1. Q: Why is PacifiCare launching a HMO Deductible product?

A: Commercial HMO products have not been growing in California. This challenge was one of the first issues that the joint efforts of CAPG and PacifiCare focused on as part of the Cypress Summit process. The conclusion of the joint workgroup on products was that low-cost HMO products were necessary that could compete with PPO products that include far less generous benefits than standard HMO products. CAPG and PacifiCare jointly approached the Department of Managed Health Care to request authority to launch low-cost HMO product designs including deductibles.

The market potential of these products has attracted significant interest. Kaiser has been marketing a deductible HMO plan for over one year, and has enrolled almost 70,000 members in California as of December 31, 2005. Kaiser also recently announced the launch of an HRA-compatible deductible HMO product. Aetna and Health Net are actively developing similar products.

2. Q: Why does the deductible apply to professional services, and not just hospital services? This makes the product much more complicated.

A: The first HMO Deductible product developed by PacifiCare applied the deductible only to inpatient hospital care. This product was previewed to CAPG participants during a Cypress Summit meeting in 2005. Unfortunately this product cannot compete on a cost basis with either low-cost PPO products or Kaiser’s full deductible product. The price of the inpatient hospital deductible product was only 2% lower than PacifiCare’s lowest existing commercial plan.

The reason that inpatient hospital only deductibles do not provide significant savings is relatively simple. Less than 5% of commercial members have inpatient hospital care in any given year. This means that the deductible is reducing cost for only a small share of membership, and the cost savings of the product are correspondingly small. In addition inpatient hospital stays are less discretionary than professional visits, so there is little utilization impact from an inpatient deductible. Only a full deductible product can compete with the low-cost products that are generating commercial growth.
3. **Q:** Who is responsible for tracking the deductible status in the new HMO Deductible products?

**A:** PacifiCare’s HMO Deductible products have both individual and family deductible limits. The deductibles will apply to a range of services for which the financial responsibility varies between the medical groups, hospitals and the health plan. Adding complexity is the fact that different individuals in the same family may be in different medical groups, and that members may transfer during the year.

For all these reasons the only practical solution is for deductibles to be tracked at the health plan level. PacifiCare has implemented systems upgrades to allow accumulators to be tracked centrally and updated based on either claims or encounters. PacifiCare will update the deductibles on a daily basis, and will make the deductible status information available to delegated providers through the normal vehicles for transmitting eligibility status: Provider Portal, interactive voice response or telephonically through Member Services.

4. **Q:** How can we determine whether a PacifiCare member is in a HMO Deductible plan?

**A:** A number of providers have expressed concern that they would have difficulty administering this product without a clear identifier of the deductible plans on the PacifiCare ID cards. PacifiCare has agreed to add “HMO Deductible” and the deductible limits to the ID cards. In addition, providers can identify HMO Deductible members from the plan codes on the eligibility files.

5. **Q:** How do providers access information about deductible limits and accumulator status?

**A:** Information on deductible status and benefit limits will be provided using the same tools medical groups currently use to access benefit information from PacifiCare: the Provider Internet Portal, Interactive Voice Response, or through Customer Service. In addition the benefit limits will be provided in PacifiCare’s electronic eligibility feeds. PacifiCare is exploring the ability to add accumulator status information to the eligibility feeds, but since groups access electronic eligibility under different schedules there is a concern that groups which download eligibility infrequently could be using outdated deductible accumulator status information. Further the addition of deductible accumulator information to the eligibility file would require groups to reprogram their systems, since existing data fields cannot accommodate the information. At the suggestion of a CAPG workgroup, PacifiCare is reviewing the possibility of adding a field to the standard eligibility file that states whether the deductible has been met, as well as creating a supplemental eligibility file that includes updated accumulator values. We will communicate the results of these efforts as soon as our internal evaluation has been completed.
6. **Q:** What is the basis for computing deductibles in a capitated environment?

**A:** Where a capitated provider is contracting for care on a fee-basis with a downstream provider the deductible would be applied to the actual contract rate used to pay the provider of care. Where the provider of care is sub-capitated or salaried a valuation must be applied to calculate the deductible. Rather than mandate a consistent standard for all providers, PacifiCare has agreed to use the cost of care specified in the PacifiCare capitation agreement to value capitated services. PacifiCare would like to evolve this toward a standard payment methodology that would maintain consistency across provider groups, but we are willing to work with medical groups to ensure that their systems can accommodate a valuation methodology.

Several providers have expressed a desire to base capitated deductibles on a local Medicare fee schedule. We are currently evaluating this suggestion from a regulatory and administrative perspective.

7. **Q:** How will capitated providers be paid for this product? What is the basis for the reduction in capitation to providers? Is there an adjustment for the increased complexity of the product and the difficulty of collecting deductibles?

**A:** The HMO Deductible plans are new commercial HMO benefit plans. PacifiCare’s commercial capitation contracts allow new commercial plans to be added mid-year with rates based on corresponding capitation factors. PacifiCare’s capitation factors for the HMO Deductible plans have been developed using appropriate actuarial assumptions. Based on recommendations from CAPG and CAPG medical groups, PacifiCare has had our internal actuarial assumptions validated by external actuaries. The results of this analysis has been included as part of this communication.

8. **Q:** Even if these new plans are not a material change from a contractual perspective, don’t they represent a significant financial impact to capitated medical groups?

**A:** No. The optimistic sales target for all low cost HMO plans is 30,000 members in the first year. If we assume all that membership growth is in HMO Deductible plans, and that membership increases linearly from July 1, 2006, the average membership for the first year would be 15,000 members. PacifiCare has over 1,500,000 commercial members in California. HMO Deductible membership would at most represent 1% of commercial membership over the next 12 months. The medical group capitation factors for most of the HMO Deductible plans range between 0.80 and 0.85. Therefore the groups will receive about 15% to 20% less cap than they would for a benchmark member. If the medical group makes NO EFFORT AT ALL to collect ANY member cost share (deductible or copays/coinsurance) for these members, the likely impact would be no more than 0.2% impact to commercial revenue.
9. Q: Why not wait for smart card technology that will make this product much easier to administer?

A: PacifiCare is exploring future upgrades that will allow deductibles to be updated real-time through “smart card” technology. While this type of refinement clearly has the potential to improve the performance and reduce the administrative workload of the product, the introduction of smart card technology into this product in the California environment will take the investment of substantial time and resources by both United and the capitated medical groups and hospitals. United’s smart card technology operates on United’s core IT systems, and PacifiCare will not be able to fully access this functionality until capitation payments transition to United systems in 2007. Neither the demands of the Department of Managed Healthcare undertakings nor the demands of the competitive marketplace will allow PacifiCare and CAPG to wait for a breakthrough technological solution to this challenge.

10. Q: Please explain why the deductible does not apply to Emergency or Urgent Care services.

A: For the plans being released 7/1/06, there are plan designs in which the deductible applies to Emergency/Urgent Care services and there are plan designs in which the deductible is waived for these services. The deductible is waived for Emergency/Urgent Care Services for the plan designs that will be available to our Small Group market segment. These plan designs also have the deductible waived for office visits. This plan design should not drive members to the Emergency Room or Urgent Care as their office visit copay will still be less out of pocket cost to them then their Emergency Room/Urgent Care copay. These plan designs are consistent with similar plan designs we have seen from our competitors in that market segment. We understand your concern that waiving the deductible on Emergency Room and Urgent Care may drive utilization of these benefits, however, there has been equal concern from our clients that applying the deductible to these benefits may prohibit members from seeking care when they need it the most. We will continue to monitor the utilization of Emergency/Urgent Care services to determine if a change in plan design is warranted in the future.

11. Q: How do copays apply to plans with deductibles?

A: Under the HMO Deductible plan a member is required to satisfy the deductible first for services that are subject to the deductible. After the deductible has been met any applicable copay would apply. Copays may vary by benefit or type of service. This is consistent with the traditional HMO plans we offer in the market place today.
12. **Q: Why do copays apply to benefits that the deductible applies to?**

**A:** The intent of the HMO Deductible product was to develop a plan design that was similar to one of our traditional HMO plans with the addition of a deductible the member must meet initially before covered services apply. While developing a plan design that has services that only the deductible applies or a copay applies (not both) would be cleaner, it is not consistent with the type of plan designs employer groups have been asking for to increase consumer cost-sharing. The ability to apply both deductible and copays to benefits enables us to offer true low-end HMO products that promote more consumer cost-sharing and offer a price point that meets our clients’ expectations.

13. **Q: Do services that a member seeks from a non-contracted provider count towards the deductible?**

**A:** The HMO Deductible plan follows the same rules and procedures that the traditional HMO plan does. If a member seeks services from a non-contracted provider on a self-referral basis these services would be considered non-covered benefits. Non-covered benefits do not count towards the member deductible. The exception to this would be Emergency or Urgently Needed Services a member seeks outside of the service area.