CalPERS STRATEGIC PLAN

INTRODUCTION

CalPERS capitalized on the evolution of California's competitive health care system and the growth of the managed care industry to provide its members unprecedented value and relative stability in the 1990s. The easy savings in the migration from indemnity to managed care, from leveraging excess provider capacity and volume uncertainties, and the savings from the positive effects of Medicare's DRG based reimbursement and Medicare's (then) healthy margins, temporarily obscured the underlying forces which are incessantly driving health care costs. CalPERS' success in the 90's is directly attributable to the growth and success of managed care in reducing the trends in health costs. This said, in a 2002 study of health care cost trends, Drew Altman and Larry Levitt of the Kaiser Foundation, concluded that health care costs trends (which rise at multiples of the CPI and well above GDP growth) have been largely untamed despite temporary respites by regulatory and managed care initiatives.

By 2000, it was becoming apparent that the forces of the commercial managed care market and the continued evolution of California's competitive health care delivery system on which CalPERS had relied, could no longer sustain the choice, value and price stability that enrollees and employers had come to expect. At its 2001 summer and winter offsites, the CalPERS Board heard from several experts that both the current health care delivery system and the health care insurance market were becoming increasingly dysfunctional and were in need of drastic restructuring.

In its highly regarded 2000 study, "Crossing the Quality Chasm", the Institute of Medicine observed:

> "The American health care delivery system is in need of fundamental change. The current care systems cannot do the job. Trying harder will not work."

The report provided its own blueprint for how both the health care and health care financing systems should be changed. Mark Smith, M.D., in his January 2002 appearance before the Board, pointed to a variety of fundamental changes in the current health and managed care market that suggested health care was "sailing into a perfect storm", the forces of which have not been previously experienced, and for which current practices and previous "solutions" would not work.

For CalPERS, the implications are compelling and formidable. CalPERS cannot expect significant change in program trends by continuing to focus on how, or through whom, it pays for coverage. Rather, to effect real change, CalPERS will have to engage its energies and influence in altering how health care is delivered, accessed, and financed in California.

In his January 2 letter to the CalPERS Board, David Lawrence, then Chairman and CEO of Kaiser Permanente, voiced a similar conclusion:

> "Purchaser and health plan costs have increased significantly and show every sign of continued growth at a rate that will substantially exceed the general rate of inflation. The root causes of these increases cannot be addressed simply through aggressive contentious, often highly publicized, negotiation of premiums charged by contracting health plans. Prudently controlling health benefit costs, while continuing to provide beneficiaries with the ability to obtain the rapidly expanding range of valuable medical technologies, requires thoughtful attention to both the manageable and unmanageable drivers of cost. These include:
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> - The aging population.
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> - Dramatic increases in the portion of the population with chronic conditions. Many of which can be mitigated through an increasing array of therapies, often at a significant cost.
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> - New and improved diagnostic and therapeutic technologies that can detect and prevent or treat disease, often at significant incremental cost.
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> - The large number of uninsured and underinsured Californians, and that the cost of care for these individuals is ultimately absorbed by those employers and individuals who do purchase coverage.
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> - A growing shortage of health care professionals in many fields, a situation that requires hospitals and other health care organizations to rapidly increase compensation.
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> - Regulatory and legislative mandates that have little impact on quality or effectiveness but add substantial costs.
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> - Costly investments in capital and infrastructure of the delivery system required as a result of capacity shortages and legislated requirements for seismic safety.
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> - Changes in Medicare payments that have not kept pace with cost and result in a cost-shift to employers.
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> - The shift away from capitated contracting by hospitals and other providers in favor of fee-for-service reimbursements."

POLICY IMPERATIVES and LONG TERM STRATEGY

In January we suggested that the response to these and other marketplace dynamics can be characterized in terms of four policy imperatives which the Board and staff must confront. They are:

COST

Health care premiums are expected to increase at an average minimum rate of 10% + CPI per year for rest of this decade. At this rate, the health premiums paid by our agencies and members will double every 5 to 6 years. It is unrealistic to assume a return to low or single digit rates in the near term. It is however, possible for CalPERS to achieve a reduced rate of increase, a more predictable trend, and improved value/outcomes for the dollars spent.

Ninety percent of premium costs are made up of provider costs and enrollee utilization; ten percent is in HMO/plan administrative cost. To deal more effectively with the cost issue, CalPERS will have to target efforts aimed at changing how all three interact: (plans, provider, and patients) and to work with all three in addressing underlying causes of higher price and increased utilization.

CalPERS should continue to use its leverage and contract negotiations to secure best services, price and value from plans/administrators. Margins for administrators should be adequate to provide needed care management, claims/data functions, and innovation, but not excessive in retention or profits. It is noted that for 2003 three of the four remaining plan vendors are not for profit.

Further consolidations of risk pools/plans are not likely to provide discernable savings or economies of scale, but may be desirable for other reasons. Unfortunately, the current "provider market" and broad network preference negate some additional potential savings. CalPERS should assist its vendor partners to secure better price and value by reconsidering its current "broad network mandate" and allow tiered or more restrictive networks of value providers in the near term. Over the longer term, it should seek to form distinctive networks of cost effective, high quality providers and assure that they remain committed toward further quality improvement and care management. The distribution of premium dollars within these provider networks should recognize and incent effective care management and quality improvement.

Perhaps the most critical change envisioned to deal with cost is to refocus competition not at the plan level, but at the provider level. It is recommended that CalPERS, using its new data warehouse (or in collaboration with other major payors), build a provider and physician profiling capacity that can ultimately provide CalPERS members meaningful comparisons. Such comparison ratings might include: safety; care quality; price/cost; service; outcomes; cultural sensitivities; as well as professional competencies. To fully realize the potential yield of this "provider market competition",

future CalPERS coverages should be designed to focus enrollees more on the quality and cost differences of providers, as well as incentives to use such.

In rural areas where tiered networks and provider competition may not be as effective against outlier pricing or performance, a special 3 to 5 year “target area performance improvement project” should be undertaken by CalPERS and its plan partners. It would use the combined data, informational, and care management resources to identify improvement opportunities within the local medical communities. Failure to progress toward a more normative mean within a set timeline could lead to less robust benefit options for area enrollees or payments based on set fee schedules more closely indexed to statewide averages.

There is validity in provider concern about “disproportionate cost burden” (uninsured, MediCal load, trauma service and rural care) not being adequately recognized in tiered arrangements. Hospital, physician and rural health experts could be invited to help identify methods to better reflect any such necessary variances in the evaluation and tiering of CalPERS networks.

Our plan vendors report that CalPERS enrollees are heavier users and users of higher cost providers than other commercial populations. We do have a slightly older average population than many commercial plans and hence a slightly more negative demographic profile. There is not however, documented evidence of overuse by our enrollees. Studies have demonstrated that increased enrollee awareness and participation in price and care decisions can diminish utilization without discernable drops in necessary care or health outcomes for most populations. CalPERS should seek to assure that its future benefit design changes encourage value awareness, prudent purchaser behavior, and greater enrollee awareness of variances in provider quality and performance, as this information becomes more available.

With the mapping of the human gene and with breakthroughs in biotics and biomedical engineering, the array of individually tailored drugs and therapies, biomedically engineered organs and parts are a near term reality. CalPERS should seek to assure that its members have access to these lifesaving innovations. Inevitably however, these will raise a host of moral, ethical, and equity issues, and further challenge total resources for CalPERS and other benefit plans. In the near term, CalPERS should consider individual lifetime maximums (or a reinsurance program for high-end/innovative care). Such consideration is particularly warranted in the self-funded plans. Any maximums should be indexed and/or be periodically revisited. Longer term CalPERS might join with other employer and Taft-Hartley plan leaders, leading scientists, medical ethicists and representatives of our enrollees in re-examining the adequacy of coverage, and the medically necessary decision processes to deal with these new emerging technologies and their human, ethical, and financial implications.

STABILITY

To our enrollees, stability may mean certainty of benefits, plan and provider selection. To our employers it may mean greater predictability in price, as well as plan choice. The managed care industry has consolidated into larger and more financially able plans. This has limited "choice" as defined in the Enthovian model of managed competition (e.g., at the plan level). CalPERS, initially in response to price issues but also inclusive of service and value measures, has consolidated its enrollees into larger plans and risk pools. By 2003, 98% of CalPERS risks will be in three larger, more stable pools. Evolving these plan partnerships into more strategic "shared management relationships" over longer contractual periods should help stabilize provider choice and improve performance and price predictability – assuming that similar strategic partnering and longer term relationships are developed by vendor partners with efficient quality-minded providers. This "stability opportunity" offered by this strategic long-term partnership approach is not without some risks. The first is the potential loss of some marginal economies that might be achieved by more frequent competitive procurements. There also is the "co-dependency" issue of being inherently more tightly tied to the larger fortunes (and provider relations) of our vendor partners. In turn, when these relationships have to be terminated, it is dramatic for both partners and impacts a large number of CalPERS enrollees. Finally, the size of CalPERS volume may make finding a replacement vendor a more difficult or protracted process.

Evolving the current risk arrangements from an insured toward a more self-funded basis may help insulate CalPERS from commercial "Wall Street" pressures and the industry's underwriting cycles. It will not however, protect against provider costs and pricing pressures. Indeed a concentration of CalPERS business into fewer plans may increase the exposure of CalPERS and its vendor partner to increased price demands and pressure tactics. In fact, self-funded (self-insured) arrangements offers some prospects of increased liability issues that CalPERS will need to evaluate.

The CalPERS Board has expressed its increasing concern about the impact of potential adverse risks to our plan's stability and price competitiveness. While remaining true to the purposes set forth in PEMHCA as a vehicle for providing public employers an attractive option for employee health benefits, CalPERS should seek legislative and regulatory standards that avoid exposing the program to identifiable, adverse risk. Envisioned here are standards that: prohibit alternative plans that might pose adverse selection; longer "out periods" for departing agencies; "non-compete protections" in outgoing vendor contracts; and increased entrance requirements - possibly some minimal underwriting or differentiated first year premiums for joining agencies.

Perhaps CalPERS greatest exposure to adverse risk and outside competition is our current "single statewide pricing" requirement. Both near and long term pressures will persist for better risks and/or groups from lower cost areas, to leave CalPERS, while higher-than-average geographic and demographic risk groups join or remain in CalPERS. Moving toward more regionalized pricing should be considered. An alternative approach would be to consider locally or regionally pricing any new optional

benefit enrichment packages. Implementing regional or multiple pricing, would require a long lead time to assure impacted labor and management groups could appropriately recalibrate their agreements and payroll systems.

CHOICE

Increasingly enrollees, constituent groups, and employers have requested a wider range of benefit plans; more flexible benefit designs; greater choice; and lower cost plan options. The disparities within our enrollees in terms of income, level of employer contribution, and local medical resources continue to grow. CalPERS staff is recommending that CalPERS re-define its "basic" or "foundation" benefit (that which CalPERS offers all enrollees regardless of location). Further, it is recommended that we provide a modest range of standardized complimentary benefit (enhancement) packages that might be selected by the employer, the bargaining unit and/or the individual. Furthermore, as noted previously, over time these benefit designs would seek to more actively engage the beneficiary in their care and cost management decisions, and in considering the relative cost quality and effectiveness of their provider and network choices. The goal would be to move enrollees from plan "brand" preference to an enlightened choice of benefit design and provider selections based on the enrollee's own health and financial needs.

Implicit in any new "enrollee choice" are major re-educational efforts complete with enrollee outreach campaigns, a major commitment to provider profiling, and the kinds of decision support tools and technologies that CalPERS has provided its members in its "retirement planner". The migration of this new benefit and provider choice will need to be coordinated with CalPERS risk management strategies (self funded or risk adjusted) to minimize risk of destabilization and adverse selection.

QUALITY/EFFECTIVENESS

In its January 2001 Offsite, the Board heard Dr. Arnie Milstein cite studies that suggest as much as 50% of the care provided in America – even in California – does not conform to scientifically or clinically proven best practices. Milstein went on to suggest that upwards to 30% of what is spent on health care (as it is currently being practiced) could be saved if known "best practices" were followed. Perhaps the greatest step CalPERS Health can take for the future health and well-being of its program and members, is to partner with other concerned purchasers and health care professional in reshaping and re-engineering how health care is delivered in California.

CalPERS should do so by:

1. Reaffirming and seeking to reinvigorate "managed care" (care management);

2. Realigning the (financial) incentives it provides plans and providers; and

3. Educating and incentivizing a more active engagement of enrollees in their own care management and disease prevention.

All CalPERS plans/products should provide as its principle approach to care, at least one form of care management – physician/provider managed, network/plan managed, and/or self-managed. Benefit design and plan care management should focus on the effective management of chronic care. An estimated two-thirds of CalPERS future costs will be for individuals who have one or more chronic conditions active care management.

CalPERS reimbursement of plans and their provider/network partners should insulate them from adverse selection due to their disease management proficiencies. It should move instead to target and more adequately reimburse actual care management and over the longer term performance and outcomes. The concentration of greater numbers of CalPERS lives into fewer plans should help provide critical and statistical mass by which vendors can invest in, monitor and reward more concerted care management efforts. CalPERS plan partners will be expected to in turn provide the appropriate recognition, support, and incentives of providers who actually manage their care in areas of heavy CalPERS populations.

Identification of better care giving performers and incentivizing CalPERS enrollees to consider such providers is but one step. Providing CalPERS enrollees informational resources, appropriate "care accessing" assistance is another.

Finally, it should be noted that the literature is mixed in terms of "demonstrated actual savings" that may accrue by more targeted disease and chronic care management. In part, this is due to the added cost of the management function and to the inevitable discovery of significant undiagnosed or untreated related conditions once care management starts. There is, however, little doubt about improved outcomes - for the patient and for the health delivery system in focusing more on patient needs, best practice, and in a more integrated approach. The proposition for CalPERS then would appear to be a win-win. Either lower cost or better care or healthier outcomes for its enrollees.

SHORT TERM OBJECTIVES

In the short term (1-3 years) we are proposing to complete the following business objectives in support of our strategic policy imperatives:

COST

1. By 2004/05, introduce incentive and risk-sharing arrangements into vendor contracts to gain better value for our health care expenditures.

2. By 2004, introduce a "tiered" product in our network HMO.

3. By 2006, establish a provider profiling mechanism, leveraging our experience and investment in our medical data "warehouse".

4. By 2003, reach agreement with our vendor partners on a joint plan to identify and address our most significant cost drivers.

5. By 2004, develop a service delivery improvement strategy that targets the highest cost communities with significant CalPERS' populations.

STABILITY

1. By 2005, include incentives for maintaining provider network stability in vendor contracts.

2. By 2004, adopt regulations to tighten public agency entrance, exit and alternative plan offerings.

3. By 2005, negotiate 3-5 year vendor contracts rather than the current single year agreements.

4. By June of 2003, present to the Board a strategy for minimizing or neutralizing the instability caused by geographic price differentials for health care services.

CHOICE

1. By 2005, introduce new product alternatives in currently underserved areas.

2. By 2005, pilot one or more consumer self-managed products.

3. By 2005, re-design the CalPERS' basic benefit to:
    a. Assure price sensitivity
    b. Increase prudent consumer choice
    c. Include better price stability
    d. Deal with new technologies and treatment protocols
    e. Include lifetime maximums

4. By 2005, implement consumer education and support technologies to assist members in making prudent and selective health care choices.

QUALITY/EFFECTIVENESS

1. By 2004, all plans will be required to offer at least 5 disease management, and a "high risk identification", programs targeted at CalPERS' members.

2. By 2004, target CalPERS specific, chronic conditions for active care management.

3. By 2005, establish specific performance incentives and penalties to maximize successful outcomes from these care and disease management programs.

CONCLUSION

The above implies a long-term commitment – not just to a new purchasing plan, but to trying to re-engineer health care in California. It is a formidable task and a long trek. There is no certainty for success. There is even greater risk in not undertaking the challenge.

Our proposed blueprint will move us closer to achieving the following vision of our future Health Benefits Program:

- CalPERS Health will (re)assert itself as a recognized leader in the provision of superior value employment-based health benefits.

- CalPERS will be the preferred choice of California's public employers, bargaining units, employees, and retirees alike because of superior value and more stable, effective products. Thus, enabling California's public employers to attract and retrain the needed workforce despite tight labor market by providing all of its enrollees the most comprehensive, highly valued, health benefits available in employment-based coverages.

- The cost increases of CalPERS coverages will be below the rest of the market (relative to our risks) and have become more predictable for enrollees and employers alike.

- CalPERS Health will provide all of its enrollees and employers (regardless of location) an affordable, comprehensive "foundation plan" and a limited choice of tiered enhancement products predicated on the price, cooperation, and capacities of local providers.

- CalPERS coverages will allow enrollees to take full advantage of any preferred tax treatment of health premiums and/or any other out-of-pocket costs that our enrollees may incur.

- CalPERS coverages will remain a "defined benefit plan" but the underlying coverage designs will be dynamic over time to adapt to new treatment technologies and modalities, and to recognize and accommodate health care inflation while still providing enrollees superior value and health security.

- All CalPERS Health enrollees will have the opportunity to make informed choices as to benefit design, form of care management, and provider networks based on consideration of the provider's competencies, quality,

service, outcomes and costs relative to the enrollee's health care and financial needs.

- In making these (above) choices, CalPERS enrollees will have access to world class health benefit planning, provider evaluative criteria, and decision support technology.

- The care provided CalPERS enrollees will be provided by distinctive networks of providers distinguished in their care management, outcomes, commitment to quality and safety, and their reliance on and use of scientifically-based clinically recognized best practices. CalPERS or its plan/administrator partner(s) reimbursement methods should re-enforce this.

- All CalPERS products will emphasize effective chronic care management, provide a range of care management options, as well as providing positive incentives for their use.

- CalPERS enrollees will be educated and motivated in lifestyle changes that improve their health status.

- Public and state agency employers (and their bargaining units) have access to and be incentivized to offer CalPERS approved workplace wellness, safety, and productivity programs, as well as on-sight lifestyle improvement and prevention programs.

- CalPERS Health purchasing power be leveraged to provide additional savings (enrollee value) in retail or allied health products and services (health club memberships, over the counter drug discounts, discounts with non-covered/non-traditional therapies).

- CalPERS leadership role in stabilizing/rationalizing its health care financing system and helping to re-engineer California's health care management/delivery system, will serve as platform for fomenting long overdue national debate on a more rational basis by which this country seeks to assure health care for its citizens.

If successful, there would no better legacy for CalPERS to provide its enrollees – and the state of California.