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HEALTH INSURANCE

California Public Employees' Alliance Has Reduced Recent Premium Growth

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Human Resources Division

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November 22, 1993

The Honorable Fortney (Pete) Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

The debate on reform of the American health care system has prompted discussions of alternative ways to purchase care. The administration's health care reform plan and other recent reform proposals call for purchasing cooperatives to manage competition among health care plans. One frequently cited example of a purchasing cooperative is the California Public Employees' Retirement System (CalPERS), which negotiates health premiums for many public employers in California.

This report responds to your request that we analyze the effectiveness of the CalPERS Health Benefits Program in controlling health plan costs for its members. Specifically, this report (1) examines CalPERS' cost-containment record, (2) identifies factors that have contributed to the trend in CalPERS' premium rates, (3) assesses the impact of CalPERS' cost-containment efforts on its members' benefits, and (4) discusses the applicability of CalPERS' Health Benefits Program as a model of managed competition—a system by which large purchasing cooperatives contract with a variety of competing health plans on behalf of employers and individuals.[1]

Background

In 1993, CalPERS was responsible for negotiating approximately $1.4 billion in health insurance premiums on behalf of 877 employers, covering nearly 900,000 people.[2] Public employers participating in the program include the state of California, which accounts for 70 percent of CalPERS' enrollment, along with state universities, local school districts, local water districts, and others. Three-quarters of these public agency employers have fewer than 100 employees each. Over 80 percent of the enrollees are current

[1]A recent analysis was conducted by the Service Employees International Union, which represents roughly half of CalPERS' active members. See "The CalPERS Experience and Managed Competition," Service Employees International Union Issue Paper (Mar. 1993).

[2]In 1962, CalPERS' was authorized by the state legislature to purchase health insurance for state employees. This role was expanded in 1967 to allow other public agencies within California to join CalPERS' Health Benefits Program.

employees and their dependents. The remaining CalPERS enrollees are retired employees and their dependents.[3]

Every year, the CalPERS program offers members a large number of health plans to choose from. Plans must accept enrollees regardless of health status, age, or previous medical condition and can charge no more than a standard premium that is the same for anyone enrolling in that specific plan. The CalPERS program emphasizes managed care by allowing members to choose from among 21 health maintenance organizations (HMO) with which it negotiates rates.[4] Currently, about 80 percent of all enrollees are in HMO plans.

When CalPERS terminated three traditional fee-for-service plans in 1989, it instituted PERSCare, a preferred provider organization (PPO) plan.[5] PERSCare accounts for about 15 percent of all CalPERS enrollees. This plan is available to all members, but it is the only choice for about one-fifth of PERSCare enrollees located in remote areas not served by participating HMOs. Because it attracts individuals with higher health risks (its enrollees include many older workers and retirees), PERSCare premiums substantially exceed HMO premiums.

Beginning in 1993, CalPERS began offering a second PPO plan, PERSChoice, with more limited coverage. PERSChoice costs members less than PERSCare but more than the highest priced HMO. In addition, CalPERS has four fee-for-service plans offered by four employee associations. (App. I contains more detailed information on the organization and operations of the CalPERS program.)

To assess CalPERS' efforts to control health plan costs, we interviewed representatives of the CalPERS program, participating health insurers, and state employee bargaining units. In addition, we analyzed the trends in

[3]All participating employers must offer health care coverage to their retirees. According to CalPERS officials, this requirement keeps many public agencies from joining the program.

[4]HMO enrollees receive comprehensive, prepaid benefits only through doctors and hospitals associated with the HMO and are generally required to obtain a referral to receive care from a specialist.

[5]The PPO plan was established by the California legislature with CalPERS assuming all financial risk of health care expenses exceeding the premiums collected. PPO enrollees receive care from a selected panel of doctors and hospitals typically reimbursed on a fee-for-services basis. They are allowed to go outside the network of providers at greater out-of-pocket costs. Specialist visits are permitted without prior authorization.

average health insurance rates for 1989 through 1993 for CalPERS,[6] California, and the nation.[7] CalPERS officials reported that they did not have information on their average health plan premium or average annual rates of increase prior to the 1989 contract year.[8] We conducted our review between January 1993 and September 1993 in accordance with generally accepted government auditing standards.

Results in Brief

CalPERS' record of controlling the growth of health insurance premiums for participating employers has improved since 1992, outperforming most other employers. The recent trend toward slower growth in premiums, due in part to the weakened California economy, followed several years in which the average CalPERS premium increased at rates near or above nationwide averages. For contract years 1989 through 1991, the average CalPERS premium grew by 16.7 percent annually, compared with average increases of 15.3 percent per year reported by employers throughout the nation. However, for contract year 1992, CalPERS negotiated premiums that increased 6.1 percent, on average, while employers nationwide reported average increases of 10.1 percent. For the 1993 contract year, CalPERS negotiated rate increases averaging 1.4 percent, far lower than the average 8.0-percent increase expected by other employers this year.

Several factors contributed to CalPERS' recent success in negotiating health insurance rates: (1) a budget crisis led the state of California to freeze its premium contribution in 1992; (2) CalPERS began exercising its purchasing power by negotiating more aggressively, for example, asking HMOs not to increase their rates; and (3) CalPERS introduced a standard benefit package for HMOs in 1993 that requires patient copayments for certain health services, thereby allowing some plans to restrain the growth in premiums.

For CalPERS' members, the recent changes in the Health Benefits Program brought mixed results. For the many enrollees in relatively expensive HMO plans, the lower premium increases have been at least partially offset by higher copayments. For state employees enrolled in the lowest cost plans,

[6]The rate of CalPERS premium increases used throughout this report is computed for the basic benefit package offered to members without supplemental Medicare coverage. Approximately 83 percent of CalPERS members are covered by the basic benefit package.

[7]Data for 1989 through 1992 for average health plan cost increases in California and the nation were obtained from Foster Higgins' annual survey of public and private employers of all sizes. Data for 1993 were obtained from KPMG Peat Marwick's survey of randomly chosen midsize and large public and private employers. Because firms volunteer to complete these surveys, there is a high turnover of respondents from year to year. In our report, we use health plan cost data projected by employers for the years in which they completed the surveys.

[8]The CalPERS contract year runs from August 1 to July 31. For simplicity, in this report we refer to the first year in the contract as the contract year.

the premium increases were largely absorbed by the government contribution, but the change in copayments was still felt directly. Also, under the standardized benefit package, some enrollees gained expanded coverage of health care services, while others lost some coverage.

CalPERS incorporates many features of a "health alliance" as proposed under the managed competition approach to health care reform. As a purchasing cooperative, it pools large and small employers to gain leverage in buying insurance coverage from competing health plans. In addition, CalPERS has begun to standardize benefits across plans to make comparisons easier. Other features of the managed competition approach have yet to be incorporated. For example, CalPERS currently collects little information on the quality of care and health outcomes that could be used to assess the plans' performances. Given that CalPERS has only recently adopted some, but not all, features of managed competition, it is unclear whether the program's recent cost-containment record demonstrates managed competition's potential to control national health care spending while maintaining quality.

CalPERS Has Limited Premium Increases Since 1992

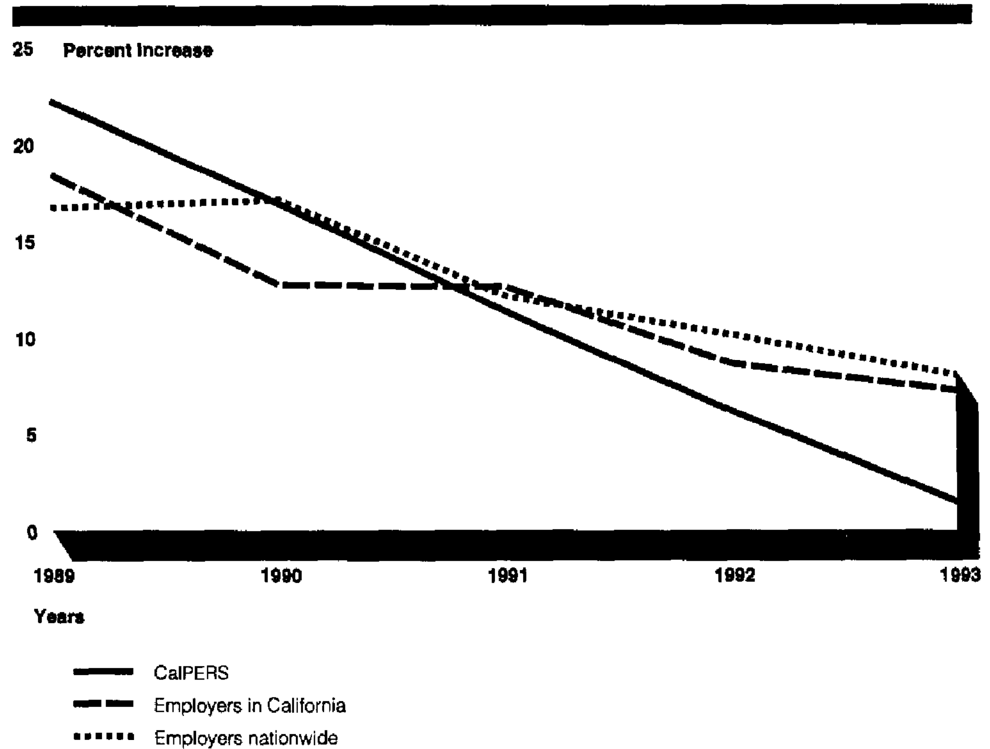
Prior to the 1992 contract year, CalPERS negotiated health insurance premiums that increased at rates near or above the average increases experienced by California employers and employers throughout the nation. Between 1989 and 1991, CalPERS' premium growth averaged 16.7 percent per year. Over the same period, employers nationwide experienced average increases of 15.3 percent per year and California employers faced increases averaging 14.5 percent per year.

More recently, CalPERS has negotiated premiums that grew more slowly than the average for employers in the state and the nation. The increase in CalPERS premiums averaged 6.1 percent in the 1992 contract year, compared with 10.1 percent for the nation. This dramatic decline reflects, in part, the overall trend in insurance premiums throughout California. After several years of double-digit increases, California employers' rates grew by only 8.6 percent in 1992. CalPERS has continued the downward trend in premium growth by negotiating rates averaging a 1.4-percent increase for the 1993 contract year. Premium increases for the state and the nation have also declined this year but not as sharply. Figure 1 shows the trend in health plan cost growth reported by CalPERS, California employers, and employers nationwide.[9] In preparing for the 1994 rate

[9]Prior to 1993, CalPERS premiums, in dollar terms, were consistently higher than national averages and below California averages. Changes in CalPERS premiums, as well as national and statewide insurance rates, follow a cyclical pattern.

negotiations, CalPERS has asked for a 5-percent premium reduction without benefit reductions.

Figure 1: Average Annual Premium Increases for CalPERS, California, and the Nation, 1989-1993



Source: Data on CalPERS premium increases were provided by CalPERS. Data on California and nationwide premium increases for 1989 through 1992 were provided by Foster Higgins; for 1993, data were provided by KPMG Peat Marwick.

State Financial Crisis Provided Impetus for Slower Premium Growth

An important factor in CalPERS' ability to negotiate more modest premium increases in recent years has been the condition of California's economy and budget. In the early 1990s, the level of economic activity in the state declined sharply, drastically reducing state revenues. Faced with a budget shortfall of $14 billion, the state legislature decided to limit its funding of employee health benefits. Thus, CalPERS negotiators may have been able to capitalize on the particularly harsh effects of the recession to contain increases in health plan premiums.

The state of California sought to contain the amount it contributes toward premiums by revising the way the contribution is determined for its active

workers. Previously, the state paid an amount equal to nearly 100 percent of the weighted average premium of the four largest health plans for employees and 90 percent for employee dependents. Since the 1992 contract year, the state agreed to set the contribution in collective bargaining agreements with state employee unions. It now pays a fixed amount, frozen at the 1991 level until renegotiated in 1994.

Despite the state financial crisis, California did not change the way it funds health benefits for its retirees, who account for approximately 22 percent of CalPERS members. The state contribution for retiree benefits continues to be based on the average premium of the four health plans with the largest enrollment.[10] Depending on family size, the state contributes between 5.2 percent and 7.5 percent more for retired workers than it does for active employees in contract year 1993.

Although the state froze contributions to reduce state expenditures, the change also made active state employees more sensitive to premium rates and gave plans an incentive to keep their rates close to the state's contribution. State employees may still enroll in one of several lower cost plans with little or no premium contribution, but when they choose one of the more expensive plans, they must pay the difference.[11] As shown in table 1, the premiums for the PPO plans require active state employees to contribute as much as $227 per month or 36 percent of the monthly premium. In contrast, the HMO plans require contributions of no more than $38 per month or less than 9 percent of the monthly premium.

[10]In January 1993, the four largest health plans were PERSCare, Kaiser Northern California, Kaiser Southern California, and Foundation Health Care. Together these plans accounted for about 60 percent of CalPERS' total enrollment.

[11]State workers' contributions to premiums generally are higher than those of state retirees and some nonstate employees. Some participating employers have followed the state's lead by adopting its fixed contribution level.

Table 1: State and Employee Contributions to Premiums for Family Coverage in Selected CalPERS Plans, 1993

		Active employees		Retired employees	
	Monthly premium	State share	Employee share	State share	Employee share
PPO plans					
PERSCare	$637	$410	$227	$431	$206
PERSChoice	499	410	89	431	68
HMO plans					
Kaiser North	424	410	14	424	0
Kaiser South	448	410	38	431	17
Foundation Health	430	410	20	430	0
Health Net	423	410	13	423	0
Cigna	408	408	0	408	0

Source: Data on premiums and state contribution levels provided by CalPERS.

CalPERS Leverages Its Buying Power to Negotiate Small Rate Increases

CalPERS officials contend that in recent years the program has begun to take advantage of its size in the health care market. As a large purchaser, representing nearly 900,000 people, CalPERS was able to negotiate more effectively and influence the behavior of health plans. Officials we interviewed at 10 participating health plans stated that CalPERS is one of their largest accounts. However, CalPERS' inability to perform better than national averages prior to 1992 suggests that size alone was not sufficient to hold down premium increases.

CalPERS began to exert its market power when it sought a zero increase in HMO premiums in negotiations for the 1992 contract year. In letters sent to health plans prior to those negotiations, officials cited the state's worsening fiscal problems and announced a departure from "business as usual." CalPERS asked the HMOs to freeze rates and benefits at the 1991 levels without changing their benefits to adjust to premium concessions. Two plans that accounted for about 40 percent of CalPERS members, Kaiser Northern California and Kaiser Southern California, insisted on increases of more than 10 percent, citing their richer benefit packages. Although CalPERS officials agreed, they demonstrated their serious negotiating stance by temporarily barring new enrollment in the Kaiser plans.[12] CalPERS held the other plans to average premium increases of 3.1 percent, with 5 of the 22 plans responding with zero increases or modest reductions in premiums.

[12]The freeze on new enrollment in Kaiser plans lasted from August 1, 1992, to April 1, 1993. Kaiser officials estimate that its plans lost 4,000 enrollees due to this sanction.

Its most recent rate negotiations were even more successful. CalPERS held premium increases to an average of 1.4 percent for the 1993 contract year. CalPERS' new standardized benefit structure (discussed below) allowed the Kaiser health plans to reduce their premiums by 2 to 3 percent, while other participating health plans increased their premiums an average of 3.7 percent. CalPERS has continued to pressure plans to reduce their administrative costs, unnecessary care, and provider reimbursement. Table 2 shows CalPERS premium rate increases for 1989 through 1993 for PERSCare and the four largest HMO plans (as of 1992).

Table 2: Premium Increases for Selected CalPERS Plans, 1989-1993

	1989	1990	1991	1992	1993
All plans	**22.2%**	**16.9%**	**11.3%**	**6.1%**	**1.4%**
PERSCare	30.1	16.6	9.5	4.9	7.9
HMO Plans	16.2	17.9	12.1	6.9	–0.4
Kaiser North	15.9	22.2	15.7	10.2	–2.2
Kaiser South	12.2	19.0	13.0	10.7	–3.3
Foundation Health	18.1	13.3	12.5	2.9	0.0
Health Net	26.4	6.8	11.3	4.6	0.5

Source: CalPERS.

Standardized Benefits Contributed to Lower Premium Increases by Altering Coverage and Copayments

The adoption of a standardized HMO benefit package was a key factor in helping CalPERS achieve an average premium increase of 1.4 percent for contract year 1993. In the past, participating HMO plans provided basic health care coverage, but they could vary patient charges, benefit definitions, and limitations. To make comparisons of plans easier, CalPERS has required that all HMO plans now offer nearly identical coverage and patient charges.

Benefit standardization contributed to slower premium growth in two ways. For program negotiators, it focused rate negotiations on the cost of plans instead of benefit design and copayment differences. For most HMO enrollees, the standardization of benefits has brought changes in both the scope of services covered and the amount of out-of-pocket costs. Of the $95 million CalPERS estimates it saved in total premium costs in 1993, it attributes $53 million to aggressive negotiations and $42 million to changes in benefits.

CalPERS staff developed the basic benefit package through discussions with its 17-member Health Benefits Advisory Council, participating health

plans, employers, and employee groups. (App. II describes in greater detail the CalPERS standardized benefit package and how it was developed.) CalPERS now requires that each plan provide the same scope of coverage for such benefits as physician and hospital care, diagnostic services, and prescription drugs. Some plans had to expand coverage for substance abuse services and skilled nursing care, while others had to reduce coverage for mental health services.

The standardization also required more uniform copayments. As a result, many HMO plans now require new or increased out-of-pocket costs. By standardizing copayments for physician office visits, for example, 13 of the 18 HMOs continuing as CalPERS health providers from 1992 had to increase costs to patients. At the same time, three HMOs had to lower copayments for prescription drugs.

Representatives of some state employee organizations have argued that the implementation of a standard benefit package is an adverse development. By restricting a member's ability to choose a plan that offers better coverage for the services the individual uses most often, standardization has eliminated the program's flexibility. CalPERS officials, on the other hand, believe the package streamlines the plan selection process by allowing members to make their plan choices based on price and other factors rather than benefit structure.

Impact on Members Varies by Plan

The recent changes undertaken in the management of the CalPERS Health Benefits Program have yielded mixed results for its members. After several years of double-digit rate increases, CalPERS' success in negotiating slower growth in premiums is an obvious benefit for many members. At the same time, however, the steps taken to limit the state's contribution to premiums and to standardize the benefits package have shifted rather than lowered costs for some members.

Health plans have different premiums, and the amount an employer contributes toward the premium differs among the public agencies participating in CalPERS. For active state government workers, the introduction of a fixed state contribution to premiums has meant that some members contribute a larger share of the premium to stay with or select certain plans. For nonstate agencies, employers must pay a minimum of $16 per month toward the premium and the member pays the balance. Depending on the plan, a member's monthly contribution could range from zero to $611.

The 1993 requirement to narrow the variation in benefits affected members in different ways. Enrollees in plans that previously provided richer benefit packages saw reductions in their coverage or increases in their out-of-pocket costs that largely offset the contained premium growth. For example, Kaiser officials contend it is the revenues to be collected from newly instituted patient copayments that have allowed the plans to reduce premium rates.[13] Previously, Kaiser enrollees could visit their physicians without having to make any copayment, and they could buy prescription drugs for a $1 fee. Under the standardized benefit package, enrollees must pay $5 for each physician office visit and drug purchase. As a result, Kaiser reduced its 1993 premiums by 2.2 percent for northern California and 3.3 percent for southern California. By contrast, other HMO plans, some of which already required $5 copayments, could not shift cost increases from premiums to copayments. Their 1993 rates increased 1.7 percent, on average.

Elements of Managed Competition May Partially Explain CalPERS' Recent Success

CalPERS' relative success in controlling health insurance premium increases for its members has been cited as an indicator of the cost-containment potential of managed competition. While CalPERS embraces some of the elements of managed competition, it is difficult to tie its cost containment record to these elements. CalPERS itself has maintained, in a letter to you, that its health program was not modeled after managed competition, as defined by the authors of the term.[14] It is possible that some of the elements of managed competition included in the CalPERS program contributed to its recent success. However, there are clear differences between the CalPERS program and managed competition.[15] Thus, it is inappropriate to characterize CalPERS' recent experience as an indicator of the potential effectiveness of managed competition in constraining health insurance premiums. Table 3 illustrates the extent to which CalPERS embraces some of the most common features of managed competition.

[13] Kaiser officials noted that because their plans are community rated, costs of caring for CalPERS members have not been shifted to other employers with whom they contract.

[14] See letter addressed to you from William Dale Crist, President, Board of Administration, dated March 4, 1993.

[15] There are a number of variants on the managed competition approach. In making our comparison, we used the plan developed by Alain Enthoven and his colleagues, known as the Jackson Hole Group.

Table 3: Comparison of Key Features of Managed Competition With CalPERS

Managed competition	CalPERS
A single entity acts as purchasing agent for all small firms and individuals in the market area	CalPERS acts as purchasing cooperative, but membership is limited to public employers such as the state, counties, and cities
Employer contributions toward premiums are limited to the cost of the lowest-price health plan	Employer contributions are fixed for active state employees. Contribution amounts differ for state retirees and other members
Consumers may choose from a variety of health plans	CalPERS offers 27 health plans; availability varies by geographic location
Standardized benefits and coinsurance are required under all plans	CalPERS began standardized benefits and coinsurance for the 1993 contract year
Plans must offer open enrollment and base premiums on community rating	Annual open enrollment season and community rating apply for all employer groups
System must provide universal health insurance coverage	Most CalPERS members reside in California where nearly 20 percent of the population is uninsured
Payments to insurers are risk-adjusted	CalPERS makes no attempt to risk-adjust premiums
Consumers are provided with information on the quality and outcomes of competing health plans	CalPERS is beginning to collect quality and outcome data but currently does not share data with consumers
Tax deductibility of premiums is limited	CalPERS has no authority to affect federal or state tax policy

CalPERS is similar to managed competition in three major respects: (1) it serves as a health insurance buying cooperative for a large number of employers,[16] (2) it annually offers all enrollees a choice of several competing health plans, and (3) it uses a standardized or community premium rate for all eligible employees. These features have been part of the CalPERS program since 1968, a period that includes the recent 2 years of relative success in constraining premium growth and several previous years when premium growth fared no better than national averages. Therefore, it is difficult to directly attribute CalPERS 1992 and 1993 cost-containment performance to these shared elements. However, these elements do contribute to another benefit expected from managed competition: improved access to health insurance for small employers. Small public employers throughout California are able to offer their

[16]Approaches to managed competition differ on whether negotiation of premium rates is an appropriate role for an insurance cooperative. Some approaches view the power of a large cooperative in negotiations with insurers as a key element of the cost-containment potential of managed competition, while other approaches suggest that purchasing groups should not have the authority to negotiate rates.

employees and retirees a choice of health plans at premium rates that are not typically available to nonparticipating small employers.

CalPERS is beginning to introduce other elements associated with managed competition: (1) the requirement that HMO plans offer a standard benefit package and (2) collection of quality of care data on its competing health plans. Although the standardization of benefits assisted CalPERS in achieving lower premiums with some plans in contract year 1993, the ongoing cost-constraining influence of this feature will not be evident until we see how consumers respond over the next few years. Similarly, CalPERS has only recently begun collecting information on outcomes of care and patient satisfaction and, thus far, has not shared this information with members. Access to this information, so that consumers can make informed choices among health plans, is an important element of managed competition.

A number of key features of managed competition are absent from the CalPERS program, including (1) a limit on employer contribution for insurance premiums set to the least expensive health plan and (2) a mechanism for risk adjusting premiums to ensure that plan selection is not affected by the demographic characteristics of members choosing that plan. As noted earlier, the state has temporarily frozen its premium contribution for active state employees, but CalPERS permits member agencies to vary the employers' contribution for enrollees. (Over time, the state contribution may, in effect, tend toward the cost of the least cost plan.) Also, CalPERS is aware that some plans attract a larger proportion of older workers and retirees, but it makes no attempt to risk-adjust premiums.[17]

Managed competition also embraces features that characterize the general health care environment and that are outside the control of an individual purchasing cooperative such as CalPERS. These include (1) universal coverage or a mandate that employers or individuals have insurance coverage and (2) restrictions on tax deductibility of employers' insurance premiums. In California, about 20 percent of employed individuals are uninsured, and neither CalPERS nor the state of California can mandate employer-provided coverage. Similarly, CalPERS cannot alter the tax code to provide incentives for consumers to choose the least cost plan. These elements of managed competition are beyond the scope and control of CalPERS.

[17]The state contribution formula for retirees is based on the average cost of the four largest plans, which include some of the most expensive plans. As a result, the retiree's share of the premium cost is generally smaller than it would otherwise be, exacerbating the adverse selection.

CalPERS Comments

CalPERS officials reviewed a draft of this report and said it fairly and accurately describes the mechanics of the CalPERS Health Benefits Program and their efforts to reduce health care costs for the employers and employees they represent.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to others on request. If you or your staff have any questions about this report, please call me at (202) 512-7119. Other major contributors are listed in appendix III.

Sincerely yours,

Mark V. Nadel
Associate Director, National and
Public Health Issues

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Abbreviations

CalPERS	California Public Employees' Retirement System
HMO	health maintenance organization
PPO	preferred provider organization

Organization and Operations of the CalPERS Health Benefits Program

In 1931, the California legislature created CalPERS to administer the retirement program for state employees. In 1962, the CalPERS Health Benefits Program was established to purchase health care for state employees, and authority was expanded in 1967 to allow other public employers to obtain insurance through the program. As of August 1993, CalPERS covered 877 public employers representing 899,199 enrollees at a total annual cost of approximately $1.4 billion. This appendix provides detailed information on the CalPERS Health Benefits Program—specifically, the program's eligibility requirements, the types of health plans offered and plan enrollment, and the program's financing and administration.

Program Eligibility

Eligibility requirements for public employers participating in the Health Benefits Program include the following:

- Employers cannot restrict enrollment due to pre-existing conditions, age, or sex.
- Employers must provide coverage for all full- and half-time employees and for retirees in covered employee groups but cannot provide coverage for employees who work less than half-time.
- Employers must contribute a minimum of $16 per month for each active employee and retiree[1] and may contribute up to the full cost of the premium including the cost for family members.
- Employers must allow their employees to choose from any of the health plans that CalPERS offers.
- Employers cannot impose a waiting period for enrollees. Coverage begins the month following enrollment for all employees and retirees of the employer.

In order to participate in CalPERS, health care plans must meet various program requirements as well:

- Plans must submit annual data on the costs and utilization of services.
- Plans must allow CalPERS to conduct an annual audit of their operations including a review of their financial statements, internal controls, and quality of care procedures.
- Plans must agree to accept all enrollees regardless of pre-existing conditions and cannot limit treatment of pre-existing conditions.

[1]Employers who have joined CalPERS on or after January 1, 1986, do not initially have to contribute an equal amount for active and for retired employees but must make yearly increases of at least 5 percent of the active employee contribution until the employer contribution for retired employees equals the employer contribution for active employees.

- New plans must show that they offer coverage in geographical areas where CalPERS members do not have access to an HMO.[2]

Types of Plans and Enrollment

In contract year 1993, the CalPERS Health Benefits Program offered a choice of 27 health plans, consisting of 21 health maintenance organizations (HMO)—including 3 out-of-state HMOs, 2 self-funded preferred provider plans (PERSCare and PERSChoice), and 4 employee association preferred provider plans. Not all plans are available to all employees. To enroll in an HMO, a member must live in a certain geographic area. To enroll in an association plan, a member must belong to that specific employee association. Only three HMOs are available to out-of-state members. Table I.1 shows the distribution of enrollment across health plans.

[2]Because CalPERS believes it offers a sufficient number of plans in most areas, since 1987, CalPERS has not been contracting with new health plans unless the plans offer expanded geographical coverage in areas where members do not have access to an HMO.

Table I.1: Enrollment in CalPERS Health Plans, August 1993

Plan	Enrollment
Total	**899,199**
Kaiser Northern California	183,404
PERSCare	134,043
Kaiser Southern California	134,024
Health Net	82,394
Foundation Health	79,373
Cigna	36,099
TakeCare	32,571
PacifiCare	30,604
Blue Shield HMO	21,500
Valucare	21,005
QualMed	20,145
California Association of Highway Patrolmen—Prudent Buyer Plan[a]	15,469
Lifeguard	14,451
California Correctional Peace Officers Association[a]	13,827
Aetna of Southern California	12,002
CaliforniaCare (Blue Cross)	10,365
Maxicare of California	10,022
PERSChoice	8,651
FHP Health Care	8,143
Health Plan of the Redwoods	7,314
Aetna of Northern California	7,298
Omni	6,936
Peace Officers Research Association of California[a]	5,193
California Professional Firefighters Association[a]	4,217

[a]Eligibility requires association membership.

Source: CalPERS. Included in the total but not shown separately are three out-of-state plans that have a combined enrollment of 149.

PERSCare and PERSChoice

In 1989, CalPERS created PERSCare, a self-funded health plan developed to replace three CalPERS fee-for-service health plans. PERSCare offers its enrollees access to a large preferred provider network; it has contracted with about 36,000 physicians, or 83 percent of the total physicians in California, and 270 California hospitals. PERSCare offers a preferred provider option to members who live out-of-state or in rural areas not covered by an HMO and to members who prefer greater flexibility in

selecting health care providers. In fact, over 80 percent of PERSCare enrollees live in areas of California covered by CalPERS-contracted HMOs.

PERSCare is often selected by older CalPERS members; the average age of a PERSCare enrollee is 55 years, compared with CalPERS' overall average of 36 years. Because PERSCare serves a population with higher health risks, its premiums are higher than those of participating HMOs. In addition, enrollees pay higher out-of-pocket costs for PERSCare than they would in an HMO. For services provided through the network, enrollees must pay 10 percent of the costs for hospital and physician services after applicable annual deductibles. When services are obtained from a nonnetwork provider, enrollees are generally responsible for 40 percent of the charges.

In July 1992, the CalPERS Board of Administration approved a second self-funded, preferred provider plan, PERSChoice.[3] Available for the 1993 contract year, PERSChoice is designed as a more affordable option for members who want a fee-for-service plan. Although it has lower premiums than PERSCare, enrollees must generally pay higher deductibles and coinsurance payments.[4] PERSChoice is expected to be an attractive option for many members, especially for families in rural areas where no HMO is available.

To provide further alternatives for members in rural areas, CalPERS has encouraged HMO plans to expand into unserved portions of the state and to geographical areas where members have limited health plan options. As previously noted, CalPERS has been requiring all new plans to offer coverage in geographical areas where CalPERS members do not have access to an HMO. As a result of these efforts, fewer members are now without an HMO option. Eleven plans expanded their service areas for the 1993 contract year, and three new HMO plans were added (two outside the state).

[3]Until PERSChoice was established, members in rural areas of California generally had one option for health insurance—PERSCare, the most expensive plan. As a result, state legislation provided a premium subsidy for CalPERS members who lived in areas where no HMO option was available. This subsidy expired July 31, 1993.

[4]A coinsurance payment is a fixed percentage of covered expenses paid by an enrollee after any deductible has been met.

Financing

Premium Rates

Each CalPERS plan has three basic premium levels: employee only, employee and one dependent, and employee and the employee's family.[5] The premiums are applicable to all CalPERS members enrolled at these coverage levels, regardless of age, sex, or any other factors. Table I.2 shows the monthly family premiums for the health plans in contract year 1993.

[5]CalPERS negotiates separate rates with health plans to cover members needing supplemental Medicare coverage.

Table I.2: CalPERS' Monthly Health Plan Premiums for Family Coverage, 1993

Plan	Monthly premium[a]
PERSCare	$637.00
Peace Officers Research Association of California[b]	559.56
California Correctional Peace Officers Association[b]	517.96
PERSChoice	499.00
California Association of Highway Patrolmen—Prudent Buyer Plan[b]	489.46
Kaiser Southern California	448.42
Lifeguard	438.90
PacifiCare	435.70
State's premium contribution for retired workers' families	**431.00**
Foundation Health	429.94
Valucare	429.50
TakeCare	428.33
Maxicare of California	425.47
Kaiser Northern California	423.71
Health Net	422.93
QualMed	420.68
Blue Shield HMO	415.00
FHP Health Care	411.87
State's premium contribution for active workers' families	**410.00**
Aetna of Northern California	410.00
Aetna of Southern California	410.00
Health Plan of the Redwoods	410.00
California Professional Firefighters Association[b]	410.00
Cigna	407.98
Omni	404.20
CaliforniaCare (Blue Cross)	401.53

[a]These premiums are for the basic health plans; premiums differ for supplemental Medicare coverage.

[b]Eligibility requires association membership.

Source: CalPERS. Not shown are three out-of-state plans that have a combined enrollment of 149.

Contributions

The share of the premium paid by an employee varies depending on the employer's contribution. Recently, California state law was amended to change the way the state's contribution to premiums is determined for its employees. Until 1992, the state used the same formula to calculate its

contribution for both active and retired workers. It paid an amount equal to 100 percent of the weighted average premium of the four largest plans for single coverage and 90 percent for dependent coverage.

The state's contribution levels for active employees are now determined through collective bargaining agreements with state employee groups. They are currently set at $174 for single coverage, $323 for two-party coverage, and $410 for family coverage, and have been frozen through 1994. However, the state's contribution for its retired employees (22 percent of all state enrollees) remains subject to the earlier formula. For contract year 1993, the state contributes $187 for single coverage, $345 for two-party coverage, and $431 for family coverage.

Administration

Program Management

The CalPERS Board of Administration governs the Health Benefits Program as well as other benefit programs. As mandated by law, the Board is composed of 13 members: 6 are elected by the membership of CalPERS,[6] and 7 represent the public, a life insurer, the state government, and other participating employers.[7] No representatives of health insurance carriers or providers are currently on the Board, although the law does not specifically prohibit such members. The Board has exclusive authority for the administration of the Health Benefits Program. The board's staff, the Health Benefits Committee, and the Health Benefits Advisory Council also play key roles in managing the program.

An 87-person staff makes up CalPERS' Health Benefit Services Division and Health Plan Administrative Division. The Health Benefit Services Division, with 65 employees, performs enrollment-related activities including processing, adjusting, and deleting enrollee coverage. It also distributes health benefit information booklets and acts as a liaison between the

[6]Of these six, two Board members are elected by all CalPERS members, one is elected by active state members, one is elected by active local members of CalPERS who work for a school district or a county superintendent of schools, one is elected by the active local members other than those employed by a school district or county superintendent of schools, and one is elected by retired members.

[7]Of these seven, one member is from the State Personnel Board; three (the Director of the Department of Personnel Administration, the State Controller, and the State Treasurer) are members by virtue of their appointed or elected positions in the California state government; two members, a representative of a life insurer and an elected official of a public agency, are appointed by the governor; and one member, a public representative, is appointed by the California Legislature.

enrollees and health plans in resolving claim service problems. The Health Plan Administration Division, with 22 employees, negotiates rates and contracts with individual health plans and oversees the two CalPERS self-funded health plans. It also evaluates and monitors the financial stability and delivery of medical services of 21 HMOs and four association plans.

The Health Benefits Committee is composed of six Board members, appointed by the Board President, who review proposed premium rates for all health plans contracting with CalPERS. The negotiated rates are then presented to the Board for approval. The committee also investigates any health benefit plan wanting to contract with CalPERS and makes a recommendation to the Board.

The Board of Administration has appointed a Health Benefits Advisory Council to provide medical, technical, and health policy advice on all matters relating to the Health Benefits Program. The Council currently has 17 members and consists of doctors, economists, health plan executives, consultants, and other experts in the health benefits field. These members review health benefit issues and make recommendations to the Board based on their findings.

Administrative Costs

Since 1988, CalPERS has charged employers 0.5 percent of their health care premiums to cover the cost of administrative services.[8] The administrative fee is used to pay all costs associated with enrollment and processing as well as prorated expenses for the CalPERS building, utilities, and related expenditures.[9] In contract year 1993, CalPERS expects revenues from administrative fees to amount to about $7 million.

CalPERS' low administrative fee is particularly beneficial for small employers but may be less so for the state. Small groups (with 1 to 50 employees) generally pay 25 to 40 percent of claims for administrative expenses when purchasing health insurance independently. By participating in a large purchasing cooperative, their plan costs are substantially reduced. At the same time, however, the state may be paying more than is required to administer the program for its own enrollees. According to the California Department of Personnel Administration,

[8]State law allows the CalPERS Board to charge between 0 and 2.0 percent of the gross premiums as an administrative fee.

[9]It does not pay for overhead costs such as those for accounting, executive, and legal staff. These costs are paid through other CalPERS programs.

administrative costs should not be increasing at the same rate as premiums, and the current 0.5 percent of premiums overcharges the state.

To administer the PERSCare and PERSChoice plans, CalPERS contracts with three companies—one to manage the operation of the plans, one to provide utilization review, and one to administer pharmacy programs. In contract year 1992, the cost of administering PERSCare was 6.5 percent of premiums.

Contract Process

CalPERS begins negotiating premiums with health plans almost 1 year before the next contract year is to begin. To prepare for negotiations, CalPERS requires plans to submit data to support their rate requests including detailed information on the cost and utilization of services and how the plan is organized and managed.[10] CalPERS analyzes these data, as well as the paid claims data from PERSCare, to determine if the plans' proposed premiums are reasonable.[11] In meetings with each plan, CalPERS staff discuss the data and the proposed premiums and, in some cases, a plan revises its proposed rates. CalPERS staff then recommend the plans' premiums to the Board for approval. At such Board meetings, plans have the opportunity to discuss any unresolved issues regarding their rate proposals.

To better contain premium growth, CalPERS staff has begun to review how well the various plans are managing the costs of specific benefits on a per-member, per-month basis. CalPERS attempts to identify any higher-than-average costs in order to encourage plans to examine specific services and implement cost-containment techniques to lower costs. Several plan officials we met with stated that while they were interested in such feedback, they doubted the accuracy of the data, given the lack of standardized reporting.

[10]The data collection and analysis were less extensive before the 1993 contract year negotiations.

[11]The plans adjust their premiums for CalPERS based on such factors as age, sex, and utilization of services by CalPERS members enrolled in their plans. CalPERS primarily considers age when assessing each plan's proposed premiums.

Standardization of the HMO Benefit Package

In August 1993, CalPERS implemented a standardized health benefits package and copayment structure that all participating health maintenance organizations (HMO) must offer. CalPERS expects this standardized package to simplify plan selection; provide a more comprehensive, uniform scope of benefits; reduce administrative costs; and significantly improve CalPERS' ability to negotiate affordable premiums. Eighty percent of CalPERS' members and their families are currently enrolled in HMO plans and thus are directly affected by the standardized benefit design.

Prior to the institution of the standardized package, HMOs had the flexibility to establish copayments as well as benefit definitions, limits, and exclusions to differentiate themselves from their competition. Such flexibility resulted in a wide variation of benefits and copayments among HMO plans.

According to CalPERS officials, the proliferation of HMO plan variations became "absurd," confusing the premium negotiation process and hindering plan selection. These officials contend that the plan variations made it difficult for them to measure the value of each plan, and the volume of data needed to compare the plans proved overwhelming to members in the plan selection process. For example, CalPERS determined that 15 separate benefits had copayment variations accounting for hundreds of possible combinations of charges, benefits, and plans. Further, there were four different copayment charges for physician office visits, and nine separate charges for prescription drugs with three different volume limitations.

In 1992, CalPERS designed an HMO standard benefit package to "make the benefit design more uniform without reducing the scope of benefits currently available." However, for most HMO enrollees, benefit standardization has brought changes in both the level of copayments and the scope of services covered. Some HMO enrollees had benefits reduced or expanded or must now pay a copayment for services where such a charge was not previously required. CalPERS estimated that implementing standardized benefits resulted in a $42 million savings in premium costs to both members and employers.

Table II.1 shows CalPERS' standardized benefits package for contract year 1993. This package consists of 13 standard benefits, 3 required benefits, and 4 optional benefits. For the standard benefits, such as hospital inpatient care, physician visits, and prescription drugs, HMOs must provide

the same scope of services and charge the same copayment. For the required benefits, HMOs must offer emergency, out-patient mental health, and outpatient substance abuse services, but may vary the number of visits or copayments within established ranges. The four optional benefits, which HMOs may or may not offer, also have established service and copayment requirements.

CalPERS plans to continue refining the standard package to better reflect the scope of benefits its members previously received. It is considering including some required and optional services as standard HMO benefits in future contract years.

Table II.1: CalPERS' Standardized Benefits Package for HMOs, 1993

Benefit category	Copayment
Standard benefits	
Hospital care	
Inpatient	No charge
Outpatient	No charge
Physician services	
Office visits	$5/visit
Allergy testing/treatment	$5/visit
Hearing exam/testing	$5/visit
Immunization/inoculation	$5/visit
Gynecological exam	$5/visit
Periodic health exam	$5/visit
Well baby care	$5/visit
Inpatient hospital visits	No charge
Surgery/anesthesia	No charge
Eye refraction (age 17 & under)	$10/visit
Diagnostic X-ray and laboratory	No charge
Prescription drugs	
30-day maximum supply for short- term or acute illnesses	$5/prescription
90-day supply of maintenance drugs	$5/prescription
Durable medical equipment (including orthotics and prosthetics)	No charge
Infertility testing and treatment	50% of charges
Inpatient mental health (maximum 30 days per year)	No charge
Inpatient substance abuse (detoxification only)	No charge
Ambulance service	No charge
Home health care	No charge
Skilled nursing care (maximum 100 days per year)	No charge

(continued)

Speech/physical/occupational therapy (short-term therapy, maximum 60 days per condition)	$5/visit
Hospice care	No charge
Required benefits	
Emergency services (copayment waived if hospitalized)	$5/visit to $50/visit
Outpatient mental health (20 visits per year)	$20/visit
Outpatient substance abuse (20 visits per year)	$5/visit
Optional benefits	
Acupuncture (up to 20 visits per year)	$5/visit
Chiropractic (up to 20 visits per year)	$5/visit
Eye refraction (adult; 1 visit per year)	$10/visit
Prescription drug—mail order (minimum 90-day supply of maintenance drugs)	$5/prescription

Source: CalPERS.

Major Contributors to This Report

Human Resources Division, Washington, D.C.

Sarah F. Jaggar, Director, Health Financing and Policy Issues
Michael Gutowski, Assistant Director, (202) 512-7128
Rosamond Katz, Assignment Manager

Los Angeles Regional Office

Ronald Viereck, Regional Assignment Manager
Tim Fairbanks, Evaluator-in-Charge
Shawnalynn Smith, Staff Evaluator
Susan Spitzer, Staff Evaluator

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