



Finance and Administration Committee Agenda Item 8b

December 20, 2016

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 include Anthem Blue Cross and Health Net, each with 2 HMO offerings; Sharp Health Plan, in San Diego County only; and United Healthcare. These plans provided coverage for over 22,000 Total Covered Lives (TCL) in 2014, in 2015 enrollment in these plans increased to 66,000, and in 2016 enrollment has reached 125,000.

In addition, Blue Shield with 2 plans, Kaiser, and the Self-Funded Preferred Provider Organization (PPO) health plans are also available. A new funding arrangement, called flex-funding, for all HMO plans except Kaiser was initiated starting in 2014. This report summarizes, as of June 30, 2016, the financial results for the HMO plans 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 \$691.0 million, which is an increase of \$94.1 million from the assets at the end of 2015. Required reserves for the PPO plans are \$543.7 million, which is an increase of \$39.6 million over the required reserves at the end of 2015. Actual reserves above the actuarial reserve requirements are \$147.4 million. Overall, the Self-Funded PPO health plans have a ratio of assets to reserves of 127 percent.

For the first 6 months of 2016, there was an overall gain of \$54.4 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. This gain is a welcome result after 2 consecutive years of losses that were driven by high pharmacy claims costs, especially in the Medicare plans.

Medical claims costs are looking favorable at the current time for Care basic, at 3.5%, Choice basic at 2.6%, Care Medicare at -0.9%, and Choice Medicare at 1.7%. The remaining plans are much less favorable, with Select basic at 11.6% and Select Medicare at 9.9%.

Pharmacy claims costs for the basic plans are currently very favorable, with Care basic at -0.4%, Choice basic at 3.2%, and Select basic 3.2%. The Medicare plans continue to show high trends, although not quite as high as the previous year. Care Medicare is at 7.1%, Choice Medicare at 7.8%, and Select Medicare at 9.1%. Specialty drugs continue to fuel the large increases.

Total enrollment in 2016 has increased by three and a half (3.5) percent over 2015 enrollment. Enrollment in Care basic continues to increase, from 26,000 to almost 29,000, while enrollment in Choice basic dropped by 6,000 (about 3%) and Select basic increased by 5,000 (about 14%). These enrollment changes are still primarily due to risk adjustment, which was implemented in 2014. Enrollment in the Medicare plans increased by almost 9,000 members in 2016.

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 of the premium 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. There have been some changes to the HMO plans. With the implementation of a Consolidated Medicare Advantage Program effective January 1, 2016, the flex-funded Medicare plans discontinued operation. The Medicare plan assets displayed in Attachment 2 are for the purpose of paying claims and expenses that have not yet been received. In addition, the Blue Shield Net Value plan will discontinue operation effective December 31, 2016. The financial information displayed in Attachment 2 has been combined for the Access+ and Net Value plans, to show one value for Blue Shield. 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.

As of June 30, 2016, the assets for the HMO plans totaled \$30.3 million, which is a decrease of \$40 million from the end of 2015. This is primarily due to the elimination of the Medicare plans and the Net Value plan continuing to experience unfavorable claims experience.

Medical and pharmacy claims costs are shown on pages 4 and 5 of the attachment. The variation in claims costs reflect the demographics of the population covered and the regions they live in. In addition, the significant enrollment changes that have occurred during the last 3 years make analysis of claims costs difficult to interpret.

Enrollments for each plan are shown on page 6. The new plans tripled their enrollment from 2014 to 2015, and then almost doubled the enrollment from 2015 to 2016.

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 - Key graphical analyses of financial and historical data for the PPO plans.

Attachment 2 - Key graphical analyses of financial and historical data for the HMO plans.

Gary McCollum

Senior Life Actuary
Actuarial Office

Doug McKeever

Deputy Executive Officer
Benefit Program Policy and Planning