Agenda Item 10a

April 14, 2015

ITEM NAME: Semi-Annual Self-Funded Health Plans Report

PROGRAM: Health Policy Research Division

ITEM TYPE: Information

EXECUTIVE SUMMARY

Starting in 2014, California Public Employees' Retirement System (CalPERS) members had several new Health Maintenance Organization (HMO) health plan options. They included Anthem Blue Cross and Health Net, each with 2 HMO offerings; Sharp Health Plan, in San Diego County only; and United Healthcare. These plans received 16,071 Total Covered Lives (TCL) through open enrollment. In addition, Blue Shield with 2 plans, Kaiser, and the Self-Funded Preferred Provider Organization (PPO) health plans were also available. A new funding arrangement, called flex-funding, for all HMO plans except Kaiser was initiated starting in 2014. This report summarizes the financial results for these new plans, for Blue Shield, and for the PPO plans.

STRATEGIC PLAN

This agenda item supports Goal A, Improve long-term health benefit sustainability by ensuring high quality, accessible and affordable health benefits.

BACKGROUND

This report is to provide the Committee with an update on the financial status for the six (6) CalPERS PPO plans and the eight (8) flex-funded HMO health plans.

ANALYSIS

PPO Plans

Attachment 1 summarizes the results for the PPO plans. Actual Reserves, or assets, for the PPO plans are currently $699.2 million, which is a decrease of $58.2 million from the assets at the end of 2013. Required reserves for the PPO plans are $493.6 million, which is an increase of $31.1 million over the required reserves at the end of 2013. Actual reserves above the actuarial reserve requirements are $205.6 million. Overall, the Self-Funded PPO health plans have a ratio of assets to reserves of 142 percent.

For calendar year 2014, there was an overall loss of $74.6 million for all six (6) self-funded PPO health plans. The gain or loss evaluates revenue against claims and expenses. Revenue includes premiums, drug rebates, subsidies from the EGWP

program, and investment income. The largest contribution to the loss was from the Choice Basic plan, due to unfavorable claims experience.

Medical claims costs are currently exhibiting favorable trends. On a year over year basis, for Care, the basic plan is trending very favorably at -9.6% and the Medicare plan is also trending very favorably at 2.4%. After 2 years of low single-digit trends, the trend in Choice basic has increased to 7.5%. Choice and Select Medicare had an extremely favorable trend of 0.8%. The medical trend for Select basic slowed considerably during the second six months, ending the year at 2.9%.

Pharmacy claims costs continue to experience double-digit trends, except for Care basic, which actually had a negative trend of 2.4%. Choice basic and Select basic had trends in excess of 20%, while the Medicare plans had increases in the 12% range. Specialty drugs continue to fuel the large increases.

When the medical and pharmacy trends are combined, Care basic was the best performing plan, with a trend of -8.1%, while Choice basic had the highest trend, at 10.1%.

Total enrollment has decreased by three (3) percent in 2014. Enrollment in Care basic doubled, from 9,000 to 20,000, while enrollment in Choice basic and Select basic decreased by 10% and 15%, respectively. This is primarily due to risk adjustment, which was implemented in 2014.

HMO Plans

In the funding arrangement that started in 2014 for the HMO plans, excluding Kaiser, the premium that is received for each plan is retained by CalPERS. An amount equal to the capitation payments is passed along to the plan for payment to their providers. Capitation is a payment arrangement for health care service providers such as physicians or medical groups. A capitation payment is a set amount per person per month that is paid by the health insurance company to their providers to cover the risk for a defined set of health care services, whether those services are provided or not. The remainder is deposited into the Health Care Fund and is used to pay the administrative expenses and fee-for-service claims when the plan submits an invoice.

Attachment 2 summarizes the results for the HMO plans. The asset value for each HMO plan is shown on the first 2 pages. The basic plans are shown on the first page and the Medicare plans are shown on the following page. Blue Shield and Sharp are the only HMO plans with a Medicare Supplement plan, which are flex-funded. Anthem, Health Net, and United operate Medicare Advantage plans which have no flex-funded component. For calendar year 2014, there was an overall loss of $32 million for all eight (8) self-funded PPO health plans. The gain or loss evaluates revenue against claims and expenses. Revenue includes premiums, drug rebates, subsidies from the EGWP program, and investment income. The loss was from the 2

Blue Shield basic plans, due to unfavorable claims experience. The other plans all had positive results for the year.

Medical and pharmacy claims costs are shown on pages 3 through 6 of the attachment. The variation in claims costs reflect the demographics of the population covered and the regions they live in.

Enrollments for each plan are shown on pages 7 and 8.

BUDGET AND FISCAL IMPACTS
This item is for information purposes only, and has no impact on the CalPERS budget. Any impact this may have on future health plan premiums will be addressed during the rate development process that generally occurs from April through June in the Pension and Health Benefits Committee.

BENEFITS AND RISKS
Benefits

- The current financial status of the PPO plans is stable, with adequate premiums and reserves to fund benefits
- The flex-funding arrangement provides better insight into medical fee-for-service and pharmacy claims in an HMO population

Risks

- The high costs in pharmacy could lead to larger than expected premium increases

ATTACHMENTS
Attachment 1-provides key graphical analyses of financial and historical data for the PPO plans.
Attachment 2-provides key graphical analysis for the HMO plans.

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