

Fact Sheet

HEALTH PROGRAM

California Public Employees' Retirement System • 400 P Street • Sacramento, California 95814

THE 2002-2003 HEALTH CARE ENVIRONMENT

The CalPERS Purchasing Experience

Background:

CalPERS is the largest purchaser of public employee health benefits in California and the second largest in the nation after the federal government. The State and public agency employers, public employees, and retirees will spend approximately \$2.6 billion for health care in the pension fund's program in 2002. Premiums are paid for by employers, often according to union agreements, and by employees or retirees.

Historically, CalPERS has relied largely on health maintenance organizations (HMOs) to manage costs and achieve quality of care. In 1993, HMO benefits were standardized to further assess healthcare costs and quality. Managed care has helped to keep costs down by coordinating treatment of a variety of complex conditions, measuring healthcare quality, reducing the length of hospital stays, consolidating services, incorporating administrative efficiencies, and discouraging over-treatment and other inflationary practices common under the old fee-for-service model. From 1993 through 1997, the average basic HMO premium for CalPERS enrollees declined by small percentages each year. However, in the late 1990s, costs began to rise again. For the year 2003, a historic 25.1% increase in premium costs is expected.

Today, CalPERS members are served by seven HMOs: Blue Shield HMO, Health Net, Health Plan of the Redwoods, Kaiser, PacifiCare, Universal Care, and Western Health Advantage. These HMOs provide prepaid comprehensive health coverage for physician and hospital services within designated geographic areas.

CalPERS also offers two self-funded, preferred provider organizations (PPOs) -- PERSCare and PERS Choice. Members pay higher premiums than they would in the HMOs, but they have more flexibility in obtaining care. They can receive services within the PPO network of physicians, hospitals and other providers, but pay more from their own pockets if they go outside the network. Of the 1.2 million health plan enrollees, 74 percent are in HMOs and 26 percent are in PPOs. These percentages include the 4 percent that are in three association plans -- California Association of Highway Patrolmen Health Benefits Trust (CAHP), a PPO; Peace Officers Research Association of California (PORAC), a PPO; and California Correctional Peace Officers Association (CCPOA), an HMO. Members must belong to and pay dues to the respective association to enroll.

What Was CalPERS Objective In Negotiating With Health Plans This Year And What Obstacles Did CalPERS Face?

The Board's objective was to maintain the current benefit design, the same service areas, protect the members' ability to keep their same primary care physician, and to minimize cost increases. The health care marketplace is undergoing major dislocations and extreme price pressures. These disturbing trends came to a head with the 2003 negotiation process. The biggest obstacles were historically high initial rate requests by the health plans, which ranged from 15.1% to 41.1% for HMO basic plans, and 12.1% to 83.4% increases for Medicare Plans. If CalPERS had accepted their rates, it would have added \$565.2 million to the cost of the program.

The underlying pressures that led to this year's historic rates have been building for some time; and indeed, CalPERS has been able to delay some of the impact through leveraging of HMO prices and by redesigning benefits in 2002.

What CalPERS believed was a justified rate and what the plans asked for was the widest it has ever been. Historically, the difference between the justified target rates and those of large HMOs has been between 5% and 10%. This year, the difference was as much as 20%, and the larger HMOs gave up little ground in negotiations. Some HMOs said they have to catch up on money lost on CalPERS by pricing too low in previous years or by staying in rural areas with older, sicker enrollees and higher provider costs. Two plans were exiting from a total of 12 counties. Some 16,000 members would have lost their only HMO option. The increases offered no additional services or value, such as improved customer service or more effective care management.

In addition, HMOs report that hospital and physician repricing is requiring them to pay the providers more than ever before. Cuts in federal government reimbursement for Medicare and Medicaid are causing physicians and hospitals to raise prices. The growing number of uninsured Californians is another cost driver. HMOs want to get back to their own profit expectations and stem losses created by these issues.

What Action Did the Board Take?

The CalPERS Board unanimously voted to accept an average rate increase of 25.1% for its HMOs, and an 18.9% to 22.1% rate for its self-funded PPOs. This translates to paying \$700 million more for benefits. (Last year's rate increase was 13%, but it was offset by increased copayments which reduced it to 6%.) In addition, the Board agreed to drop Health Net and PacifiCare from the lineup, providing its members with one large network HMO, Blue Shield, and one large staff model HMO, Kaiser. It maintained relationships with other regional HMOs, including Health Plan of the Redwoods, Universal Care and Western Health Advantage. (Universal Care's acceptance is conditional upon a successful financial solvency review by the state Department of Managed Health Care by May 1.)

The PERSCare Basic rate increase will be 22.1%; the PERS Choice Basic rate increase will be 18.9%. Part of this increase is due to the mental health parity legislation, which comprises about 2.7% of the increase in PERS Choice and 3.3% of the PERSCare increase. This rate increase will ensure continued prudent reserves to cover claims and administrative costs. This action means enrollees and our employers will continue to have sound coverage and good value.

This action signals to health care providers and plans that these trends are no longer sustainable. We must embark on a new vision that enables us to work with plans that can be accountable for results and that distinguish themselves in healthcare quality and member service.

Today's marketplace dynamics show national policy makers that the way in which society has chosen to provide health care to citizens is in peril. A larger public policy debate that includes how to properly fund Medicare and Medicaid and the uninsured is needed immediately.

What are the Advantages to Dropping Health Net and PacifiCare? Are They Not Worthy Plans?

CalPERS staff also solicited creative suggestions from the large HMOs, such as regional rating or alternative products, to help lower premiums and preserve HMO coverage. The responses reflected little willingness to expand service areas without adding cost. By reducing the three large network plans to one, CalPERS is able to combine three separate risk pools into one larger pool and save about \$77 million in premium increases.

All three plans were given an opportunity to reprice as the single partner, and Blue Shield provided the best balance between cost, quality and service area. In addition, Blue Shield was the only one to offer a dedicated CalPERS-member customer service unit to meet our members' needs. In July 2003, they will also have a 24-hour advice nurse line available for CalPERS members. Another important reason for choosing Blue Shield is their commitment to developing a partnership to deliver better care and reduced cost through disease management, care management and wellness programs. Health Net and PacifiCare's rates in this process were approximately 7% higher than Blue Shield and offered no distinguishable added value.

Without consolidating, over 6,000 state members would have been eligible for the state's rural subsidy program; nine additional counties would have been dropped by the HMOs; and most members would have paid more individually for coverage. Blue Shield will serve all the counties that were served last year. PacifiCare had proposed to leave additional counties that they serve today.

Why Is CalPERS Keeping the Regional HMOs?

Health Plan of the Redwoods covers more than 10,000 enrollees in rural areas. Universal Care has a good following in Los Angeles, Orange, Riverside, San Bernardino, San Diego and Ventura counties and plans to expand to Fresno and Madera counties. Western Health Advantage, a new plan in 2002, covers 4,000 members in northern California. These plans are well liked by members and are affordable.

What Does Consolidation Do for CalPERS Members Who May Not Like Losing their HMO?

Consolidation enables members to keep current comprehensive benefits and maintain the 2002 HMO service area. The primary care physician relationship is not likely to be disturbed in about 90% of the cases, and Blue Shield will work with CalPERS to try to increase that percentage. In instances where members need service from Blue Shield, they will have the benefit of a dedicated telephone customer service agent specially trained on the CalPERS program.

What Is The Significance of the Board Action on CalPERS Members?

The decision by the CalPERS Board ensures that members will see no change in benefit design and no higher copays. The service areas will be maintained; and the overall increases, while high, are lower than they would otherwise be without this action. It is an important step in our efforts to contain costs by ensuring better risk management. Most importantly, it provides the best value for the greatest number of CalPERS members.

Will CalPERS Guarantee that Its Members Will Receive Their Health Card in Time for Next Year?

CalPERS expects to move 150,000 members as a result of consolidation. We are planning early and have placed our highest priority on ensuring a smooth and seamless transition.

What is CalPERS doing to restrain costs beyond 2003?

CalPERS Board of Administration is engaged in the development of a longer range strategy. The assessment will continue into the summer. Two ideas are being explored:

--The "segmented-risk pool" model involves two or three fully-insured health vendors, each with a statewide network offering at least one HMO-type benefit plan and other coverage choices in all 58 counties. CalPERS would function as a purchasing agent or broker to negotiate with vendors on behalf of its members. Vendors would subcontract with others to offer services, if necessary. Standard benefit designs would be required for each product. CalPERS would reimburse vendors for enrolling high-risk members.

--The "single-risk pool" model would provide a self-funded, single pool administered by a third party chosen by CalPERS. The program would have HMO-like coverage, PPOs and other products in a statewide network of physicians and hospitals. CalPERS would insure the pool, manage costs, set premiums, and adjust risks. Premiums would vary, depending on the type of plan a member selected.

What are the potential advantages of each?

--The "segmented-risk pool" would minimize the higher cost of enrolling people in rural counties, including older, sicker members. The cost would be spread among vendors since they would be required to offer products in every county. Members may choose at least one HMO-type product in their area.

--The "single-risk pool" would place all enrollees in a single pool. A one-checkbook approach would allow fairer, more flexible methods of managing premium costs and treatments. Enrollees would pay the same premiums for similar services, with costs spread across a single statewide pool. The large pool could facilitate administrative efficiency and save money. A single system might make it easier to implement disease management, wellness ventures and other programs to contain costs.

What are the potential disadvantages?

--In the "segmented-risk pool," it might be difficult to persuade vendors to offer a complex statewide network of multiple products. Members might perceive less choice with fewer vendors than the five (after consolidation) HMOs and two PPOs now offered.

--In the "single-risk pool," CalPERS would be at risk for all financial and legal liability. Members might perceive less choice with fewer vendors than under the present plan. Yet they would have more choice with HMO/PPO-like products offered statewide. Advanced plan preparation would be critical to the program's success.

What is the timeline for a longer-term solution?

CalPERS will focus on benefit design after the Board of Administration selects one of the two models for further planning. Whatever model that emerged would be phased in over the next few years, possibly beginning in 2004. A workshop is scheduled for May.

We intend to move toward more strategic, longer-term partnerships with a more selected group of outcomes-based plans and providers. Implicit in our consolidation is the fact that we will seek to replace the current year-to-year pricing with longer-term, performance-based compensation that is aimed at improving care management by plans and providers and into an era when our enrollees will become more engaged.

Does This Mean The Health Care System in California and the U.S. Is In Crisis?

The CalPERS view is that the health care purchasing structure in the U.S. is in need of public policy discussion and resolution. Employer based plans are being asked to carry an undue financial burden for the health care delivery system, and prices are not likely to stabilize. As prices go up, the number of uninsured will also rise, exacerbating the situation further, causing an ultimate death spiral. CalPERS can't solve this problem, but is willing to work with others toward a fundamental shift in how health care costs are managed.

For more information, contact the CalPERS Office of Public Affairs, at (916) 326-3991