serious financial trouble.

12 PacifiCare board saw to it to bring in a
 13 management team that would be committed to turning the
 14 organization around. They did a remarkable job in
 15 turning the organization around from a financial
 16 perspective. As a result of that, the stock of
 17 PacifiCare has gone up significantly.

18 And they have reaped the benefit of that. That
 19 is the most significant component of the compensations.
 20 The compensation, and it is not really related directly
 21 to this transaction. It is something the acceleration is
 22 that the actual options themselves were offered before
 23 this transaction was contemplated.

24 The other component that I think is permanent
 25 the other significant component is United's interest in

1 keeping the executive management of PacifiCare engaged
2 and on board and working and not leaving the organization
3 for the sake of continuity, and that is the component we
4 have put in place.

5 It is a combination of equity and cash to keep
6 that is paid out over a period of time to keep the
7 PacifiCare executives engaged and continuing to lead the
8 organization.

9 COMMISSIONER GARAMENDI: Did you read the
10 transcript of the WellPoint Anthem hearing that took
11 place in this room?

12 MR. SHEEHY: Commissioner, I did.

13 COMMISSIONER GARAMENDI: You know what I am
14 about to say. You claimed a moment ago that the
15 providers and consumers are not going to pay for the
16 executive compensation.

17 My understanding is executive compensation is
18 composed of two elements.

19 One is a certain amount of cash payment which is
20 relative to a small compared to the stock incentives that
21 were provided I think that is correct, isn't it?

22 MR. SHEEHY: There is a potential change in
23 control. Our intention is to pay as little of that as
24 possible by keeping the executive on board with us.

25 COMMISSIONER GARAMENDI: I understand. None the

1 less, there is a payment, and there I will short circuit
2 this cause got to be pretty clear to you and others where
3 I am coming from in this.

4 There is no other place for this company to get
5 its stock price up than money from the consumers, and
6 minus payment to providers that is it.

7 Am I right the stock price is driven by the
8 difference between the money you collect from consumers
9 and what you pay providers, and then other expenses other
10 administrative expenses that is it. It is the bottom
11 line, correct, yes, that is correct.

12 So when you say that this is going to be paid
13 for by United the only way it gets paid for by United is
14 to drive up the stock price, and you drive up the stock
15 price by increasing the margin; am I wrong.

16 MR. SHEEHY: Commissioner, that is one
17 component, but increasing the value in the eyes of the
18 investors where people would say that is a better company
19 now. We are willing to pay more for that.

20 COMMISSIONER GARAMENDI: It is the bottom line.
21 Come on. It is the bottom line.

22 You get a better company in the view of stock
23 price by having a better line that not only comes from
24 the consumers or less payment to the providers.

25 This is a major issue. We are talking about

1 more than one quarter of a billion dollars here, and yes,
2 I know it is a stock option, but the only way the stock
3 option has any real value is that the stock price has
4 gone up which means that your profits and projected
5 future prices and future goal, and that is kind of the
6 way it works.

7 Well, what is your view with regard to calipers
8 resolution to unwind all of this?

9 MR. SHEEHY: Our view is, I guess, we were --
10 that calipers supported the transaction the unwinding it
11 is more complex because of the commitments to the
12 PacifiCare management were made, are made, and they are
13 not necessarily United HealthCare commitments.

14 They are commitments made by the board of
15 PacifiCare to their executives for the performance.

16 So we are not. We don't have the ability to
17 unwind that.

18 We are going forward exception the going forward
19 compensation the incentives to keep PacifiCare executives
20 on board we think is good for the marketplace. We think
21 it keeps continuity of management.

22 We think we can build upon the leadership
23 position that they have built.

24 COMMISSIONER GARAMENDI: It is more than just
25 PacifiCare; isn't it?

1 Mr. McGuire made \$124,000,000 on his stock
2 options last year as reported in the Wall Street Journal.
3 I assume those stock options were valuable because of the
4 four billion dollar profit, correct?

5 MR. SHEEHY: That is an important component.
6 The performance of the organization contributes directly
7 to the value of his stock.

8 COMMISSIONER GARAMENDI: You know, it is
9 unconscionable flat out unconscionable that this is not
10 about making computers.

11 It is not about making automobiles, it is about
12 the lives of human-beings and a large amount of money,
13 billions is taken out of the medical, out of the pockets
14 of consumers and delivered to Wall Street not delivered
15 to benefit the consumers and their healthcare, a huge,
16 huge profit.

17 And specifically a portion of that winds up in
18 the pockets of executives to a point that is just flat
19 out unconscionable.

20 So there is a template.

21 A template that was laid out in the last time I
22 was in this room having to do with investment in the
23 communities.

24 If the executives are going to get a fat take,
25 then the people of California are going to get an equal

1 amount of money available for their healthcare.

2 And it was the last time with WellPoint Anthem
3 it was a wonderful one, whatever the executives are
4 getting, the under-served communities of California are
5 getting the same.

6 Are you prepared to do that?

7 MR. SHEEHY: Commissioner, we are prepared to
8 engage in those discussions.

9 COMMISSIONER GARAMENDI: No, no, no.

10 You did not hear me. I was very clear. What
11 the executives get, the under-served communities in
12 California get.

13 It is not a discussion. If it is a discussion,
14 then you are wasting my time and your time.

15 MR. SHEEHY: Commissioner, I would respectfully
16 suggest there are differences between the two
17 transactions, and there are differences in the nature of
18 the two transactions that we warrant.

19 COMMISSIONER GARAMENDI: What are those
20 differences?

21 MR. SHEEHY: Pardon me?

22 COMMISSIONER GARAMENDI: What are those
23 differences?

24 MR. SHEEHY: Our view is that the value that we
25 bring to the marketplace, to the consumer by bringing

1 these two organizations together will accrue to the
 2 consumers and the broader California marketplace.

3 COMMISSIONER GARAMENDI: I thought you were
 4 going to tell me that there is a difference because of
 5 the stock options and the way in which they work.

6 I thought you were going to tell me that there
 7 was a difference in the way in which the amounts are
 8 calculated. We could discuss that.

9 The matrix or the template, I don't know how
 10 many times I have said this, but I will say it one final
 11 time before I excuse you as the panel, the WellPoint
 12 Anthem undertakings are a template.

13 It would be inconsistent of me to apply to your
 14 merger a different template or a template that
 15 significantly varies from what WellPoint Anthem had to
 16 do.

17 You are familiar with each of those
 18 undertakings. The first day you guys came to us to
 19 present this, I said if you want to know what my view is,
 20 look to the WellPoint Anthem merger in its totality and
 21 the undertakings that were secured during that merger
 22 discussion.

23 That is both with regard to specifics that apply
 24 to my department as well as to the DMAC. I can assure
 25 you this:

1 If you want my approval, you will look carefully
2 at that, and you will note the applicability of each and
3 everyone plus the issue of claims which was not included
4 in that.

5 Further comments from your side?

6 COMMISSIONER GARAMENDI: I thank you for your
7 participation.

8 We are now going to go to the 10 or 11 people
9 that want to comment.

10 You can stay there, if you were you, I would
11 recommend our first has already spoken Carl Coen.

12 Mike Ross, this is by order of sign-up. No
13 other order from that except for the guy that signed up
14 34th who wanted to be last. Mike Ross, Consumer First
15 California.

16 Mike, excuse me. No, go ahead. You are already
17 up there. Go ahead.

18 MR. ROSS: I am only going to be a minute or two
19 anyway.

20 My name is Michael Ross from Sacramento. I am
21 here on behalf of Consumers First and California Alliance
22 for Consumer Protection.

23 We wanted to go on record to supporting the
24 merger.

25 We support the merger for a couple of reasons.

1 Real quickly first of all, we believe that the merger
2 will allow more people to become covered.

3 Second of all, we believe that United has
4 greater financial resources that will bring more
5 innovation to consumers in California, and the last
6 reason is we believe that this will enhance competition
7 in California with regards to Bluecross and Kaiser. With
8 that we ask you to support the merger.

9 Thank you.

10 COMMISSIONER GARAMENDI: Thank you, very much.
11 You were less than a minute.

12 I have here a number ten which apparently was
13 the 10th person to sign up today, but apparently also
14 talked to Nettie some days ago, Jerry Flanagan, Janice
15 Doering, Foundation for Taxpayer and Consumer Rights.

16 Thank you.

17 MR. FLANAGAN: Jerry Flanagan, healthcare Policy
18 Director for the Foundation for Taxpayer and Consumer
19 Rights.

20 Two folks with me are not with the foundation,
21 but they are consumers, I think probably the only two
22 actual members of PacifiCare that are in the room today.

23 Before I begin, I could hope you folks would do
24 additional hearings particularly in the evening.

25 We are getting a lot of e-mails, some calls from

1 people that can't make the hearings in the evening.

2 I think a weekend or evening you would get
3 people from the public that would like to talk to you
4 directly about these mergers but cannot.

5 It is deja-vus all over again. Dave Parker
6 standing next to me was in this room with you last year
7 to talk about the Wellpoint merger.

8 Dave Parker has the unfortunate experience of
9 going from a member of BlueCross which was gobbled up by
10 WellPoint to switching over to PacifiCare, Secure
11 Horizons so he has gone from one merger to another.

12 He entered Medi-Care, and I think he and his
13 wife, Pat, thought they had escaped the HMO market, but
14 now they are facing another merger effect.

15 We have heard all the promises before, but
16 Californians have no reason to think that we can believe
17 PacifiCare this year that they won't pass costs on.

18 Bluecross, as you know, made that exact same
19 commitment last year.

20 I called this department also the Schwarzeneger
21 Administration whose department managed healthcare who
22 has a piece of the sign-up authority not to entertain any
23 additional mergers to find out what happened with the
24 WellPoint merger and how Bluecross post-merger has been
25 able to raise the premiums 20 to 30 percent by their own

1 admission at a previous public hearing.

2 Those types of activities, raising costs to
3 premium payers are exactly what those executives promised
4 not to do for at least three years following the merger.

5 That deal was about a 16 million dollar merger.
6 They gave away about 400 million dollars in cash, still
7 counting.

8 This merger is only an eight million dollar
9 merger, and there are 445,000,000 in total cash there.
10 Just to break that down there is 315 million in bonuses,
11 CEO Harvard Phanacol of PacifiCare a month before the
12 merger was announced received \$130,000,000 retirement
13 bonus increase.

14 PacifiCare is being smart about how they handle
15 these payments. They made that retirement bonus increase
16 prior to the merger announcement, so technically it is
17 not considered a merger bonus, but it is clearly is
18 related to the merger and is meant to be a payoff.

19 That is a lot of cash in that deal. The change
20 in control bonuses where a lot of the cash resides, there
21 are technicalities in those deals that allow executives
22 to take the higher payout packages of their small changes
23 in their duties or where they go to work so they can opt
24 for those higher payments.

25 Also these accelerated bonuses something this

1 department has the specific authority over because
 2 bonuses are accelerated with this merger.

3 These accelerations award executives before the
 4 outcome of the merger can be assessed meaning that
 5 executives will have less at stake for the future
 6 financial health of the company, less beholdng to both
 7 patients or the promise they make actually comes to
 8 fruition and less interest in the outcome of shareholders
 9 in the future. So that is something this department has
 10 clear authority under existing regulations to handle.

11 COMMISSIONER GARAMENDI: I am sorry. How is
 12 that so?

13 MR. FLANAGAN: My understanding of the raise and
 14 reading the authority given to the department is that
 15 this department has the authority to make determinations
 16 on whether mergers can be, change in control should be
 17 approved depending on how they affect the financial
 18 health of a company, the financial holdings and also the
 19 wherewithal, the protection of patients.

20 When you accelerate a bonus that is already been
 21 provided, but accelerated, you are taking a lot of the
 22 value of the company quickly, taking away all the
 23 incentives the executives might have in the future to
 24 make sure the company will actually do well once the
 25 merger is completed, not just do well financially, but

1 also do well in terms of a patient care perspective.

2 I would be happy to talk to your staff
3 afterwards.

4 COMMISSIONER GARAMENDI: You talked to me right
5 now, and you did.

6 MR. FLANAGAN: The other issue is not only big
7 executive bonuses a threat to patient care United Health
8 has not shown any interest in staying in California.

9 Back in 2000, United Health was a major player
10 in California, pulled out to focus on more lucrative
11 national accounts.

12 The Wall Street folks tell us exactly that is
13 happening now. United Health wants to buy PacifiCare for
14 purposes of its Medi-Care membership and Secure Horizons
15 brand name.

16 There is predictions that they will leave the
17 market or severely reduce the HMO market, cherry pick
18 members out of that if that happens it is not only a
19 problem for patients like United Health left their
20 patients high and dry in 2000, it will affect the market
21 system wide because fewer players in the market means
22 more consolidation, less pressure through efficiency.

23 We put it in your staff five points that are
24 proposed by the Foundation for Taxpayer and Consumer
25 rights and my colleagues at the Latino Coalition for a

1 healthy California, to be adopted prior to be part of the
2 undertakings before the merger is approved.

3 The most important thing is that as we are
4 looking at ways to compensate the under-served
5 communities which are absolutely appropriate in mergers
6 like this.

7 We all have to make sure that the future rate
8 increases are approved before PacifiCare mails them out
9 because if the companies simply raises rates to pay off
10 to pay for appropriate payments to the under-served
11 communities, that is not a solution for the system
12 because the PacifiCare patients who are going to face new
13 premium rate increases are going to be the ones that are
14 joining the ranks of the uninsured, and that ultimately
15 is a bad situation for the market.

16 Clearly investment in underserved communities
17 that PacifiCare's high rates have contributed to problems
18 of un-insured rates that is totally appropriate.

19 Other issues I mentioned making sure that folks
20 are not cherry picked, that patients in the course of
21 treatment have access to hospitals and physicians that
22 they need.

23 And that we study the effects of consolidation.
24 Right around the corner of this merger everyone expects
25 that Humana, Cigna and Aetna, two of those companies are

1 significant players in California all are all part of
 2 merger talks, as HMO's are trying to shoulder their way
 3 in and take advantage of the Medi-Care part D
 4 prescription drug benefit that HMO's are going to be
 5 administering.

6 So there will be a lot of these on the horizon.
 7 I think excess reserves are a major problem. PacifiCare
 8 has about 389 million dollars in reserves on its HMO
 9 side.

10 I haven't seen the number for the PacifiCare of
 11 California business, but those monies can be up streamed
 12 and paid back by future rate increases.

13 Again, a key focus has to be all future rate
 14 increases are approved, and the burden of proof is on
 15 PacifiCare to prove that rate increases are not
 16 associated with the merger costs, but are part of the
 17 medical inflation rate.

18 Now we know already the PacifiCare rates are
 19 going up about two or three times faster than Medi-Care,
 20 inflation physicians and doctors because of these huge
 21 administrative and overhead costs, profits and excess
 22 reserves.

23 Folks here are already paid ultimate premiums in
 24 the last year to finance PacifiCare's profit, make it an
 25 attractive player in the market so United Health to

1 encourage a big company like United Health to come in and
 2 buy it out.

3 The department has a lot of authority under the
 4 law to protect patients, but clearly your leadership in
 5 the future to make sure that Wall Street doesn't continue
 6 to drive the California market into the ground is
 7 absolutely necessary.

8 These companies are, as you said, the benefits
 9 to the company are exactly opposite to those of the
 10 patients.

11 The more money taken out of the premium dollar
 12 and put towards profit and overhead, the better for Wall
 13 Street the worse for patients, and that we are at a point
 14 now where that is leading to the bread lines of
 15 healthcare in California where working Californians
 16 cannot afford health insurance.

17 We will either have a complete meltdown or put a
 18 stop to it, and I am looking to you to help us stop that
 19 in the future.

20 COMMISSIONER GARAMENDI: Thank you.

21 MR. COHEN: One question Senator Alicon asked,
 22 posed the question of whether the scrutiny under law that
 23 mergers like this should be increased or heightened
 24 whether our authority should be different than what it
 25 is.

1 Do you have any thoughts about that?

2 MR. FLANAGAN: I think the first thing one we
3 have been very consistent throughout under the existing
4 authority both The Department of Insurance also the
5 department of healthcare and the rates have quite
6 authority to ensure that when a merger occurs that the
7 financial health of the company is sustained in a way
8 that protects the patient's experience and health in the
9 future.

10 That and our reckoning gives a very, very wide
11 authority that needs to be exercised and was exercised to
12 some large extent during the last merger. The problem
13 was was getting WellPoint and Bluecross to do what they
14 said they were going to do so.

15 So that to me is maybe not a regulatory problem
16 as much as it is a legal issue that these folks now need
17 to be hauled in court by the department, the WellPoint
18 people, to say you said you would do this you didn't do
19 it.

20 That might be an authority to be exercised, but
21 in our estimation, and I think the plain reading of the
22 law is you have the authority right now to pull these
23 folks in for breaking a contractual agreement they made
24 to the state of California.

25 In large part I would say you have a lot of

1 authority at the end of the day if there are additional
2 items that need to be viewed there may be more
3 clarifications to remind people what the authority is,
4 but, you know, I think it is important to realize the
5 broad authority that this department already has in law.

6 COMMISSIONER GARAMENDI: I assume by your
7 comment that you are not aware that we have an ongoing
8 investigation?

9 MR. FLANAGAN: I am aware.

10 COMMISSIONER GARAMENDI: Of WellPoint, and the
11 question of whether they are passing through general
12 inflation or costs associated with the merger you and
13 anybody else who cares to watch this should know that I
14 will enforce the contract that they have with the state
15 of California.

16 The investigation is not yet complete, and the
17 study is not yet complete, but should we find that
18 WellPoint is passing any part of the cost of the merger
19 on to its customers, there will be a rollback with
20 appropriate money being returned to the consumers.

21 That is going to happen, and as you may have
22 summarized or may have learned from the earlier
23 discussion that we will be nailing down in this
24 contractual undertaking, the issue in more, much more
25 clearly so that there is not going to be a discussion

1 about what is and is not an appropriate accounting
2 mechanism.

3 MR. FLANAGAN: I appreciate that, and that is
4 very good news for Californians for the issue of the
5 ongoing.

6 My point is that until we get that report the
7 investigation of how Bluecross and WellPoint may have
8 gained the system and played around the agreements, we
9 shouldn't make any other, allow any other mergers to
10 occur here.

11 The problem is that although repayment may be
12 something that you can require in the future, it will be
13 too late for many patients who are one more rate increase
14 away from being uninsured.

15 COMMISSIONER GARAMENDI: I believe you sponsored
16 a piece of legislation and then backed away from it on
17 rate regulation for health insurance?

18 MR. FLANAGAN: We did not back away from it.

19 It was killed in its first insurance hearing by
20 the HMO's.

21 That is a great piece of legislation that would
22 mirror regulations under prop 103 for auto insurance
23 requiring healthcare companies to justify their rate
24 increases. That was not our decision.

25 COMMISSIONER GARAMENDI: This department does

1 not have regulatory authority as you know.

2 Okay.

3 MR. FLANAGAN: But you do have special authority
4 under this merger that you normally don't have.

5 COMMISSIONER GARAMENDI: I was the first
6 commissioner ever to exercise it. Let's take the next
7 witness, Janice Doering.

8 MS. DOERING: I became insured by FHP in 1996
9 and later on PacifiCare purchased FHP.

10 Along with that purchase was a promise for
11 improved quality of care, more access to doctors, and
12 also several premium increases.

13 I started out with FHP at 134. Shortly after
14 PacifiCare took over, my premium went up again, and since
15 that time my premiums have gone now to as of November
16 1st, it is now \$379.52 for an HMO policy which now has
17 less coverage than the HMO policy I had at 134.

18 And also this year alone in January, I had an
19 increase from \$245.49 that I had paid in parts of 2003
20 and 2004 which was then raised to 302.44.

21 And then that was 302.44 in January, and I was
22 told that was because I had turned 47, and then I got a
23 second raise this year that was effective as of today.

24 What is happening is I am being promised medical
25 care. I felt that when I purchased insurance I purchased

1 it for the purpose to protect myself, so I could work so
 2 I would never be in a position where I couldn't work due
 3 to a medical condition that could be corrected could be
 4 treated or could be alleviated to some extent.

5 I have now been disabled since 1997. I have not
 6 been able to work. I have had to go through the social
 7 security process, and it is because I have been denied
 8 care.

9 I am in constant, chronic pain.

10 My doctors have requested procedures.

11 There have been times when it looks like we will
 12 get a procedure done. I was notified the day before a
 13 procedure after going through an MRI and all the pre-op
 14 tests for a procedure went through all those things fully
 15 expecting to get a procedure to relieve my pain so
 16 possibly could at least go to work part time or half
 17 time.

18 And I got a phone call the morning of the day
 19 before, and I was told it is off. We got a fax from
 20 PacifiCare they said no. When I contacted PacifiCare, I
 21 was told there would be no way, no how I could have this
 22 procedure.

23 It wasn't going to happen, and get it through my
 24 head it was never going to happen.

25 The doctor I spoke to was an internist. He was

1 not even an orthopedic surgeon. I don't feel he was
 2 qualified to make that decision, and that of course did
 3 not make me happy, but what concerns me also is there is
 4 no talk about the individual insured. I am an individual
 5 insured.

6 I am not part of a group policy, and I wholly
 7 feel after what I have listened to today and what I have
 8 been reading in the newspaper, that I have no way to know
 9 what other people at my age group are paying that are
 10 part of a group policy.

11 And I fully believe that to a great extent that
 12 part of how these executive salaries and all these high
 13 benefits these people get are done on the back of, you
 14 know, insured people such as myself who have no group to
 15 speak for us, no employer to speak up and say, hey my
 16 bookkeeper isn't working. You are not taking care of
 17 what you promised to, providing us service and coverage.

18 I don't think anyone buys an insurance policy
 19 with the intent to never use it. They hope they never
 20 have to, but they are relying on it to be there so they
 21 can work. I have no savings. My retirement is gone. It
 22 is all gone.

23 I don't know how I will afford to pay this
 24 premium or for how long. I am dependent on my mother who
 25 is 75. At 47 no one wants to be there.

1 No one wants to be in my place. I don't think
2 there is anyone in this room that wants to be in my
3 place, and I certainly don't wish it on anyone.

4 I sleep less than five hours a night due to the
5 chronic pain I experience, and currently there is no hope
6 in sight.

7 It is always well, we will try.

8 We will ask again. We will ask again, and then
9 you know, you have these contracts come up, and there is
10 a change in what is being offered.

11 COMMISSIONER GARAMENDI: Do you have an HMO
12 policy or a PPO?

13 MS. DOERING: I used to have a point of service,
14 but PacifiCare saw fit to discontinue point of service,
15 and then I was demoted to only having an HMO policy
16 unless of course I would submit myself to underwriting
17 which at that time PacifiCare fully knew that I needed
18 back surgery or substantial treatment.

19 So of course that would put me in a range where
20 I would never be able to afford the premium.

21 COMMISSIONER GARAMENDI: Have you filed a
22 complaint with the DMAC?

23 MS. DOERING: Yes, because it is a chronic pain
24 issue.

25 I have been told good luck.

1 They have been really no help because I don't
2 have cancer. It is not going to kill me.

3 It is chronic pain, but eventually the drugs
4 that I am taking are not helping my liver or any other
5 part of my body, and eventually I won't have any
6 healthcare.

7 And I will be a burden on the state which is
8 not, you know, the whole picture is poor, and I am just
9 asking someone to hold these people to where they are not
10 putting the burden onto people like me who have any voice
11 as a group, the self-insured.

12 COMMISSIONER GARAMENDI: Presumably, ma'am, the
13 DMAC does have the responsibility, and apparently they
14 did carry out that responsibility of looking at your
15 specific problem and making some judgment as to whether
16 or not you were properly cared for.

17 I would suggest that with regard to your own
18 treatment you should and we will certainly help you with
19 this take your issue back to the DMAC for a new review of
20 your case.

21 MS. DOERING: I am at a total disadvantage.

22 COMMISSIONER GARAMENDI: I understand the
23 problem of individuals in the marketplace both in the
24 purchase as well as privately.

25 We are going to have to move along, but if you

1 will, I will talk. Before you leave, my staff will talk
2 to you about how to assist you in getting an additional
3 review of the particular problem you have.

4 Thank you.

5 MR. PARKER: Thanks, John Garamendi, for holding
6 these hearings.

7 I am getting to be a regular thing for me
8 unfortunately.

9 Just I would like to say this much about the
10 WellPoint situation. I feel, and I think by conservative
11 estimate, WellPoint took \$12,000 from me to support that
12 merger by raising the rates when they did.

13 It was precluded, the merger and developed the
14 nest egg for them to divide up. That cost me personally
15 \$12,000.

16 At the time I was out of work, and the money to
17 pay for my medical insurance came out of the value of my
18 home which I am still paying for.

19 So, with that having said that, you can
20 understand why I have a very dim view of the management
21 practices of the HMO's.

22 I don't think they really have at their heart
23 the welfare of the policy holders.

24 If they did, they would go out of their way to
25 insure as many people as possible at the most affordable

1 rates to all without consideration of the cherry picking
 2 that we hear about in which does occur cause it happened
 3 to me with WellPoint as well, over pre-existing medical
 4 conditions.

5 They should participate in the society as a
 6 whole to make sure, to make sure that well being of the
 7 populus. It is their moral responsibility in this
 8 business.

9 I did receive a letter in reply to some points
 10 that I made at the last meeting in Santa Ana, from
 11 Mr. Reed Tuckson, and I really appreciate that letter.

12 It, at that meeting, I had brought up the point
 13 that HMO's generally are not required to employ people at
 14 the same level that medical practitioners have to go
 15 through.

16 That is the educational and the licensing that
 17 they go through in order to treat patients.

18 They, in effect, are treating patients when they
 19 take their money beforehand.

20 And I think there should be some regulations put
 21 into effect to change that, and maybe they will change
 22 the ethical standards under which they operate.

23 The other point that I would like to make and to
 24 make this as brief as possible, one of the things missing
 25 in this whole mix is the voice of the consumer on an

1 ongoing real-time basis.

2 And fair warning, you have a group of people
 3 that always go to the polls and vote. They are the
 4 senior citizens. I am on the leading edge of this baby
 5 boom, and these are all wise people.

6 We know what is going on in the world. We keep
 7 up with current events, and we will vote, and we see a
 8 problem. I am talking to a lot of these people now
 9 because I am retired, so I hobnob with seniors, and they
 10 are all concerned about the state of the medical care in
 11 the country.

12 Number one, we want everybody to get equal care
 13 no matter what their financial straits we want everybody
 14 to be get the healthcare that they need.

15 But we also want to get equal treatment. We
 16 want to pay our way. I want to pay my premiums. I want
 17 to pay a realistic amount which in a case of being on
 18 Medi-Care, the taxpayers are actually paying my bill.

19 I would like to have more control over it. I
 20 would like to know exactly how much they are paying
 21 Secure Horizons at this point, and so I can measure the
 22 effect and the quality and the ethicacy of their
 23 practices in the community as a whole.

24 Because I would much prefer to have my service
 25 provided by somebody that is doing what I feel is the

1 right job in the community.

2 So, one of the things I would like to see happen
3 in government is give the consumers, the people that make
4 the decision OF which HMO they participate with, they
5 partner up with, some kind of power over that spending
6 decision.

7 One thing I think would be very, very effective
8 is to give the right to the consumer to change their HMO
9 to somebody that they feel is to go away from somebody
10 that has made bad decisions, to go with somebody that has
11 they are convinced is doing the right job and take about
12 six months of their premiums with them, the previous six
13 months. Think about it.

14 There has to be a tool. Spending decisions is a
15 consumer is the strongest thing that a consumer has. You
16 go buy a car. You buy it based on that you want to buy
17 that car. You are not forced to buy the Japanese car or
18 the American car.

19 So if you give that right to the consumer, I
20 think that will help the industry as a whole.

21 Thank you.

22 COMMISSIONER GARAMENDI: Next we will take Don
23 Fein.

24 MR. FEIN: Thank you, Mr. Commissioner and
25 members of the panel.

1 I look forward to this opportunity to testify.

2 COMMISSIONER GARAMENDI: This microphone working
3 or Ira Schoenholtz is the next witness so she can come on
4 down.

5 MR. FEIN: Once again, for the record, I am Don
6 Fein. I am the CEO of Don Fein.

7 Thank you, Mr. Commissioner for the opportunity
8 to testify here this morning. I can be fairly brief
9 because of the two commitments I heard made moments ago.

10 Let me start first with a little bit of
11 introduction. Capchi is the professional association in
12 California that represents the some 150 capitated
13 delegated groups that we have heard testimony about the
14 vast majority of which have contracts with PacifiCare.

15 The vast majority of PacifiCare HMO enrollees in
16 California receive their care through CapChi's capitated
17 delegated members, so we are highly interested in this
18 transaction.

19 I think we have a stake in it. We have had a
20 long and strong relationship of collaboration with
21 PacifiCare that has been particularly true in the last
22 couple of years as we have worked closely together to
23 fashion new initiatives to improve the care for
24 California.

25 So we are very, very delighted to have that

1 relationship and looking forward to continuing in the
 2 future. We have concerns about market direction
 3 generally. This is not necessarily peculiar to
 4 PacifiCare United.

5 There has been a lot of talk about the coming
 6 tide of high deductible products. Mr. Commissioner, we
 7 have discussed this with your office at length.

8 These indeed are problematic for our capitated,
 9 delegated, model. Delegated groups at the moment don't
 10 have the administrative capacity to administer those
 11 deductibles.

12 Though they are coming, and we can debate
 13 whether they are good or they are bad, and do that for
 14 hours, but the critical fact for today it seems to me is
 15 that we understand that our current system which is
 16 served Californians so well and produced such value and
 17 relatively low commercial premiums is at risk given these
 18 high deductibles.

19 So the, you know, I am happy to conclude by I
 20 think repeating just for the record our concurrence and
 21 our welcoming in the two commitments I have heard this
 22 morning. First as logic would suggest PacifiCare and
 23 United were quick to say they would commit to preserving
 24 the capitated, delegated model in California. We welcome
 25 that we concur in that.

1 Secondly and though this will take some work I
2 know, likewise heard the commitment that they would work
3 together on the development of the technology necessary
4 to administer those deductibles.

5 If we accomplish that, as I am hearing committed
6 now, and as I hear the commissioner say we will be in an
7 undertaking, I think that we will have seized an
8 opportunity actually to improve the system.

9 And in light of those commitments where Capchi
10 is certainly happy to say it will continue to work with
11 PacifiCare and now United.

12 With that I conclude and be happy to answer any
13 questions.

14 COMMISSIONER GARAMENDI: I don't have a question
15 I do have a comment. I am sitting up here thinking about
16 that word that the french don't use at least according to
17 our president entrepreneur. I think there is a business
18 opportunity here to create a collection agency to collect
19 the high deductible that your folks won't be able to
20 collect.

21 What do you think?

22 MR. FEIN: Well, I think that is certainly one
23 of the issues associated with all of the kind of patient
24 pay methodology whether it is co-insurance or
25 co-payments or deductibles hospitals and physicians alike

1 are concerned about the rising levels of patient pay
2 because it is.

3 COMMISSIONER GARAMENDI: You guys are willing to
4 you have 100 bucks discounted. I will give you ten bucks
5 go collect.

6 MR. FEIN: We are not wild about high
7 deductibles, but if they are coming, and if it is
8 inevitable we want a play in that world.

9 So developing the accumulated technology that
10 James Frey spoke of so well, will go a long way I think
11 to improve healthcare in California and giving them
12 something affordable. We have reservations about high
13 deductibles, but I think we will work.

14 COMMISSIONER GARAMENDI: I think you better get
15 yourself a collection an agency.

16 MR. FEIN: Be I think that is a sub industry
17 that will develop.

18 COMMISSIONER GARAMENDI: Perhaps United would do
19 that along with the banking program they set up with our
20 HSA. Think about it.

21 A new revenue source, thank you very much.

22 Ira, you are in the back there. You position
23 yourself perfectly under the lights.

24 MR. SCHAUNHOLTZ: Thank you very much. My name
25 is Roy Shaunholtz.

1 I am the president of the American Association
2 of Disabled Persons with disabilities.

3 And we are unhappy for individuals and small
4 business owners with disabilities.

5 The association monitors and comments on many
6 diverse issues that impact the lives and livelihood of
7 individuals and small business owners with disabilities.

8 We feel that the merger will allow PacifiCare to
9 be part of a larger network that will provide more
10 doctors and healthcare professionals to its members.

11 United will bring greater resources to programs
12 that go beyond what PacifiCare can currently provide to
13 its members.

14 United's greater financial resources and
15 technological superiority will bring more innovation to
16 PacifiCare members in California.

17 We feel that the combined company will offer a
18 challenge both Bluecross and Kaiser inquisitive of that
19 situation because they will be competing for business by
20 quality and care and costs.

21 And this benefits, we feel, all Californians. I
22 want to thank you for allowing me to share our views on
23 this important healthcare transaction.

24 Thank you, very much.

25 COMMISSIONER GARAMENDI: Thank you, very much.

1 Our next witness is Vivian Shimayama.

2 Vivian?

3 Sam Gilbert, California small business
4 association, Sam.

5 Eileen Fend, California small business
6 association, Lupe Alonzo Diaz, Latino Coalition for
7 Healthy Californians.

8 MS. DIAZ: Thank you for calling me Lupe
9 although you pronounce my name Lupe, no name calling.
10 However, I have been known to be a little loopy.

11 My name is Lupe.

12 I am executive Director of the Latino Coalition
13 for Healthy California. The Latino Coalition is a public
14 policy and advocacy organization that works with about
15 1800 community based organizations throughout the state
16 to develop policy, services and conditions that improve
17 the health of Latinos.

18 Insurance Commissioner Garamendi, we really want
19 to thank you for your leadership on this issue as well as
20 for brokering the previous deal with WellPoint Anthem and
21 re-investing in medically under-served areas.

22 This proposed merger has a potential to become a
23 better deal for California as well as for Latinos, and so
24 there really needs to be a specific measurable
25 commitments that should be made and kept.

1 One of the questions that was posed to me
 2 earlier by one of the reporters is why am I here and why
 3 do I care.

4 And two answers. There is a policy perspective
 5 and the personal perspective, and the policy perspective
 6 is the one that I am a staff junkie I know the quotes the
 7 future of Latino is really intimately tied to the future
 8 of California.

9 So one third of the states population the Latino
 10 half of the children born in California are Latino.

11 By the year 2025 Latinos will be the largest
 12 ethnic group in California.

13 By the year 2040 we will actually be the
 14 majority of California, so while you look around the room
 15 and this room might not necessarily be representative of
 16 California, they are coming.

17 They will be in your neighborhood soon, so watch
 18 out and look for them. And as we think about the policy
 19 perspective, let's also think about the personal
 20 perspective to me is actually equally as personal to my
 21 heart.

22 From a policy perspective as a consumer I grew
 23 up uninsured as did my folks. We were -- we actually
 24 didn't receive Medi-Cal until I was about high school
 25 age, and I actually didn't get my first real health

1 insurance until I had my first real paying job right
 2 after graduate school.

3 And so, as a consumer, I am actually currently a
 4 consumer of Bluecross WellPoint, so I obviously have some
 5 concerns about that, but on a different perspective as
 6 the CEO of a non-profit, we represent Latinos, and we are
 7 a public policy and advocacy organization that does
 8 health advocacies works.

9 From a consumer perspective as well as a CEO
 10 perspective we have seen, and I have seen a rise in terms
 11 of the premiums and deductibles to my staff. As a
 12 healthcare advocacy organization, I find it inappropriate
 13 to actually pass those costs on to my staff, and we are a
 14 very small staff.

15 So of course what we have done as an
 16 organization I think that it is only wholly appropriate
 17 for me as the CEO to make sure that our staff has
 18 appropriate healthcare, and I believe that that is also
 19 appropriate for all Californians not just for my staff,
 20 and so we really need to think about those persons that
 21 are significantly affected.

22 And I just want to concur with some of the
 23 comments made by Jerry Flanagan in terms of the five
 24 points we should consider, and I would just like to
 25 reiterate two of them.

1 We need to hold California and Californians
 2 harmless. So what does that mean? There shouldn't be an
 3 interruption of care whether we are looking at insurance
 4 policies, benefits or health services.

5 And we also need to think about level premiums,
 6 co-pays and deductibles, and that should be for at least
 7 a period of three years.

8 And if there are any changes to that, then the
 9 merging companies should be held accountable, and they
 10 should have the burden of proof to verify and to prove
 11 that they are not in fact a product of the merger.

12 Secondly and equally as important, we need to
 13 think about what that means for Californians in terms of
 14 re-investing in medically under-served areas.

15 I would like to thank you for your leadership in
 16 that area. I think it is wholly important and wholly
 17 appropriate for us to continue something of that nature
 18 whether it is expanding children's coverage, looking at
 19 liens and grants to community specifically in the medical
 20 technology area or whether looking at work as far as
 21 advocacy issues. Those issues really need to come at the
 22 forefront.

23 Finally in terms of closing, I think we need to
 24 find a balance, and I am not sure I know what that
 25 balance is, but I believe others do, and I think we need

1 to find a balance between allowing companies to thrive as
2 responsible corporate citizens but also making sure that
3 when we think about all these different numbers that we
4 stop thinking about all those numbers and we start
5 thinking about the real people and start thinking about
6 healthcare not as a market commodity or as a vehicle
7 emerging from stock prices, but just as it is.

8 It is an essential human right.

9 Thank you.

10 COMMISSIONER GARAMENDI: Thank you, very much.

11 We note about 22 percent of Latinos are uninsured not
12 including the un-documented portion of the population.

13 Thank you. Charles Tampert. Charles Tampert.

14 Javier, Chicano youth center, Javier.

15 JAVIER: Honorable Commissioner, members of the
16 commission, and company representatives.

17 I am here to advocate on behalf of the people
18 that are the voiceless, the people who are obscure, the
19 people that you never see, the people that go unattended,
20 the people that go un-heard.

21 Those are the people who live and produce one
22 quarter of the nation's foods and commodities in this
23 country.

24 I reside in Fresno, California. The Brooks
25 institute just recently informed us that Fresno

1 California has the highest concentration of poverty in
 2 the nation.

3 And it is almost obscene to me that we are
 4 talking about billions of dollars. Those billions of
 5 dollars attract each other.

6 What was the state gross product in California
 7 in 1977 about 285 million dollars, the state gross
 8 product in California today is 1.45 billion dollars today
 9 making California the sixth largest economy in the world
 10 so are we attracting mergers, you bet you.

11 The problem is that those mergers are taking
 12 money from California and not investing in the poor and
 13 the medically under-served communities of the state of
 14 California, and that is no lie.

15 I haven't seen anything yet in Central Valley
 16 which has a disproportionate number of medically
 17 under-served areas health professional shortage areas.
 18 We had five farm workers who died of heat exhaustion in
 19 the nation that leads in healthcare prevention and
 20 delivery shame on us.

21 This is important, Mr. Commissioner, and you are
 22 a pioneer in healthcare.

23 The reason why we have 9, 10 million medical
 24 visits today, is because you introduced AB2250 when you
 25 were an assemblyman in 1977 okay. So let's get with it.

1 The thing that gravitates multi-million dollar
2 corporations to California is a trillion dollar economy.

3 It doesn't take a genius to understand that.

4 But what we need to do is we need to build in
5 safeguards to protect the people who produce and thrive
6 and make that economy work.

7 If this merger goes through without no attention
8 to the medically under-served communities in California,
9 it will be a travesty.

10 Right now to serve the needs of Latinos in the
11 state of California you need to graduate 20,000 bilingual
12 physicians.

13 We don't have them, not in medically
14 under-served areas not in health professional shortage
15 areas.

16 So if this is going to happen, Mr. Commissioner,
17 please do some real trail blazing and holds these mergers
18 accountable to serving the needs of the medically
19 under-served.

20 Thank you, very much.

21 COMMISSIONER GARAMENDI: Thank you, very much,
22 Javier.

23 That completes the list of people that have
24 signed up to testify today.

25 I appreciate all of that testimony. I

1 appreciate the panel from United and PacifiCare for their
2 participation today.

3 Obviously there is going to be considerable
4 discussion between this department, the department of
5 managed healthcare.

6 Let me say that there will be considerable
7 discussion with this department together with the
8 department of managed healthcare as we would through the
9 undertakings necessary to fulfill the obligations that I
10 have under the law which requires me to consider the
11 implications of the merger on policy holders.

12 Is it to the benefit or the detriment of the
13 policy holders. This merger will only take place when it
14 is to the benefit of policy holders in so far as I have
15 the power to achieve that goal.

16 I appreciate the information given today from
17 all.

18 This hearing is now concluded.

19 Thank you.

20

21

22 (whereupon at the hour of 1:05 P.M.,
23 the hearing was adjourned.)

24

25

1 STATE OF CALIFORNIA)

2) ss

3 COUNTY OF LOS ANGELES)

4 I, Carol L. Crawley CSR #7518, in and
5 for the State of California do hereby certify:

6 That said hearing was taken down by me in
7 shorthand at the time and place therein named, and
8 thereafter reduced to typewritten form, and the same is a
9 true, correct and complete transcript of said
10 proceedings.

11 I further certify that I am not
12 interested in the event of the action.

13 WITNESS MY HAND this 2nd day of November, 2005.

14

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Carol L. Crawley

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Carol L. Crawley CSR No. 7518

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