

# Health Benefits Program | Annual Report

November 1, 2017

# Table of Contents

Executive Summary	1
About CalPERS	2
2012-17 Strategic Plan	3
Strategic Direction and Policy Initiatives	4
<b>Health Benefits Program Information</b>	
Health Coverage Overview	6
Medical Trends	10
Member Health	11
Federal Subsidies	14
Member Satisfaction	15
<b>Health Plan Information</b>	
Geographic Coverage	17
Historic Enrollment	18
Historic Expenditures	20
Benefits Beyond Medicare	22
Health Plan Premium Trends	24
Health Plan Quality Measures	26
<b>Financial Information</b>	
Reserves	30
Administrative Expenditures	32
Investment Strategies	33
<b>Appendices</b>	35



## Executive Summary

I am pleased to present the CalPERS Health Benefits Program Annual Report for plan year 2016. In this report, we provide information about the CalPERS Health Benefits Program, pursuant to California Government Code Section 22866 (see Appendix A). This report fulfills an annual requirement to provide information about the CalPERS Health Benefits Program to the California Legislature and Director of Finance.

We provide information on the Health Benefits Program including state and federal benefit requirements, health benefit designs offered to enrollees, member health characteristics, information on federal Medicare subsidies, and member health plan survey data relative to satisfaction and quality.

Health plan information in the report includes CalPERS' health plans' geographic coverage areas, historic enrollment and expenditure data, health plan premium information including medical trend by aggregate service category, and health plan quality measures.

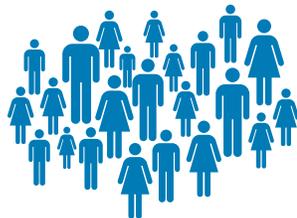
Additionally, we provide financial information including actuarial reserve levels, historic investment performance of the Public Employees' Contingency Reserve Fund (CRF) and the Public Employees' Health Care Fund (HCF), and administrative expenditures.

Marcie Frost  
Chief Executive Officer

# About CalPERS

For more than eight decades, CalPERS has strived to ensure retirement security for the public employees who serve the people of California. In addition to being a public employee retirement system, beginning in the 1960s, CalPERS became the health benefits purchaser for state employees, and public agencies and schools that join the health program on a contract basis. CalPERS has a vested interest in the health of our members, not only during their tenure as employees, but also throughout retirement. This long-term relationship with active and retired members drives the comprehensive, quality health benefits we provide to help our members maintain their quality of life no matter what their age.

Today CalPERS is the largest purchaser of public employee health benefits in California and the second largest public purchaser in the nation after the federal government. We purchase health benefits for approximately 1.4 million active and retired members and their families on behalf of the State of California (including the California State University), and approximately 1,200 public agencies and schools. CalPERS is projected to spend approximately \$9.1 billion in 2018 to provide health benefits to our members. The CalPERS Health Benefits Program is primarily governed by the California Public Employees' Medical and Hospital Care Act (PEMHCA) and is also subject to various state and federal laws, regulations, and guidance.



CalPERS is the largest purchaser of public employee health benefits in California with 1.4 million total covered lives.

# 2012-17 Strategic Plan

The CalPERS 2012-17 Strategic Plan is the roadmap that guides the enterprise to meet the investment, retirement, and health benefit needs of our members and their families. CalPERS' Strategic Plan includes the following vision and mission statements, and goals and objectives:

## Our Vision

A trusted leader respected by our members and stakeholders for our integrity, innovation, and service.

## Mission

Provide responsible and efficient stewardship of the System to deliver promised retirement and health benefits while promoting wellness and retirement security for members and beneficiaries.

## Goals and Objectives

### Goal A: Improve long-term pension and health benefit sustainability

- Fund the System through an integrated view of pension assets and liabilities.
- Educate employers and other stakeholders to make informed decisions about retirement security and health care.
- Deliver target risk-adjusted investment returns.
- Ensure high-quality, accessible, and affordable health benefits.
- Create a lifestyle of wellness among members and employers.

### Goal B: Cultivate a high-performing, risk-intelligent, and innovative organization

- Use a focused approach to generate, test, refine, and implement new ideas.
- Deliver superior end-to-end customer service that is adaptive to customer needs.
- Recruit, retain, develop, and empower a broad range of talents against organizational priorities.
- Actively manage business risks with an enterprise-wide view.

### Goal C: Engage in state and national policy development to enhance the long-term sustainability and effectiveness of our programs

- Clarify and communicate CalPERS' perspective on pension, health, and financial markets.
- Provide education and engagement opportunities to shape policy agenda and expand impact.

# Strategic Direction and Policy Initiatives

While CalPERS' Strategic Plan provides overarching goals and direction, CalPERS uses its Business Plan to outline specific initiatives that help achieve our Strategic Plan goals. On an annual basis CalPERS conducts a refresh of our business plans and periodically provides status updates to the Board of Administration (Board).

In 2016, CalPERS implemented changes to support our strategic direction and major policy initiatives. This information can be found in the CalPERS Strategic Plan, the CalPERS Business Plan, and the CalPERS Finance and Administration Committee agenda items. The plans and agenda items are interrelated and focus on cost, quality, and accessibility.

The table below shows the status of health-related Business Plan Initiatives during the 2016 plan year.

## 2016 Business Plan Initiatives: Health Benefits

Initiative Title	Description	Status
Contracting Agency Outreach and Health Data Sharing	Engage employers in Health Policy discussions and identify ability to share health data with employers to develop workplace health improvement strategies.	Deferred <sup>1</sup>
Provide Health Costs Education and Outreach	Provide employers with aggregate views of health data to identify major health care costs and assess impacts.	Completed <sup>2</sup>
Medicare-Only Health Contracting Alternatives	Explore feasibility of simplifying Medicare Advantage contracts and, if directed by the Board, implement changes.	Completed <sup>3</sup>
Complete Pilot to Improve Long-Term Care Hospital Transition Care for Senior Members	Assess the specialized hospital transition care management program to improve quality and reduce hospital readmissions for preferred provider organization (PPO) health plan members with Long-Term Care policies.	Transitioned <sup>4</sup>
Promote Access to High-Value Health Care Services	Explore the feasibility to introduce incentives to promote access to quality and preventive services, increase treatment adherence, and adopt healthy behaviors.	New <sup>5</sup>
Employer Excise Tax	Assess appropriately the impacts of the excise tax and execute an outreach plan that provides stakeholders information on the excise tax policy and other Affordable Care Act components.	New <sup>6</sup>

<sup>1</sup> Initiative deferred in 2015 because additional resources to support the added workload were not approved in the Budget Change Proposal process. As an alternative, CalPERS implemented a separate initiative: Provide Health Costs Education and Outreach. *Finance and Administration Committee Agenda Item, 7a, Attachment 2, page 10.* February 17, 2016. <https://www.calpers.ca.gov/docs/board-agendas/201602/financeadmin/item-7a-02.pdf>

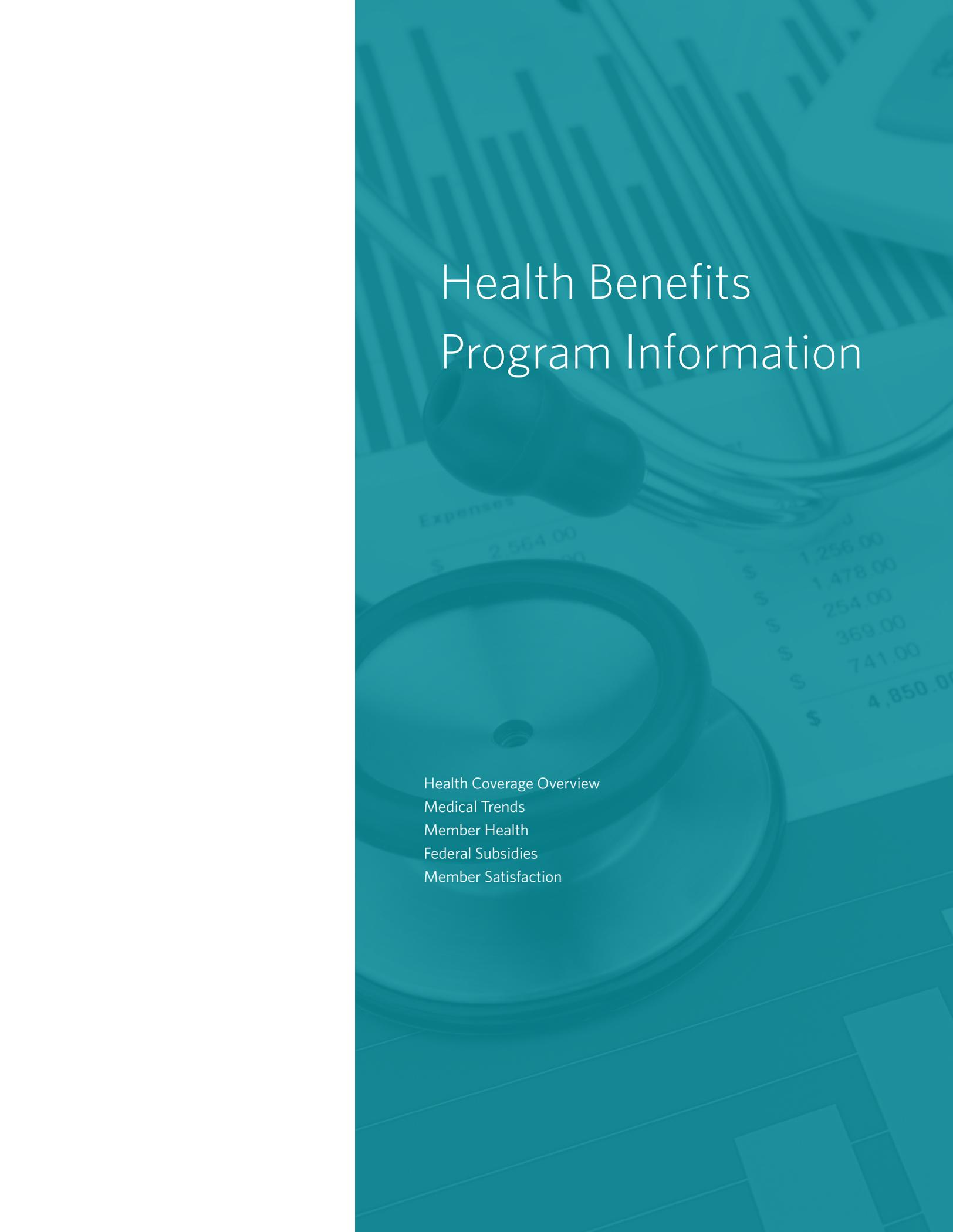
<sup>2</sup> This information was provided in the November 1, 2016, Health Benefits Program Annual Report. <https://www.calpers.ca.gov/docs/forms-publications/health-benefits-program-annual-report-2016.pdf>

<sup>3</sup> This project was completed in January 2016 when members were able to enroll in a single, non-Kaiser Medicare Advantage health plan. *Finance and Administration Committee Agenda Item 7a, Attachment 1.* February 17, 2016. <https://www.calpers.ca.gov/docs/board-agendas/201602/financeadmin/item-7a-01.pdf>

<sup>4</sup> This project ended in March 2016 and the final report on pilot findings was transitioned to a future date. *Finance and Administration Committee Agenda Item 4h.* September 20, 2016. <https://www.calpers.ca.gov/docs/board-agendas/201609/financeadmin/item-4h-00.pdf>

<sup>5</sup> *Finance and Administration Committee Agenda Item 6b, Attachment 1, page 2.* March 15, 2016. <https://www.calpers.ca.gov/docs/board-agendas/201603/financeadmin/item-6b-01.pdf>

<sup>6</sup> *Finance and Administration Committee Agenda Item 6b, Attachment 1, page 6.* March 15, 2016. <https://www.calpers.ca.gov/docs/board-agendas/201603/financeadmin/item-6b-01.pdf>



# Health Benefits Program Information

Health Coverage Overview  
Medical Trends  
Member Health  
Federal Subsidies  
Member Satisfaction

# Health Coverage Overview

CalPERS provides a wide selection of high quality health plan options to our members and their families. For the 2016 plan year, CalPERS' Basic health plan offerings included fully-insured and flex-funded health maintenance organization (HMO) plans, self-insured preferred provider organization (PPO) plans, and self-insured and fully-insured exclusive provider organization (EPO) plans. CalPERS contracted with the following carriers to provide or administer these plans:

- Anthem Blue Cross
- Blue Shield of California
- Health Net of California
- Kaiser Permanente
- Sharp Health Plan
- UnitedHealthcare

CalPERS' Medicare health plan offerings include both Medicare Advantage plans and Medicare Supplemental plans. In 2016, CalPERS contracted with UnitedHealthcare to provide their UnitedHealthcare Group Medicare Advantage (PPO) plan as our single non-Kaiser Medicare Advantage plan. All other non-Kaiser HMO Medicare plans were terminated at the end of 2015. In addition to Kaiser and UnitedHealthcare, CalPERS contracted with Anthem Blue Cross to administer our Medicare Supplemental plans - PERS Choice, PERS Select, and PERSCare.

Three Association plans (ASN) - California Association of Highway Patrolmen (CAHP), California Correctional Peace Officers Association (CCPOA), and Peace Officers Research Association of California (PORAC) - are also available to members who belong to one of these employee associations. CalPERS does not negotiate rates and is not responsible for the benefit administration of these three plans.

## Benefit Requirements

### State Law

CalPERS' Basic HMO plans, regulated by the Department of Managed Health Care (DMHC) under the Knox-Keene Act of 1975, are required to cover medically necessary basic health care services, including:

- Physician services
- Hospital inpatient services and ambulatory care services
- Diagnostic laboratory, and diagnostic and therapeutic radiologic services
- Home health services
- Preventive health services
- Emergency health care services, including ambulance and ambulance transport services, out-of-area coverage, and ambulance transport services provided through the 911 emergency response system
- Hospice care

CalPERS' self-funded Basic PPO plans are not regulated under state law but their benefit designs are comparable to our HMO plans.

### Federal Law

Under the Affordable Care Act (ACA), all non-grandfathered plans sold in the individual and small group markets must offer a core package of health care services known as essential health benefits (EHB). The ACA does not define this core package but instead lists 10 benefit categories that must be included in these plans. Large group health plans are not required to provide these EHBs; however, CalPERS' HMO and PPO Basic health plans provide benefits in all the EHB categories, except for pediatric dental and vision care.<sup>7</sup>

<sup>7</sup> For state employees, dental and vision care for children and adults is administered separately through the California Department of Human Resources. Each public agency and school district is responsible for its own dental and vision benefits.

Under the ACA, EHBs are categorized as:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

Federal regulations define EHBs for plans sold in the individual and small group market based on a state-specific EHB benchmark plan. The benchmark plan defines the EHBs that health plans must cover in that state. The benefits that follow are included in California's benchmark plan and are in addition to the EHB categories required by the ACA. CalPERS' Basic plans also provide these additional benefits:

- Acupuncture
- Blood and blood products
- Durable medical equipment
- Family planning services
- Health education
- Organ and bone marrow transplants
- Reconstructive surgery (non-cosmetic)
- Skilled nursing care

## Other Benefits

CalPERS' Basic health plans also provide the following benefits that are not considered EHBs:

- Biofeedback
- Chiropractic services
- Hearing aid services

## Benefit Design Changes

Each year CalPERS and our health plan carriers consider potential changes to the benefit design of our health plans. Changes to our benefit designs can be the result of federal legislation or regulation, state legislation or regulation, or direction by the Board. Benefit designs for CalPERS' health plans, including covered benefits and cost-sharing requirements, are summarized in Appendix B.

In June 2015, the Board adopted the following five benefit changes for the 2016 health plan year:

### Welvie

The Board elected to add Welvie, at a cost of \$1.04 per subscriber per month (PSPM) (weighted average cost), to the following Basic plans: Anthem HMO Select, Anthem HMO Traditional, Blue Shield Access+, Blue Shield NetValue, PERS Choice, PERS Select, and PERSCare. Welvie is an online decision-support tool that helps minimize unnecessary and inappropriate surgeries.

### **Castlight Pilot Extension**

The Board elected to extend the Castlight Pilot through December 2016 for all PPO plans at a cost of \$1.41 PSPM (weighted average cost). Originally piloted in 2014, this tool educates users about price variation across medical procedures with an easy-to-use online application with expanded cost transparency based on CalPERS claims data.

### **Acupuncture and Chiropractic Benefits Standardization**

The Board elected to standardize acupuncture and chiropractic benefits, to a \$15 copayment and a combined 20 visits per year, at a cost of 45 cents PSPM (weighted average cost), across the following plans: Kaiser (Medicare), PERS Choice (Basic and Medicare), PERS Select (Basic and Medicare), and PERSCare (Medicare).

### **Blue Shield Prescription Enhancement**

The Board elected to enhance the prescription benefit for Blue Shields' Basic plans at no impact to the rates. When mail service by PrimeMail is not feasible or desired, members with a 90-day supply option may fill their prescriptions at select participating retail pharmacies.

### **UnitedHealthcare Medicare Prescription Enhancement**

The Board elected to enhance the prescription benefit for UnitedHealthcare's Medicare plan at no impact to the rates. Members with a 90-day supply option may fill their maintenance medications at select participating retail pharmacies at the mail order price.

## **Actuarial Value**

CalPERS' Basic HMO and PPO plans have a higher Actuarial Value (AV) than many plans sold in the individual or small group markets. AV is calculated as the percentage of total average costs for covered benefits that a health plan will cover. Under the ACA, a health insurance plan's AV indicates the average share of medical spending that is paid by the plan, as opposed to being paid out-of-pocket by the member.

The ACA stipulates that AV be calculated based on the provision of EHBs to a standard population. The statute groups health plans into four tiers: bronze, with an AV of 60-69 percent; silver, with an AV of 70-79 percent; gold, with an AV of 80-89 percent; and platinum, with an AV of 90 percent or above. CalPERS has determined that its Basic HMO plans fall in the platinum tier and its Basic PPO plans in the gold tier.

## **Member Out-of-Pocket Costs**

Member out-of-pocket costs include deductibles, coinsurance, copayments, and other out-of-pocket costs as specified in CalPERS' health plans' Evidence of Coverage (EOC) booklets. For example, a typical copayment for a physician office visit for members enrolled in a Basic HMO plan or a Basic PPO plan is \$15 and \$20, respectively. A typical deductible for members enrolled in a Basic PPO plan is \$500 for individuals and \$1,000 for a family. In 2016, CalPERS' members paid on average \$319 out-of-pocket for health care services and prescription drugs.

There was considerable variation in health care and prescription drug out-of-pocket costs in 2016 depending on whether the CalPERS member chose an HMO or PPO, or was enrolled in a Basic or Medicare health plan. On average, a member in a Basic HMO plan paid \$137 in out-of-pocket costs, while a member in a Medicare Advantage plan paid \$300. On average, a member in a Basic PPO plan paid \$940 in out-of-pocket costs, while a member in a Medicare PPO plan paid \$348. These numbers are

based on submitted health claims. CalPERS does not collect data on non-covered services such as over-the-counter medications or out-of-network care.

Average out-of-pocket costs may vary due to benefit design or policy changes. An individual member may experience significantly different costs from the averages depending on their overall utilization of medical services and the number of prescriptions filled each year.



CalPERS' life-long relationship with active and retired members drives the comprehensive and affordable benefits we provide.

# Medical Trends

The overall cost trend for CalPERS' HMO and PPO Basic health plans increased 4.2 percent in calendar year 2016, compared to 7.2 percent between calendar year 2014 and calendar year 2015. Trends are reported in the following service categories:

- Inpatient
- Emergency Room
- Hospital Outpatient
- Ambulatory Surgery
- Office Visit
- Laboratory
- Radiology
- Mental Health/Substance Abuse
- Other Professional
- Medical Prescriptions
- Prescription Drugs
- Preventative Care
- All Other

The 2016 trend in service category costs varied, with the largest contributions from inpatient care, prescription drugs, and ambulatory surgery categories. Utilization rate increases occurred in average length of stay, emergency room services, and office visits, while all other service categories had a decreasing trend in utilization for calendar year 2016. See Appendix C for graphs displaying these medical trend changes.

# Member Health

## Chronic Conditions

CalPERS employs several mechanisms to evaluate overall member health as reflected by data on chronic conditions, review of population demographics, analysis of member health, and claims data for chronic conditions. This evaluation showed that, for 2016, approximately 38 percent of members enrolled in a CalPERS health benefit plan have an existing chronic condition and 25 percent have one or more of the seven most prevalent chronic conditions. In 2016, the seven most prevalent chronic conditions, affecting between 0.4 and 10.8 percent of CalPERS' population, were:

1. Hypertension
2. Diabetes
3. Depression
4. Asthma
5. Coronary Artery Disease
6. Chronic Obstructive Pulmonary Disease (COPD)
7. Congestive Heart Failure

In CalPERS' Basic plans, one in five members have a chronic condition, and in CalPERS' Medicare plans, nearly one in two members have a chronic condition.

Members enrolled in CalPERS' health benefit plans are, on average, older and have a higher prevalence of chronic conditions when compared to other insured populations. According to the two largest carriers by enrollment, which account for roughly two-thirds of CalPERS' population, the prevalence of diabetes, depression, coronary artery disease, congestive heart failure, and asthma are all higher among members enrolled in CalPERS' plans.

The table on the next page shows a breakdown of chronic conditions prevalence in Northern and Southern California counties, and statewide, based on information from CalPERS' data warehouse for 2016. Note that some members may have more than one chronic condition.

## 2016 Chronic Conditions Prevalence Among CalPERS Members\*

Chronic Condition	Northern California		Southern California		Total California	
	Population	Prevalence (%)	Population	Prevalence (%)	Population	Prevalence (%)
Hypertension	74,460	10.3	68,076	11.6	142,536	10.9
Diabetes	57,208	7.9	49,174	8.4	106,382	8.1
Depression	33,082	4.6	28,530	4.9	61,612	4.7
Asthma	24,043	3.3	18,881	3.2	42,924	3.3
Coronary artery disease	15,146	2.1	14,251	2.4	29,397	2.2
COPD	13,253	1.8	15,656	2.7	28,909	2.2
Congestive heart failure	3,437	0.5	2,931	0.5	6,368	0.5

\* The CalPERS Health Care Decision Support System medical episode grouper was used to measure prevalence of chronic conditions.

The map below displays the counties that encompass northern and southern California as it relates to chronic conditions prevalence among CalPERS members.

### Northern Counties

Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Glenn, Humboldt, Lake, Lassen, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Placer, Plumas, Sacramento, San Benito, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tuolumne, Yolo, Yuba

### Southern Counties

Fresno, Imperial, Inyo, Kern, Kings, Los Angeles, Madera, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara, Tulare, Ventura



## Population Risk

CalPERS periodically conducts a population risk analysis to determine the overall risk of the Health Benefits Program, and this analysis includes an evaluation of the risk profiles of state and contracting agencies to determine the comparative impact of their populations. State and contracting agency segments have similar risk profiles, and the Health Benefits Program as a whole is not greatly affected by the addition or departure of contracting agencies.

In addition to analyzing the risk of population segments, CalPERS uses age, gender, and diagnosis data from a 12-month period to determine current and future expected cost and utilization for individuals. CalPERS' health plan membership is approximately 55 percent female and 45 percent male. Women exceed men in total CalPERS spending but the proportion and type of spending differs between women and men. The age pattern of this disparity suggests that childbirth may account for a large portion of total spending for women while spending on men appears attributable to preventable chronic diseases.

Variance in health care costs across California is another potential risk to the Health Benefits Program. Health insurers use standard actuarial practices to calculate rates

based on enrollment assumptions, anticipated changes in population risk, and regional factors. For example, a health insurer might adjust its regional rate due to changes in negotiated provider charges and/or changes in medical management of some regions compared to others. Another factor could be new provider contracts that reflect different relative costs. The utilization of health services in a prior year could also be a factor in counties with low membership because even a single catastrophic health event can temporarily skew costs. In larger populations, such events are distributed over more members, and therefore have less impact on overall cost factors.

CalPERS sets one statewide rate for state employees in order to mitigate this cost variance, but contracting agency rates are set by region and therefore regional risk dynamics affect contracting agencies much more than the State. Historically, prior to the 2005 adoption of regional pricing for contracting agency Basic premiums, the single statewide premium offered by each health plan carrier did not permit carriers to establish competitive rates in areas with lower healthcare costs. In 2004, the CalPERS Health Benefits Program lost approximately 37,000 contracting agency members in areas with lower healthcare costs, with continued losses projected. The implementation of regional pricing helped avert these threats, stabilizing contracting agency membership.

# Federal Subsidies

Federal subsidies or contributions have a positive impact on the overall affordability of health care for CalPERS' Medicare members. CalPERS' health plan carriers and Pharmacy Benefit Managers manage federal eligibility and enrollment, benefits, claims adjudication, and subsidy payments. Federal subsidies that CalPERS receives to offset the cost of health care include: direct subsidies, reinsurance, coverage gap discounts, low income cost-sharing subsidies, and low income premium subsidies. In 2016, CalPERS collected \$32,539,000 in federal subsidies, which makes up less than one percent of the total collected in health premiums.

Direct subsidies are fixed amounts that the Centers for Medicare & Medicaid Services (CMS) pays to plan administrators to reimburse for Medicare Part D administrative costs. Reinsurance payments subsidize plan administrators for a portion of gross prescription drug costs incurred after a member exceeds the annual True Out-Of-Pocket (TrOOP) cost threshold. The Coverage Gap Discounts are pharmaceutical drug discounts paid by pharmaceutical manufacturers to plan administrators to offset the reduced member cost-sharing for eligible members in the coverage gap.

CalPERS Medicare Advantage Plans and the PERSCare, PERS Choice, and PERS Select Part D Employer Group Waiver Plan rates are reduced by the estimated amount of the federal subsidies for the following year. The collected premium amount combined with the subsidy amount received is sufficient to pay medical and pharmacy claims. The premiums paid by CalPERS' members and employers for Medicare health plans represent the cost of coverage above the federal contribution to Medicare.

The Low Income Subsidy (LIS) program helps people with Medicare pay for prescription drugs and lowers the cost of prescription drug coverage. Low Income Cost-share Subsidies (LICS) are payments to plan administrators to offset the statutory reduction in cost sharing for qualified low-income members. Low Income Premium Subsidies (LIPS) are payments to plan administrators to lower the costs of premiums for members that meet low-income guidelines. LIPS (also referred to as LIS) program is administered by CalPERS' health plan carriers. The carriers are responsible for collecting the subsidy from the federal government and distributing the subsidy to the member and/or employer if the subsidy exceeds the member's share of the premium. CalPERS' role is to review the enrollee data and provide additional information to the carriers as needed.



On a scale of 1-10, on average, CalPERS Basic members rate their health plans 8.2 and Medicare members rate their plans 9.2.

# Member Satisfaction

CalPERS conducts an annual Health Plan Member Survey to assess members' experience and satisfaction with their health plan over the last 12 months. The latest survey, for the 2016 plan year, concluded on March 6, 2017.

The survey asks members to rate certain aspects of their health care experience using any number from 0 to 10 where 0 is the lowest possible rating and 10 is the highest possible rating. The overall rating is the average rating of total respondents on the 10-point scale. Graphical data on specific responses are included in Appendix D. The following summarizes those responses.

## Member Survey Questions (rated from 0 to 10)

### What number would you use to rate your health plan?

Basic plan respondents	8.2
Medicare plan respondents	9.2

### What number would you use to rate your personal doctor?

Basic plan respondents	8.7
Medicare plan respondents	9.1

### What number would you use to rate the specialist you saw most often in the last 12 months?

Basic plan respondents	8.6
Medicare plan respondents	9.1

### What number would you use to rate your overall satisfaction with your pharmacy services (i.e., your experience with obtaining prescriptions from a retail or mail order pharmacy)?

Basic plan respondents	7.9
Medicare plan respondents	8.7

## Rural Healthcare Accessibility

The survey also asks members to report their level of accessibility to care using a variety of multiple choice answers. According to survey data, 236 Basic plan respondents did not have access to an HMO in their area. These respondents live in rural coverage areas and are enrolled in a PPO Basic Plan. This section is specific to Basic plan members, as CalPERS' Medicare plan subscribers have access to Medicare Advantage in all 58 counties in California. Graphical data on specific responses are included in Appendix D.

### Emergency Room Care

Out of the 236 Basic plan respondents, 47 utilized the emergency room to get care for themselves.

Of these 47 respondents, six responded that they went to the emergency room because there were no urgent care services within 15 miles/30 minutes of their homes. These individuals resided in Calaveras, Inyo, Plumas, Riverside, and Siskiyou counties.

### After-Hours Care

Out of the 236 Basic plan respondents, 12 responded that it was not easy to get after-hours care.

Of these 12 respondents, five felt that the reason it was not easy to get the after-hours care they needed was because the doctor's office or clinic was too far away. These individuals resided in Calaveras, Lassen, Modoc, Nevada, and Shasta counties.

# Health Plan Information

Geographic Coverage  
Historic Enrollment  
Historic Expenditures  
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Health Plan Premium Trends  
Health Plan Quality Measures

## Geographic Coverage

CalPERS is the purchaser of health benefits for the State of California (including the California State University) and approximately 1,200 public agencies and schools. As such, CalPERS members, both active and retired, are located across the state as well as outside of California.

CalPERS offers Basic and Medicare health plan options in all of California's 58 counties. The majority of our members have access to both HMO and PPO plan options; however, members in some rural counties only have access to CalPERS' PPO plans.<sup>8</sup> CalPERS also offers

limited Basic and Medicare health plan options for members who live out-of-state.

Each year during CalPERS' open enrollment period, members are provided with a matrix indicating the availability of health plans by county and by state. This geographic coverage information assists members in selecting health plans available where they live or work. Please refer to Appendix E for a comprehensive view of health plan availability by county.



CalPERS offers Basic and Medicare health plan options in all of California's 58 counties.

<sup>8</sup> Alpine, Calaveras, Inyo, Lake, Lassen, Modoc, Mono, Plumas, Shasta, Siskiyou, Tehama, Trinity, and Tuolumne counties.

# Historic Enrollment

CalPERS has seen its health plan enrollment grow over the past ten years. Between 2007 and 2016, CalPERS' total enrollment has increased by almost 16 percent.

## Basic and Medicare

The table to the right displays ten years (2007-2016) of CalPERS' total estimated enrollment counts by Basic and Medicare as of January 1, each year (which captures changes made during the annual open enrollment period). Changes outside of open enrollment are minimal and include adding new employees and qualifying life events such as the birth or adoption of a child, marriage or divorce, moving outside a plan's coverage area, etc.

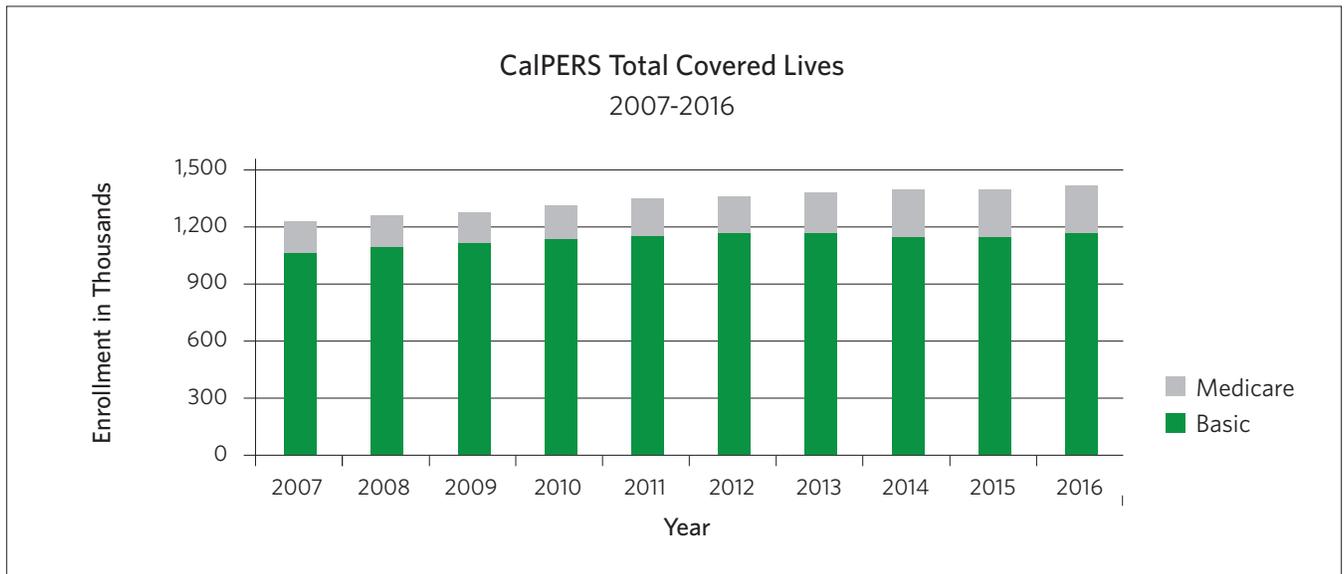
The chart below displays CalPERS' total covered lives by Basic and Medicare over 10 years.

## Estimated Basic and Medicare Enrollment (Enrollment in Thousands)

	Basic	Medicare	Total*
2007	1,073	154	1,228
2008	1,096	162	1,258
2009	1,114	170	1,285
2010	1,130	183	1,312
2011	1,160	194	1,355
2012**	1,166	205	1,371
2013**	1,169	220	1,389
2014**	1,160	232	1,391
2015	1,155	243	1,398
2016	1,166	255	1,420

\* Total Program may not equal the sum of Basic and Medicare totals due to rounding.

\*\* Reflects corrections to data reported in the November 1, 2016, Health Benefits Program Annual Report.



## Other Enrollment Information

In addition to the Basic and Medicare enrollment information on the previous page, the CalPERS Historic Enrollment tables (see Appendix F) provide enrollment data for plan years 2015 and 2016 (future reports will include multiple years of historic enrollment information). The CalPERS total enrollment count

includes state, public agency, and school members, excluding individuals on Consolidated Omnibus Budget Reconciliation Act (COBRA). The tables also display enrollment by plan name, health coverage type (Basic or Medicare), program (state or contracting agency [i.e., public agencies and schools]), employment status (active or retired), and subscriber and dependent tier (single, two-party, or family).



CalPERS has seen its health plan enrollment grow over the past ten years. Between 2007 and 2016, CalPERS' total enrollment has increased by almost 16 percent.

# Historic Expenditures

CalPERS' Health Benefits Program's total estimated expenditure in 2016 was \$8.63 billion.

## Basic and Medicare

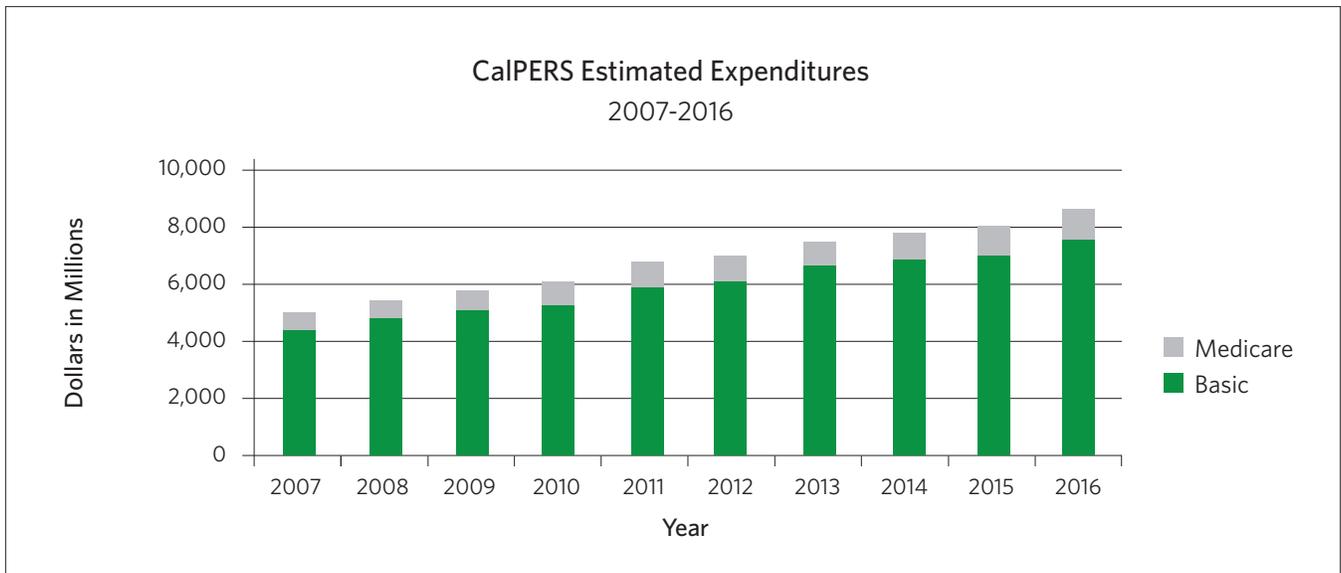
The table to the right displays ten years (2007-2016) of CalPERS' total estimated expenditures by Basic and Medicare. Since actual membership fluctuates during any given month, the numbers presented in the table are estimated expenditures, not actual. Estimates are determined by applying the corresponding year's premium amounts to the annualized January subscriber enrollment counts (e.g., 2016 expenditures were calculated based on 2016 premium rates and January 2016 enrollment counts).

The chart below displays total program spending by Basic and Medicare over 10 years.

**Estimated Basic and Medicare Expenditures**  
(Dollars in Millions)

	Basic	Medicare	Total*
2007	\$4,400	\$613	\$5,013
2008	4,820	662	5,482
2009	5,137	697	5,833
2010	5,363	753	6,116
2011	5,929	825	6,754
2012	6,156	867	7,022
2013	6,678	833	7,511
2014	6,864	858	7,722
2015	7,045	975	8,020
2016	7,573	1,058	8,631

\* Total Program may not equal the sum of Basic and Medicare totals due to rounding.



The average annual increase for the program's total estimated expenditures was approximately 6.2 percent over the past 10 years. In any given year, Basic estimated expenditures represent about 88 percent of the total program, while Medicare expenditures represent about 12 percent.

## Other Expenditure Information

In addition to the Basic and Medicare information on the previous page, the Historic Expenditures tables (see Appendix G) provide estimated expenditures for 2015 and 2016 (future reports will include multiple years of historic expenditure information). The Historic Expenditures tables include a breakdown by plan name, health coverage type (Basic or Medicare), program (state or contracting agency [i.e., public agencies and schools]), status (active or retired), and subscriber and dependent tier (single, two-party, or family).



CalPERS' Health Benefits Program's total estimated expenditure in 2016 was \$8.63 billion.

# Benefits Beyond Medicare

In 2016, CalPERS offered Medicare supplemental plans for its PERS Select, PERS Choice and PERSCare health plans. These plans supplemented Medicare payments for Medicare-approved services. The plans also provided coverage for some benefits not covered by Medicare (e.g., acupuncture). Furthermore, the plans provided coverage for medically necessary services and supplies when benefits under Medicare were exhausted or when charges for the services and supplies exceeded amounts covered by Medicare. The benefits beyond Medicare were:

## PERS Select and PERS Choice

- Acupuncture or Acupressure Services: A \$15 copayment will apply
- Hearing Aid: Up to \$1,000 every 36 months
- Smoking Cessation Programs: Up to \$100 per calendar year
- Vision Care: Vision benefits are administered by Vision Service Plan (VSP)

## PERSCare

- Acupuncture or Acupressure Services: Up to 20 visits per calendar year
- Blood Replacement: First three pints of blood disallowed by Medicare
- Christian Science Nurse or Practitioner: Outpatient treatment up to 24 sessions per calendar year
- Hearing Aid: Up to \$2,000 once every 24 months

- Hospital Services and Supplies (inpatient and outpatient): Services after a member exhausts the benefit period specified by Medicare
- Immunizations: Age appropriate routine immunizations
- Lancets: Lancets and lancing devices for the self-administration of blood tests
- Mental Health Services and Supplies (inpatient and outpatient): Services after a member exhausts the benefit period specified by Medicare
- Physical or Occupational Therapy: Services provided by a licensed provider for treatment of an acute condition upon referral by a physician
- Skilled Nursing Services: From the 101st through the 365th day during each benefit period
- Speech Therapy: Up to a lifetime maximum of \$5,000 per member
- Smoking Cessation Programs: Up to \$100 per calendar year
- Vision Care: Vision benefits are administered by VSP

## CalPERS Medicare Advantage Health Plans

UnitedHealthcare Group Medicare Advantage and Kaiser Permanente Senior Advantage plans cover all Medicare Parts A and B benefits as well as Part D prescription drug benefit. Additional benefits beyond those covered under the Original Medicare program include acupuncture, chiropractic, and hearing aid services. In addition, Kaiser covers eyeglasses for its members. We are exploring the feasibility with our Medicare Advantage health plans of quantifying aggregated costs for benefits beyond Medicare to display in future years.

## Aggregated Cost

The table below shows the aggregated cost of claims paid for benefits beyond Medicare for PERS Select, PERS Choice, and PERSCare Medicare members in calendar year 2016.

### 2016 Benefits Beyond Medicare

(Dollars in Thousands)

Benefit	Aggregated Cost
Acupuncture or acupressure services	\$1,631
Blood replacement	15
Christian Science nurse or practitioner	0
Hearing aid	5,180
Hospital services and supplies (inpatient and outpatient)	100,314
Immunizations	85
Lancets	177
Mental health services and supplies (inpatient and outpatient)	3,808
Physical or occupational therapy	3,724
Skilled nursing services	2,888
Smoking cessation programs	2
Speech therapy	28
Vision care	121
<b>Total</b>	<b>\$117,972</b>

# Health Plan Premium Trends

CalPERS' health plan premiums are established by analyzing estimated future health care costs. In accordance with generally accepted actuarial standards of practice, CalPERS uses the most recent data available to estimate health care costs. The process to establish the 2016 plan year premiums started in 2015, using data from 2014.

The Health Care Decision Support System (HCDSS) is CalPERS' data warehouse, which contains more than a decade of anonymized claims data for all CalPERS Health Benefits Program enrollees. This data enables CalPERS to analyze health plan performance, disease management programs, member utilization, and health care costs, including pharmacy costs. The HCDSS has helped validate healthcare costs and ensured delivery of the best care at the best cost. With HCDSS data, CalPERS can continuously evaluate and advocate for the needs of the Health Benefits Program.

## Trend Factors

CalPERS has been successful in moderating premium trend increases without compromising quality health care. The CalPERS Board mitigates medical trend increases through cost and quality conscious actions such as promoting narrow hospital networks, adding narrow health plan networks, utilizing value-based purchasing, integrated health models, competition, and flex funding.

Past experience has shown that the following factors drive CalPERS' health plan premiums:

- Population age and gender
- Prevalence of chronic conditions
- Hospital utilization
- Pharmaceutical utilization
- Population geographic location

The estimated future health care costs used to set CalPERS' rates are based on the data available during the rate development process. Actual costs are affected by numerous factors occurring in the time period between rate setting and the conclusion of the plan year. Some factors occurring in the intervening time may not be anticipated. CalPERS uses third party verified actuarial models to account for anticipated factors, but the models cannot predict the future with certainty. This uncertainty results in the year-over-year fluctuations in rates and premiums. Any variation between forecasted and actual costs will impact the percent change between years.

Fluctuations (increases and decreases) in premiums result from a number of factors including higher medical and pharmaceutical costs, and benefit design changes. For 2016, premiums increased by 7.1 percent for all Basic and Medicare plans combined. About 45 percent of the overall rate increases for both HMO and PPO plans can be attributed to pharmacy costs. The remaining balance is comprised of medical expenses, ACA fees, and administrative fees.

## Regional Factors

After the HMO and PPO state premiums are established, regional factors are applied to the state premiums to determine regional health premiums for the public agencies and schools (contracting agencies). Appendix H shows tables reflecting premium increases or decreases between plan years 2015 and 2016 for state and contracting agency HMO, PPO, and ASN. CalPERS does not negotiate rates and is not responsible for the benefit administration of ASNs.

## Premium Reconciliation

CalPERS performs a monthly enrollment reconciliation process with each health plan to ensure accuracy of enrollment information. The data in my|CalPERS, which is the “system of record” for all Health Benefits Program health enrollment information, is entered and/or validated by various sources including the state, public agencies and schools, health benefit officers, the State Controller’s Office, health plan carriers, and CalPERS.

The following premium table is derived from information from my|CalPERS that originated at the subscriber enrollment level by coverage month, plan code, and health plan, and was summarized to reflect the amount owed to each carrier for the months of January through December 2016. The premium information in this report is extracted from a point in time from my|CalPERS as of May 28, 2017.

### Health Premium Management Report for Calendar Year 2016

(Dollars in Thousands)

Health Plan Carriers	Health Premiums Amount
Anthem Blue Cross	\$2,565,320
ASNs (CAHP, CCPOA, and PORAC)	526,245*
Blue Shield of California	1,610,146
Health Net	102,552
Kaiser Permanente	3,336,705*
Sharp Health Plan	51,521
UnitedHealthcare	442,578
<b>Total</b>	<b>\$8,635,067</b>

\* Kaiser Permanente and ASN premiums are outside of CalPERS financial data, and therefore are not validated or reconciled by CalPERS.



CalPERS has been successful in moderating premium trend increases without compromising quality health care.

# Health Plan Quality Measures

## Healthcare Effectiveness Data and Information Set (HEDIS®)

In the early 1990s, the National Committee for Quality Assurance (NCQA), a not-for-profit organization, began to manage the Healthcare Effectiveness Data and Information Set (HEDIS®). HEDIS® is a set of health plan performance measures regarding care and service.<sup>9</sup> The current set of HEDIS® measures addresses “preventive services, chronic disease management, behavioral health care, appropriateness/overuse of services, and value.”<sup>10</sup>

Employers, consultants, and consumers use HEDIS® data to help them choose the best health plan for their needs. HEDIS® measures are used by more than 90 percent of health plans in the United States to compare their plan performance and, more importantly, to make improvements in their quality of care and service. Health plans collect and publicly report data used in the HEDIS® measurement process. To ensure that health plan data meets HEDIS® specifications, NCQA requires an independent auditor to examine each health plan’s data and data analyses. NCQA then publishes HEDIS® data for health plan carriers annually on its website.<sup>11</sup> Other organizations such as Consumers Union and the California Office of the Patient Advocate disseminate HEDIS® data as well.

Large health plan carriers that contract with CalPERS are required to submit HEDIS® and HEDIS-like<sup>12</sup> data specific to CalPERS members on an annual basis. Data analysis and reporting during the reporting year<sup>13</sup> is based on data collected from health plans during the measurement year.<sup>14</sup>

This report includes HEDIS® and HEDIS-like data for reporting year 2017 based on data collected during measurement year 2016. The tables in Appendices I and J show HEDIS-like and HEDIS® data for CalPERS Basic members in HMO and self-funded PPO plans. The tables do not include data from HMO plans that did not report CalPERS-specific HEDIS-like data. Additionally, measures that are retired or not reportable (e.g., because they are “first year” measures) are excluded from the tables.

Furthermore, the scores in Appendices I and J are not strictly comparable. For some of the measures (marked with asterisk), a PPO’s score may be lower than an HMO’s score solely because of the way the data are collected, not necessarily because the PPO’s actual performance is worse. For those measures marked with an asterisk, HMO’s gather additional information from patients’ medical records for HEDIS purposes, but the HEDIS-like HMO data in the tables are based only on claims or other administrative data.

<sup>9</sup> <http://www.ncqa.org/hedis-quality-measurement/what-is-hedis>

<sup>10</sup> <http://www.ncqa.org/hedis-quality-measurement/performance-measurement>

<sup>11</sup> <http://healthinsuranceratings.ncqa.org/2016/Default.aspx>

<sup>12</sup> True HEDIS measures must be audited. Unaudited CalPERS-specific measures that follow HEDIS specifications are classified as “HEDIS-like.”

<sup>13</sup> The calendar year in which data are analyzed and reported.

<sup>14</sup> The calendar year preceding the reporting year, during which the events measured actually occurred.

## Medicare Star Ratings

Medicare uses a Star Rating System to measure how well Medicare Advantage and Medicare Prescription Drug (Part D) plans perform.<sup>15</sup> Medicare scores how well plans did in several categories, including quality of care and customer service. Ratings range from 1 to 5 stars,

with five being the highest and one being the lowest score. Medicare assigns plans an overall star rating to summarize the plan’s performance as a whole. Plans also get separate star ratings in each individual category reviewed. Medicare star ratings are unavailable for CalPERS’ Medicare Supplemental plans because they are neither Medicare Advantage plans nor Part D plans.

## Other Quality Measurements

Other quality measurements contained in the Board’s health plan carrier contracts include the following:

### 2016 Health Plan Contract Quality Measures

Item	Health Plan Contractor Requirements
Behavioral Health Program	Provide a behavioral health program for mental health and substance abuse designed to objectively monitor and evaluate the efficiency, appropriateness and quality of mental health and substance abuse care provided to plan members.  Ensure that National Committee for Quality Assurance (NCQA) or Utilization Review Accreditation Commission (URAC) accreditation standards are maintained and that the program complies with applicable sections of federal and Knox-Keene Health Care Service Plan Act of 1975 mental health parity requirements. Upon CalPERS request, contractor will provide reports to CalPERS.
CalPERS Staff Satisfaction Survey	Responsiveness and quality of administrative services as measured on an account management survey.
Evidence-Based Medicine (EBM)	Have clinical committees that establish clinical practice pathways and guidelines and use national sources to identify EBM practice guidelines (e.g., from the Agency for Healthcare Research and Quality or Milliman).
Leapfrog Group Initiatives Participation	Use best efforts to require its participating provider hospitals to undertake the safety and quality initiatives supported by the Leapfrog Group consisting of computer physician order entry, evidence-based hospital referral, and appropriate intensive care unit physician staffing.
Office of the Patient Advocate’s Health Care Quality Report	Maintain a minimum of a two star rating for “Getting Care Easily” in the “Member Ratings” section from the Office of the Patient Advocate’s Health Care Quality Report Card.
Performance Measures	Provide data on inpatient acute care quality and clinical quality.
Provider Network Quality Review	Conduct ongoing participating provider network reviews for quality and appropriate care (e.g., physician, hospital, and ancillary services) and report findings to CalPERS.

<sup>15</sup> <http://www.medicareinteractive.org/get-answers/overview-of-medicare-health-coverage-options/changing-medicare-healthcoverage/the-five-star-rating-system-and-medicare-plan-enrollment>

2016 Health Plan Contract Quality Measures, cont.

Item	Health Plan Contractor Requirements
Quality Management and Improvement	<p>Review, measure, and improve the quality of services provided and the clinical practices of its participating providers and provide reports to CalPERS.</p> <p>Maintain internal quality improvement policies and procedures designed to achieve significant, sustained, improvement in clinical care, plan member satisfaction, and health outcomes for plan members receiving capitated services.</p> <p>Perform an assessment of access to non-capitated services by plan members, including, but not limited to, the quality of outcomes and timeliness of these services; review the assessment with participating providers providing non-capitated services; and report semi-annually to CalPERS any clinical situation in which a question exists as to whether medically necessary care was delivered by those providers.</p>
Reporting and Public Regulatory Studies	<p>Submit to CalPERS a copy of any financial audit report and any public quality of care study or access study prepared by a federal or state regulatory agency, or by an accrediting body (e.g., The Joint Commission, NCQA, or URAC).</p>



# Financial Information

Reserves  
Administrative Expenditures  
Investment Strategies

# Reserves

## Reserve Levels/Adequacy

As of December 31, 2016, the required actuarial reserve level for the PPO plans was \$586.3 million, and the total reserve level was \$690.4 million (i.e., \$104.1 million above the actuarial reserve level). In addition to establishing a conservative actuarial reserve requirement, CalPERS has also assessed a higher total reserve level to account for worst-case scenarios, e.g., paying for Incurred But Not Reported (IBNR) medical claims due to a shutdown of all PPO plans or an unexpected health pandemic.

There are no actuarial reserves for CalPERS' flex-funded HMO plans, but CalPERS does employ a risk mitigation strategy for these plans.

## Expected Change in Reserve Levels

CalPERS forecasts the reserve at the end of every fiscal year. In addition, we assess a worst-case scenario whereby the reserve is simultaneously designed to cover the IBNR reserve from a shutdown of all the plans, the risk-based capital (RBC) reserve (a reserve established to account for unforeseen pressures on premiums, such as a pandemic) for the PPO plans, and an increase in interest rates which would reduce the value of the reserve fund since it is invested in high quality, fixed income securities with a duration of approximately five years. Based on an evaluation of the above, current reserves are at a secure level sufficient to cover unforeseen events.

## Policies to Reduce Excess Reserves/ Rebuild Inadequate Reserves

CalPERS' policies to reduce excess reserves or rebuild inadequate reserves are as follows:

- If there are any plan specific excess reserve balances, either the subsequent year's plan premiums may be reduced, or excess reserves could be used to fund other health benefit plan programs, such as wellness programs.
- If there are inadequate reserves for any plan, the subsequent year's premiums may be increased.

For 2016, CalPERS did not lower any plans' premiums with excess reserves.

## Reinsurance/Other Alternatives to Maintain Reserves

The RBC requirement for the PPO plans is designed to provide adequate protection against adverse claims experience, thereby making reinsurance unnecessary.

As part of the annual rate development process, for each flex-funded HMO plan, CalPERS' actuaries evaluate whether proposed premiums are sufficient to cover the costs of health benefits under a plan. This evaluation employs the following analysis:

CalPERS compares the projected current year per member per month (PMPM) amounts for capitation and fee-for-service (FFS) against the negotiated capitation and FFS amounts in the contract. If this comparison reveals CalPERS owes more than what it is being contractually collected for a plan, CalPERS then determines if there is existing money in the plan's account that is not already slated for any other purpose (e.g., risk adjustment), which can be used to fill the gap. If there are not any or enough funds in the plan's account to fill this gap, an amount is added to the plan's proposed premium to address the deficit.

As of December 31, 2016, the assets for the self-funded portion of CalPERS' HMO plans totaled \$93.4 million.

# Administrative Expenditures

Administrative expenditures include personnel services — a category of expenditure which includes payment of salaries and wages, the state’s contribution to the Public Employees’ Retirement Fund, insurance premiums for workers’ compensation, the state’s share of employees’ health insurance and the state’s share of Social Security. The information being provided below is for the 2016-17 fiscal year.

CalPERS Health Benefits Program staffs 445.2 positions out of the total organization of 2,875 positions. The Health Benefits Program direct positions are located in the Health Policy and Benefits Branch. Enterprise Support Operation positions are throughout the organization, including the Operations and Technology Branch.

## Staff Levels

Direct	254.6
Enterprise Support Operations	190.6
<b>Total Staffing Levels</b>	<b>445.2</b>

## Personnel Services

(Dollars in Thousands)

Salary and Wages	\$32,486
Staff Benefits	15,548
<b>Total Personnel Services</b>	<b>\$48,034</b>

In addition to professional internal and external consulting services, operating expenses and equipment expenditure items include general expenses, printing, communication, travel, data processing, equipment, and accessories for the equipment.

## Operating Expenses & Equipment

(Dollars in Thousands)

Operating Expenses	\$7,221
Consultant and Professional Services - Internal	330
Consultant and Professional Services - External	7,474
Statewide Administrative Cost (Pro Rata)	3,115
<b>Total Operating Expenses &amp; Equipment</b>	<b>\$18,140</b>

The funding sources for the CalPERS Health Benefits Program are the Public Employees’ Contingency Reserve Fund (CRF) and the Public Employees’ Health Care Fund (HCF).

## Funding Sources

(Dollars in Thousands)

Public Employees’ CRF	\$27,325
Public Employees’ HCF	38,849
<b>Total Funding Sources</b>	<b>\$66,174</b>

# Investment Strategies

## Public Employees' Contingency Reserve Fund

The Public Employees' CRF is invested at the State Treasurer's Office in the Surplus Money Investment Fund (SMIF). The Pooled Money Investment Account (PMIA), of which SMIF is one part, is managed as follows:

- The pool ensures the safety of the portfolio by investing in high quality securities and by maintaining a mix of securities that provide reasonable assurance that no single investment or class of investments will have a disproportionate impact on the total portfolio.
- The pool is managed to ensure that normal cash needs, as well as scheduled extraordinary cash needs, can be met.
- Pooled investments and deposits are made in such a way as to realize the maximum return consistent with safe and prudent treasury management.

## Historical Investment Performance\* (Net of Fees)

Fiscal Year End	Allocation	Invested Assets	Annual Return
12/13	Surplus Money Investment Fund (SMIF)	\$356,890,578	0.31%
13/14		415,534,715	0.25%
14/15		653,620,918	0.27%
15/16		508,869,863	0.43%
16/17		597,371,880	0.75%

\* See Appendix K for historical quarterly yields of the SMIF.

## Expected Investment Returns

The SMIF does not follow a benchmark; however, comparison of PMIA yields to the Federal Funds Rate and the S&P Government Investment Pool index are provided in Appendix L.

## Public Employees' Health Care Fund

The Public Employees' HCF is invested at the State Treasurer's Office in the SMIF and with State Street Global Advisors (SSGA). The strategic objective of the Public Employees' HCF, as stated in the Investment Policy, is as follows:

The HCF seeks to provide stability of principal while avoiding large losses, enhance returns within prudent levels of risk, and maintain liquidity to meet cash needs.

### Historical Investment Performance\*

(Net of Fees)

Fiscal Year End	Allocation	Invested Assets	Annual Return
12/13	State Street Global Advisors (SSGA) U.S. Aggregate Bond Index Fund	\$390,849,831	0.70%
13/14		410,261,785	4.98%
14/15		420,752,861	2.55%
15/16		445,934,031	5.99%
16/17		444,708,612	(0.28%)
12/13	Surplus Money Investment Fund (SMIF)	263,865,397	0.31%
13/14		414,074,398	0.25%
14/15		263,835,202	0.27%
15/16		190,517,344	0.43%
16/17		225,940,476	0.75%

\*See Appendix K for historical quarterly yields of the SMIF.

### Expected Investment Returns

The SSGA U.S. Aggregate Bond Index Fund is passively managed to follow the Bloomberg Barclays U.S. Aggregate Bond Index. While the 10-year historical annualized investment return for the index as of June 30, 2017, is 4.48 percent, past performance is not a guarantee of future results.

The SMIF does not follow a benchmark; however, comparison of PMIA yields to the Federal Funds Rate and the S&P Government Investment Pool index are provided in Appendix L.

# Appendices

## Table of Contents

- A Implementing Statute
- B Health Benefit Design
- C Medical Trends
- D Member Satisfaction
- E Geographic Coverage
- F Historic Enrollment
- G Historic Expenditures
- H Premium Increases or Decreases from Prior Plan Year
- I Basic HMO Plan HEDIS-Like Measures
- J Basic PPO Plan HEDIS Measures
- K Surplus Money Investment Fund
- L PMIA, S&P GIP, and Federal Funds Average Monthly Yield Comparison

# Appendix A – Implementing Statute

## Government Code Section 22866

22866. (a) The board shall report to the Legislature and the Director of Finance on or before November 1, 2016, and annually thereafter, regarding the health benefits program. The report shall include, but not be limited to the following:

- (1) General overview of the health benefits program, including, but not limited to, the following:
  - (A) Description of health plans and benefits provided, including essential and nonessential benefits as required by state and federal law, member expected out-of-pocket expenses, and actuarial value by metal tier as defined by the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).
  - (B) Geographic coverage.
  - (C) Historic enrollment information by basic and Medicare plans, by state and contract agencies, by active and retired membership, and by subscriber and dependent tier.
  - (D) Historic expenditures by basic and Medicare plans, by state and contract agencies, by active and retired membership, and by subscriber and dependent tier.
- (2) Reconciliation of premium increases or decreases from the prior plan year, and the reasons for those changes.
  - (A) Description of benefit design and benefit changes, including prescription drug coverage, by plan. The description shall detail whether benefit changes were required by statutory mandate, federal law, or an exercise of the board's discretion, the costs or savings of the benefit change, and the impact of how the changes fit into a broader strategy.

- (B) Discussion of risk.
- (C) Description of medical trend changes in aggregate service categories for each plan. The aggregate service categories used shall include the standard categories of information collected by the board, consisting of the following: inpatient, emergency room, ambulatory surgery, office, ambulatory radiology, ambulatory lab, mental health and substance abuse, other professional, prescriptions, and all other service categories.
- (D) Reconciliation of past year premiums against actual enrollments, revenues, and accounts receivables.

- (3) Overall member health as reflected by data on chronic conditions.
- (4) The impact of federal subsidies or contributions to the health care of members, including Medicare Part A, Part B, Part C, or Part D, low-income subsidies, or other federal program.
- (5) The cost of benefits beyond Medicare contained in the board's Medicare supplemental plans.
- (6) A description of plan quality performance and member satisfaction, including, but not limited to, the following:
  - (A) The Healthcare Effectiveness Data and Information Set, referred to as HEDIS.
  - (B) The Medicare star rating for Medicare supplemental plans.
  - (C) The degree of satisfaction of members and annuitants with the health benefit plans and with the quality of the care provided, to the extent the board surveys participants.
  - (D) The level of accessibility to preferred providers for rural members who do not have access to health maintenance organizations.
  - (E) Other applicable quality measurements collected by the board as part of the board's health plan contracts.

(7) A description of risk assessment and risk mitigation policy related to the board's self-funded and flex-funded plan offerings, including, but not limited to the following:

- (A) Reserve levels and their adequacy to mitigate plan risk.
- (B) The expected change in reserve levels and the factors leading to this change.
- (C) Policies to reduce excess reserves or rebuild inadequate reserves.
- (D) Decisions to lower premiums with excess reserves.
- (E) The use of reinsurance and other alternatives to maintaining reserves.

(8) Description and reconciliation of administrative expenditures, including, but not limited to, the following:

- (A) Organization and staffing levels, including salaries, wages, and benefits.

(B) Operating expenses and equipment expenditure items, including, but not limited to, internal and external consulting and intradepartmental transfers.

(C) Funding sources.

(D) Investment strategies, historic investment performance, and expected investment returns of the Public Employees' Contingency Reserve Fund and the Public Employees' Health Care Fund.

(9) Changes in strategic direction and major policy initiatives.

(b) A report submitted pursuant to subdivision (a) shall be provided in compliance with Section 9795.

*(Amended by Stats. 2015, Ch. 323, Sec. 5. (SB 102) Effective September 22, 2015.)*

# Appendix B – Health Benefit Design

## CalPERS Health Plan Benefit Comparison—Basic Plans

For more details about the benefits provided by a specific plan, refer to that plan’s Evidence of Coverage (EOC) booklet.

Benefits	EPO & HMO Basic Plans									
	Anthem Blue Cross			Blue Shield			CCPOA (Association Plan)	Health Net		Kaiser Permanente
	EPO	Select HMO	Traditional HMO	Access+	Access+ EPO	NetValue		Salud y Más	SmartCare	
<b>Calendar Year Deductible</b>										
Individual	N/A			N/A			N/A	N/A		N/A
Family	N/A			N/A			N/A	N/A		N/A
<b>Maximum Calendar Year Co-pay or Co-insurance (excluding pharmacy)</b>										
Individual	\$1,500 (co-pay)			\$1,500 (co-pay)			\$1,500 (co-pay)	\$1,500 (co-pay)		\$1,500 (co-pay)
Family	\$3,000 (co-pay)			\$3,000 (co-pay)			\$4,500 (co-pay)	\$3,000 (co-pay)		\$3,000 (co-pay)
<b>Hospital (including Mental Health and Substance Abuse)</b>										
Deductible (per admission)	N/A			N/A			N/A	N/A		N/A
Inpatient	No Charge			No Charge			\$100/ admission	No Charge		No Charge
Outpatient Facility/ Surgery Services	No Charge			No Charge			\$50	No Charge		\$15

Continued on next page

EPO & HMO Basic Plans		PPO Basic Plans									
Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	CAHP (Association Plan)		PERS Select		PERS Choice		PERSCare		PORAC (Association Plan)	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
N/A	N/A	N/A		\$500 (not transferable between plans)		\$500 (not transferable between plans)		\$500 (not transferable between plans)		\$300	\$600
N/A	N/A	N/A		\$1,000 (not transferable between plans)		\$1,000 (not transferable between plans)		\$1,000 (not transferable between plans)		\$900	\$1,800
\$1,500 (co-pay)	\$1,500 (co-pay)	\$2,000 (co-insurance)	N/A	\$3,000 (co-insurance)	N/A	\$3,000 (co-insurance)	N/A	\$2,000 (co-insurance)	N/A	\$4,500	N/A
\$3,000 (co-pay)	\$3,000 (co-pay)	\$4,000 (co-insurance)	N/A	\$6,000 (co-insurance)	N/A	\$6,000 (co-insurance)	N/A	\$4,000 (co-insurance)	N/A	\$9,000	N/A
N/A	N/A	N/A		N/A		N/A		\$250		N/A	
No Charge	No Charge	10%	Varies	20-30% (hospital tiers)	40%	20%	40%	10%	40%	10%	
No Charge	No Charge	\$50 (exceptions may apply)		20-30% (hospital tiers)	40%	20%	40%	10%	40%	10%	

## CalPERS Health Plan Benefit Comparison—Basic Plans, cont.

For more details about the benefits provided by a specific plan, refer to that plan’s Evidence of Coverage (EOC) booklet.

Benefits	EPO & HMO Basic Plans									
	Anthem Blue Cross			Blue Shield			CCPOA (Association Plan)	Health Net		Kaiser Permanente
	EPO	Select HMO	Traditional HMO	Access+	Access+ EPO	NetValue		Salud y Más	SmartCare	
<b>Emergency Services</b>										
Emergency Room Deductible	N/A			N/A			N/A	N/A		N/A
Emergency (co-pay waived if admitted as an inpatient or for observation as an outpatient)	\$50			\$50			\$75	\$50		\$50
Non-Emergency (co-pay waived if admitted as an inpatient or for observation as an outpatient)	\$50			\$50			\$75	\$50		\$50
<b>Physician Services (including Mental Health and Substance Abuse)</b>										
Office Visits (co-pay for each service provided)	\$15			\$15			\$15	\$15		\$15
Inpatient Visits	No Charge			No Charge			No Charge	No Charge		No Charge
Outpatient Visits	\$15			\$15			\$15	\$15		\$15
Urgent Care Visits	\$15			\$15			\$15	\$15		\$15
Vision Exam/ Screening	No Charge			No Charge			\$15	No Charge		No Charge
Surgery/Anesthesia	No Charge			No Charge			No Charge	No Charge		No Charge
<b>Diagnostic X-Ray/Lab</b>										
	No Charge			No Charge			No Charge	No Charge		No Charge

Continued on next page

EPO & HMO Basic Plans		PPO Basic Plans									
Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	CAHP (Association Plan)		PERS Select		PERS Choice		PERSCare		PORAC (Association Plan)	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
N/A	N/A	N/A		\$50 (applies to hospital emergency room charges only)		\$50 (applies to hospital emergency room charges only)		\$50 (applies to hospital emergency room charges only)		N/A	
\$50	\$50	\$50+10% (co-pay reduced to \$25 if admitted on an inpatient basis)		20% (applies to other services such as physician, x-ray, lab, etc.)		20% (applies to other services such as physician, x-ray, lab, etc.)		10% (applies to other services such as physician, x-ray, lab, etc.)		10%	
\$50	\$50	\$50+10%	\$50+40%	20%    40% (payment for physician charges only; emergency room facility charge is not covered)		20%    40% (payment for physician charges only; emergency room facility charge is not covered)		10%    40% (payment for physician charges only; emergency room facility charge is not covered)		50% (for non-emergency services provided by hospital emergency room)	
\$15	\$15	\$15	40%	\$20	40%	\$20	40%	\$20	40%	\$20	10%
No Charge	No Charge	10%	40%	20%	40%	20%	40%	10%	40%	10%	10%
\$15	\$15	10%	40%	\$20	40%	\$20	40%	\$20	40%	10%	10%
\$15	\$15	\$15	40%	\$20	40%	\$20	40%	\$20	40%	10%	10%
No Charge	No Charge	Not Covered		Not Covered		Not Covered		Not Covered		Not Covered	
No Charge	No Charge	10%	40%	20%	40%	20%	40%	10%	40%	10%	10%
No Charge	No Charge	10%	40%	20%	40%	20%	40%	10%	40%	10%	10%

## CalPERS Health Plan Benefit Comparison—Basic Plans, cont.

For more details about the benefits provided by a specific plan, refer to that plan’s Evidence of Coverage (EOC) booklet.

Benefits	EPO & HMO Basic Plans									
	Anthem Blue Cross			Blue Shield			CCPOA (Association Plan)	Health Net		Kaiser Permanente
	EPO	Select HMO	Traditional HMO	Access+	Access+ EPO	NetValue		Salud y Más	SmartCare	
<b>Prescription Drugs</b>										
Deductible	N/A			N/A			Brand Formulary: \$50 (not to exceed \$150/family)	N/A		N/A
Retail Pharmacy (not to exceed 30-day supply)	Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50			Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50			Generic: \$10 Brand Formulary: \$25 Non- Formulary: \$50	Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50		Generic: \$5 Brand: \$20
Retail Pharmacy Maintenance Medications filled after 2nd fill (i.e. a medication taken longer than 60 days) (not to exceed 30-day supply)	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100			Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100			Generic: \$10 Brand Formulary: \$25 Non- Formulary: \$50	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100		N/A
Mail Order Pharmacy Program (not to exceed 90-day supply for maintenance drugs)	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100			Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100			Generic: \$20 Brand Formulary: \$50 Non- Formulary: \$100	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100		Generic: \$10 Brand: \$40 (31-100 day supply)
Mail order maximum co-payment per person per calendar year	\$1,000			\$1,000			N/A	\$1,000		N/A
<b>Durable Medical Equipment</b>										
	No Charge			No Charge			No Charge	No Charge		No Charge

Continued on next page

EPO & HMO Basic Plans		PPO Basic Plans									
Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	CAHP (Association Plan)		PERS Select		PERS Choice		PERSCare		PORAC (Association Plan)	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
N/A	N/A	N/A		N/A		N/A		N/A		N/A	
Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50	Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50	Generic: \$5 Single Source: \$20 Multi Source: \$25		Generic: \$5 Preferred: \$20 Non-Preferred: \$50		Generic: \$5 Preferred: \$20 Non-Preferred: \$50		Generic: \$5 Preferred: \$20 Non-Preferred: \$50 (not to exceed 34-day supply)		Generic: \$10 Brand Formulary: \$25 Non-Formulary: \$45 Compound: \$45	
Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Single Source: \$40 Multi Source: \$50		Generic: \$10 Preferred: \$40 Non-Preferred: \$100		Generic: \$5 Preferred: \$40 Non-Preferred: \$100		Generic: \$10 Preferred: \$40 Non-Preferred: \$100 (not to exceed 34-day supply)		N/A	
Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Single Source: \$40 Multi Source: \$50		Generic: \$10 Preferred: \$40 Non-Preferred: \$100		Generic: \$10 Preferred: \$40 Non-Preferred: \$100		Generic: \$10 Preferred: \$40 Non-Preferred: \$100		Generic: \$20 Brand Formulary: \$40 Non-Formulary: \$75	N/A
\$1,000	\$1,000	N/A		\$1,000		\$1,000		\$1,000		N/A	
No Charge	No Charge	10%	40%	20% (pre-certification required for equipment)	40%	20% (pre-certification required for equipment)	40%	10% (pre-certification required for equipment \$1,000 or more)	40%	20%	20%

## CalPERS Health Plan Benefit Comparison—Basic Plans, cont.

For more details about the benefits provided by a specific plan, refer to that plan’s Evidence of Coverage (EOC) booklet.

Benefits	EPO & HMO Basic Plans									
	Anthem Blue Cross			Blue Shield			CCPOA (Association Plan)	Health Net		Kaiser Permanente
	EPO	Select HMO	Traditional HMO	Access+	Access+ EPO	NetValue		Salud y Más	SmartCare	
<b>Infertility Testing/Treatment</b>										
Office Visits (co-pay for each service provided)	50% of Covered Charges			50% of Covered Charges			50% of Allowed Charges	50% of Covered Charges		50% of Covered Charges
<b>Occupational/Physical/Speech Therapy</b>										
Inpatient (hospital or skilled nursing facility)	No Charge			No Charge			No Charge	No Charge		No Charge
Outpatient (office and home visits)	\$15			\$15			No Charge	\$15		\$15
<b>Diabetes Services</b>										
Glucose monitors	No Charge			No Charge			No Charge	No Charge		No Charge
Self-management training	\$15			\$15			\$15	\$15		\$15
<b>Acupuncture</b>										
	\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)			\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)			N/A	\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)		\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)
<b>Chiropractic</b>										
	\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)			\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)			\$15 exam (up to 20 visits)  No Charge diagnostic services; chiropractic appliances (up to \$50)	\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)		\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)

EPO & HMO Basic Plans		PPO Basic Plans									
Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	CAHP (Association Plan)		PERS Select		PERS Choice		PERSCare		PORAC (Association Plan)	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
50% of Covered Charges	50% of Covered Charges	Not Covered		Not Covered		Not Covered		Not Covered		50%	
No Charge	No Charge	10%	40%	No Charge		No Charge		No Charge		10%	10%
\$15	\$15	10%	40%	20%	40%; Occupational therapy: 20%	20%	40%; Occupational therapy: 20%	20%		\$20	10%
		(pre-certification required for more than 24 visits)		(pre-certification required for more than 24 visits)		(pre-certification required for more than 24 visits)					
No Charge	No Charge	Coverage Varies		Coverage Varies		Coverage Varies		Coverage Varies		Coverage Varies	
\$15	\$15	\$20		\$20		\$20		\$20		\$20	
\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	10%	40%	\$15/visit	40%	\$15/visit	40%	\$15/visit	40%	\$20 (10% for all other services)	10%
		(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)			
\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	10%	40%	\$15/visit	40%	\$15/visit	40%	\$15/visit	40%	\$20/up to 20 visits	\$35/visit
		(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)			

## CalPERS Health Plan Benefit Comparison—Medicare Plans

For more details about the benefits provided by a specific plan, refer to that plan’s Evidence of Coverage (EOC) booklet.

Benefits	Medicare Plans		
	CCPOA Medicare Supplement (Association Plan)	Kaiser Permanente Senior Advantage	UnitedHealthcare Group Medicare Advantage (PPO)
<b>Calendar Year Deductible</b>			
Individual	N/A	N/A	N/A
Family	N/A	N/A	N/A
<b>Maximum Calendar Year Co-pay or Co-insurance (excluding pharmacy)</b>			
Individual	\$1,500 (co-pay)	\$1,500 (co-pay)	\$1,500 (co-pay)
Family	\$4,500 (3 or more)	\$3,000 (co-pay)	N/A
<b>Hospital (including Mental Health and Substance Abuse)</b>			
Inpatient	\$100/admission	No Charge	No Charge
Outpatient Facility/ Surgery Services	No Charge	\$10	No Charge
<b>Skilled Nursing Facility</b>			
Medicare (up to 100 days/ benefit period)	No Charge	No Charge	No Charge
<b>Home Health Services</b>			
Medicare	\$15/visit (up to 100 visits per calendar year)	No Charge	No Charge
<b>Hospice</b>			
Medicare	No Charge	No Charge	No Charge
<b>Emergency Services</b>			
Medicare (waived if admitted or kept for observation)	No Charge	\$50	\$50
<b>Ambulance Services</b>			
Medicare	No Charge	No Charge	No Charge
<b>Surgery/Anesthesia</b>			
	No Charge	No Charge inpatient; \$10 outpatient	No Charge

Continued on next page

Medicare Plans							
CAHP Medicare Supplement (Association Plan)	PERS Select		PERS Choice		PERSCare		PORAC (Association Plan)
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	\$3,000 (co-insurance)	N/A	\$15,000 calendar year stop-loss
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge

## CalPERS Health Plan Benefit Comparison—Medicare Plans

For more details about the benefits provided by a specific plan, refer to that plan’s Evidence of Coverage (EOC) booklet.

Benefits	Medicare Plans		
	CCPOA Medicare Supplement (Association Plan)	Kaiser Permanente Senior Advantage	UnitedHealthcare Group Medicare Advantage (PPO)
<b>Physician Services (including Mental Health and Substance Abuse)</b>			
Office Visits	\$10	\$10	\$10
Inpatient Visits	No Charge	No Charge	No Charge
Outpatient Visits	\$10	\$10	\$10
Urgent Care Visits	\$10	\$10	\$25
Preventative Services	No Charge	No Charge	No Charge
Allergy Treatment	No Charge	\$3 (for allergy injections)	No Charge
<b>Diagnostic X-Ray/Lab</b>			
	No Charge	No Charge	No Charge
<b>Durable Medical Equipment</b>			
Medicare	No Charge	No Charge	No Charge
<b>Prescription Drugs</b>			
Deductible	N/A	N/A	N/A
Retail Pharmacy (not to exceed 30-day supply)	Generic: \$5 Preferred: \$20 Non-Preferred: \$35	Generic: \$5 Preferred: \$20	Generic: \$5 Preferred: \$20 Non-Preferred: \$50
Retail Pharmacy Long-Term Prescription Medications filled after 2nd fill (i.e. 90-day supply)	Generic: \$5 Preferred: \$20 Non-Preferred: \$35	N/A	Generic: \$10 Preferred: \$40 Non-Preferred: \$100
Mail Order Pharmacy Program (not to exceed 90-day supply)	Generic: \$10 Preferred: \$40 Non-Preferred: \$70	Generic: \$10 Preferred: \$40 (31-100 day supply)	Generic: \$10 Preferred: \$40 Non-Preferred: \$100
Mail order maximum co-payment per person per calendar year	N/A	N/A	\$1,000
<b>Occupational/Physical/Speech Therapy</b>			
Inpatient (hospital or skilled nursing facility)	No Charge	No Charge	No Charge
Outpatient (office and home visits)	No Charge	\$10	\$10

Continued on next page

Medicare Plans							
CAHP Medicare Supplement (Association Plan)	PERS Select		PERS Choice		PERSCare		PORAC (Association Plan)
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	
\$10	No Charge	No Charge					
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
N/A	N/A	N/A	N/A	N/A	N/A	N/A	\$100
Generic: \$5 Single Source: \$20 Multi Source: \$25	Generic: \$5 Preferred: \$20 Non-Preferred: \$50	Generic: \$10 Preferred: \$25 Non-Preferred: \$45					
Generic: \$10 Preferred: \$40 Non-Preferred: \$50	Generic: \$10 Preferred: \$40 Non-Preferred: \$100 (not to exceed 30 day supply)	Generic: \$10 Preferred: \$40 Non-Preferred: \$100 (not to exceed 30 day supply)	Generic: \$10 Preferred: \$40 Non-Preferred: \$100 (not to exceed 30 day supply)	Generic: \$10 Preferred: \$40 Non-Preferred: \$100 (not to exceed 30 day supply)	Generic: \$10 Preferred: \$40 Non-Preferred: \$100 (not to exceed 30 day supply)	Generic: \$10 Preferred: \$40 Non-Preferred: \$100 (not to exceed 30 day supply)	N/A
Generic: \$10 Preferred: \$40 Non-Preferred: \$50	Generic: \$10 Preferred: \$40 Non-Preferred: \$100 (not to exceed 90 day supply)	Generic: \$10 Preferred: \$40 Non-Preferred: \$100 (not to exceed 90 day supply)	Generic: \$10 Preferred: \$40 Non-Preferred: \$100 (not to exceed 90 day supply)	Generic: \$10 Preferred: \$40 Non-Preferred: \$100 (not to exceed 90 day supply)	Generic: \$10 Preferred: \$40 Non-Preferred: \$100 (not to exceed 90 day supply)	Generic: \$10 Preferred: \$40 Non-Preferred: \$100 (not to exceed 90 day supply)	Generic: \$20 Preferred: \$40 Non-Preferred: \$75
N/A	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	N/A
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge

## CalPERS Health Plan Benefit Comparison—Medicare Plans, cont.

For more details about the benefits provided by a specific plan, refer to that plan’s Evidence of Coverage (EOC) booklet.

Benefits	Medicare Plans		
	CCPOA Medicare Supplement (Association Plan)	Kaiser Permanente Senior Advantage	UnitedHealthcare Group Medicare Advantage (PPO)
<b>Diabetes Services</b>			
Glucose monitors, test strips	No Charge	No Charge	No Charge
Self-management training	\$10	\$10	\$10
<b>Hearing Services</b>			
Routine Hearing Exam	No Charge	\$10	No Charge
Physician Services	\$15	\$10	\$10
Hearing Aids	\$500 max/member	\$1,000 max/36 months	\$1,000 max/36 months
<b>Vision Care</b>			
Vision Exam	\$10	\$10	\$10
Eyeglasses (following cataract surgery)	No Charge	No Charge	No Charge
Contact Lenses (following cataract surgery)	No Charge	No Charge	No Charge
<b>More Benefits Beyond Medicare (Services covered beyond Medicare coverage)</b>			
Acupuncture	N/A	\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)
Chiropractic	\$15/visit (up to 20 visits per calendar year)	\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)

## Medicare Plans

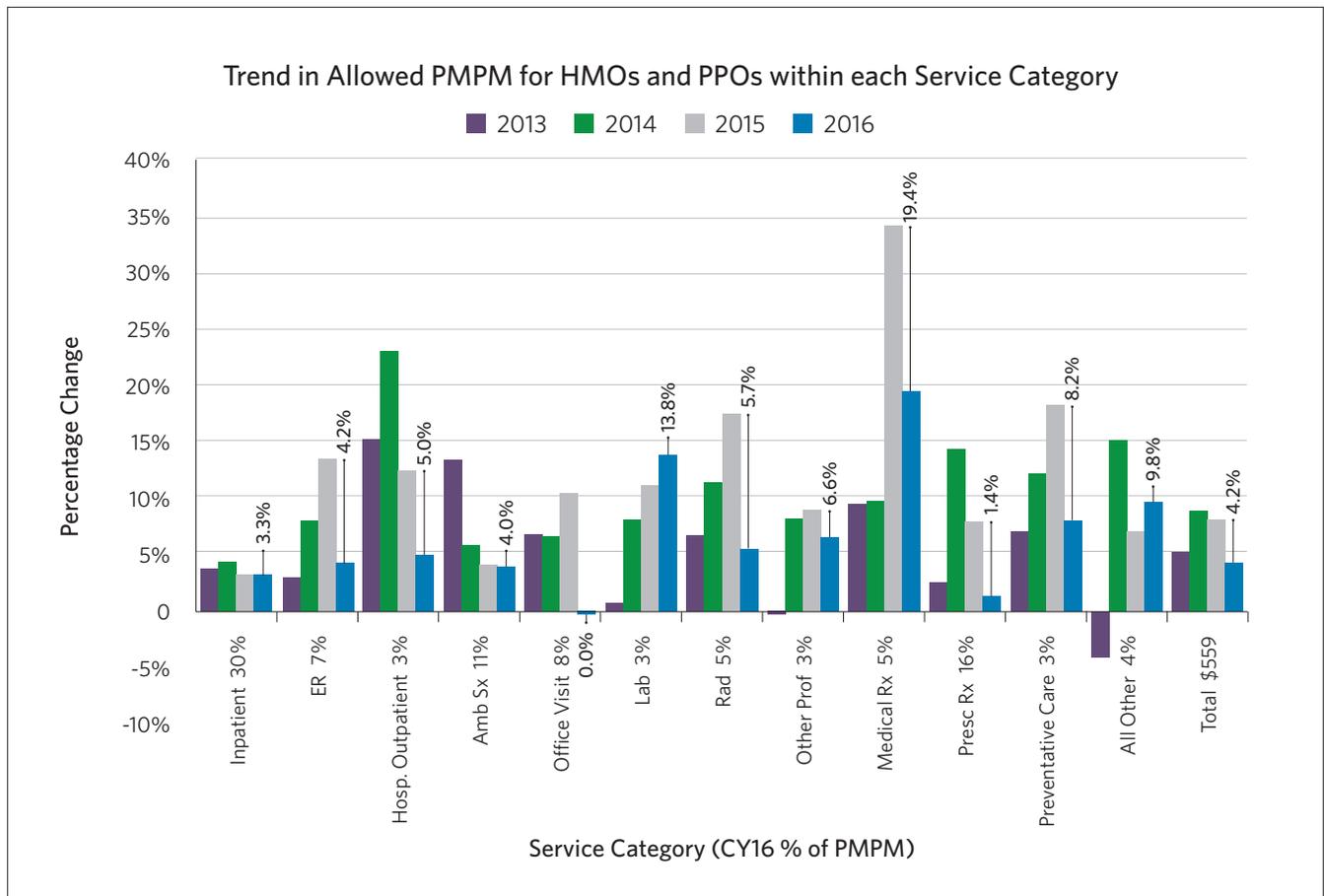
CAHP Medicare Supplement (Association Plan)	PERS Select		PERS Choice		PERSCare		PORAC (Association Plan)
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	20%
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	20%
20% (\$1,000 max/36 months)	20% (\$1,000 max/36 months)	20% (\$1,000 max/36 months)	20% (\$1,000 max/36 months)	20% (\$1,000 max/36 months)	20% (\$2,000 max/24 months)	20% (\$900 max/36 months)	20% (\$900 max/36 months)
N/A	N/A	N/A	N/A	N/A	N/A	N/A	20%
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	20%
No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	20%
20%	\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	20%					
20%	\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	20%					

# Appendix C - Medical Trends

## Service Category Per Member Per Month (PMPM) Change, Trend Drivers

The trend in allowed PMPM<sup>1</sup> cost<sup>2</sup> is examined across 13 service categories, revealing the key drivers of medical trend changes for the last four years.<sup>3</sup>

The chart below shows the three major drivers that account for approximately 57 percent of the total allowed PMPM are inpatient (30%), prescription drugs (PrescRx) (16%), and ambulatory surgery (AmbSx) (11%). For individual categories, the highest variable was in Medical Rx for a total percent differential of 19.4 percent.



<sup>1</sup> Allowed cost divided by sum of member months in period, adjusted for population size.

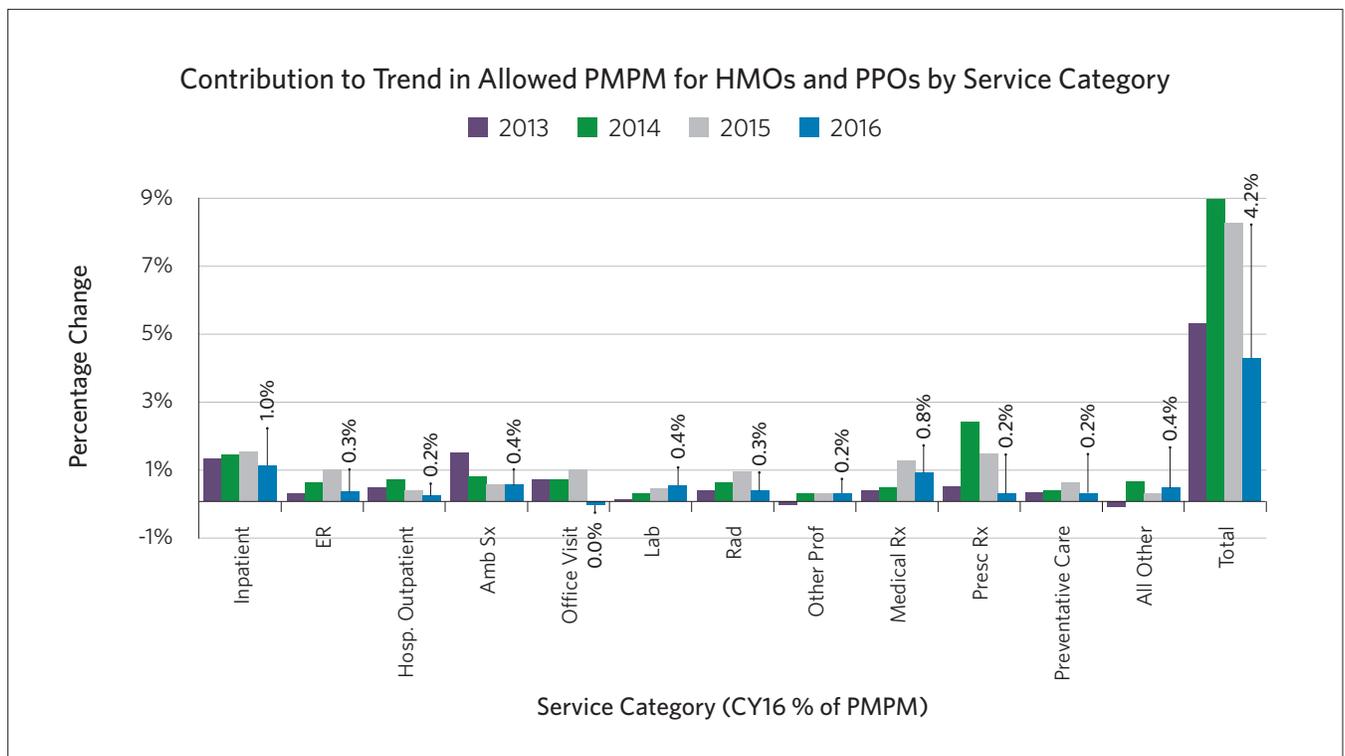
<sup>2</sup> Contractual "allowed amounts" due to providers inclusive of member out-of-pocket obligations such as coinsurance, copays, deductibles, etc. Report shows "allowed" rather than "net" to provide easier comparisons between plans with different benefit designs (e.g., HMO plans vs PPO plans).

<sup>3</sup> Due to insufficient 2016 mental health and substance abuse (MH/SA) claims data from one of our health plans, CalPERS is not including MH/SA trend in this report.

### Service Category Per Member Per Month (PMPM) Change, Trend Drivers

In calendar year 2016, the total allowed PMPM increased 4.2 percent across all service categories compared to 7.2 percent in 2015.

The chart below shows the three major drivers that contributed to trend in allowed PMPM for calendar year 2016. Inpatient accounts for one percent, prescription drug was 0.2 percent, and ambulatory surgery was 0.4 percent.

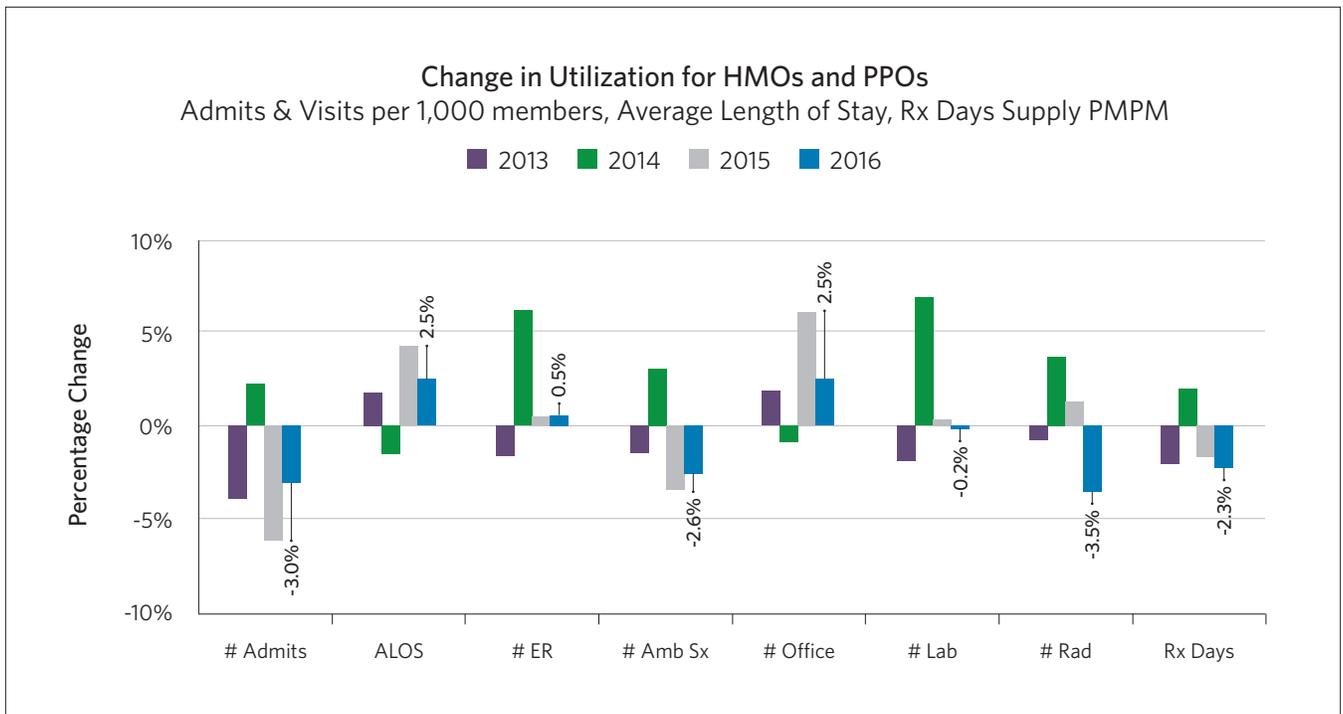


## Appendix C – Medical Trends, cont.

### Change in Utilization and Unit Price by Key Service Categories

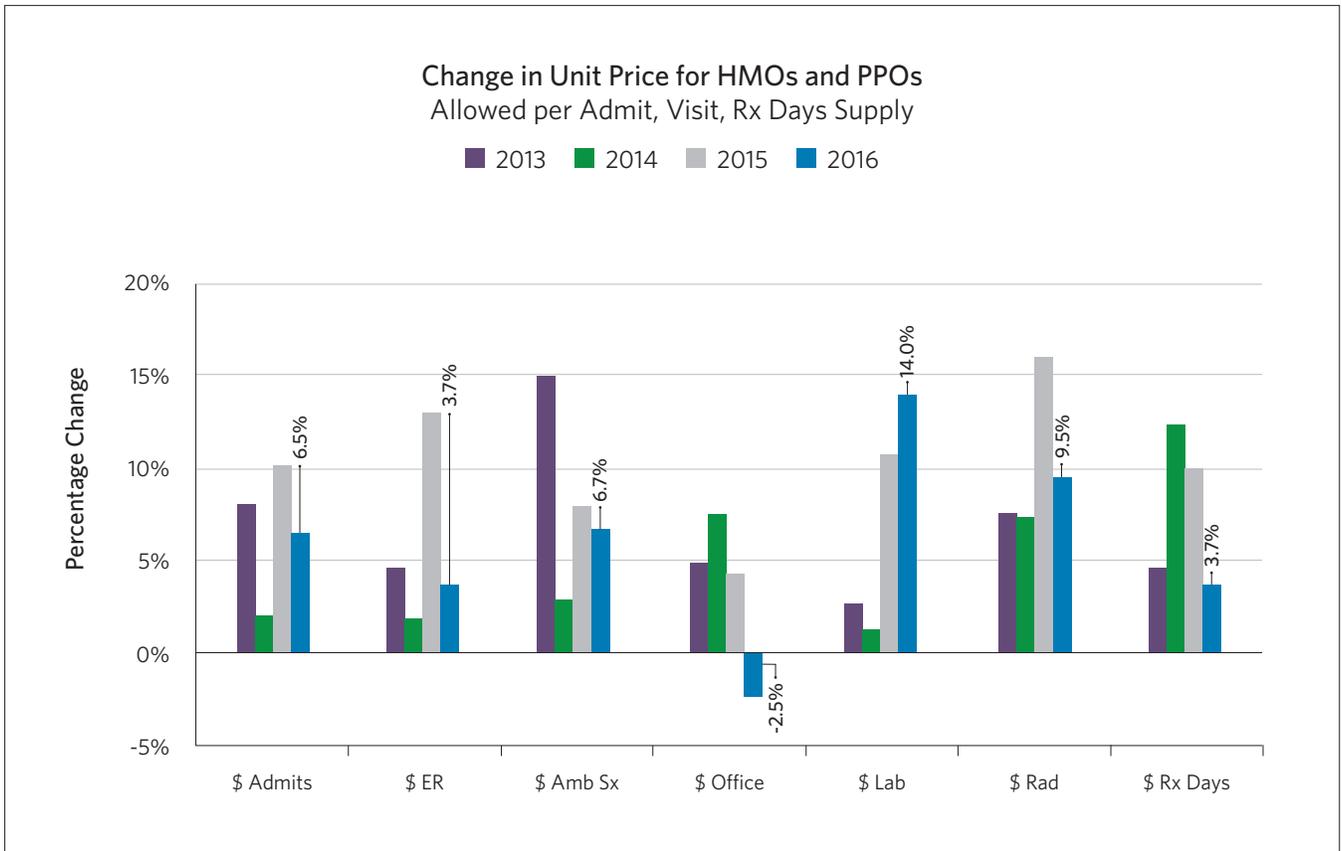
Among the largest service categories, allowed PMPM is driven by change in utilization and price per unit.

- Increases in utilization occurred in average length of stay (ALOS) by 2.5 percent, number of emergency room visits (# ER) by 0.5 percent, and number of office visits (# Office) by 2.5 percent.
- Decreases in utilization occurred in number of admits (# Admits) by 3.0 percent, number of ambulatory surgery (# AmbSx) by 2.6 percent, number of laboratory services (# Lab) by 0.2 percent, number of radiology services (# Rad) by 3.5 percent, and number of prescription drug days (Rx Days) by 2.3 percent.



### Change in Utilization and Unit Price by Key Service Categories - Continued

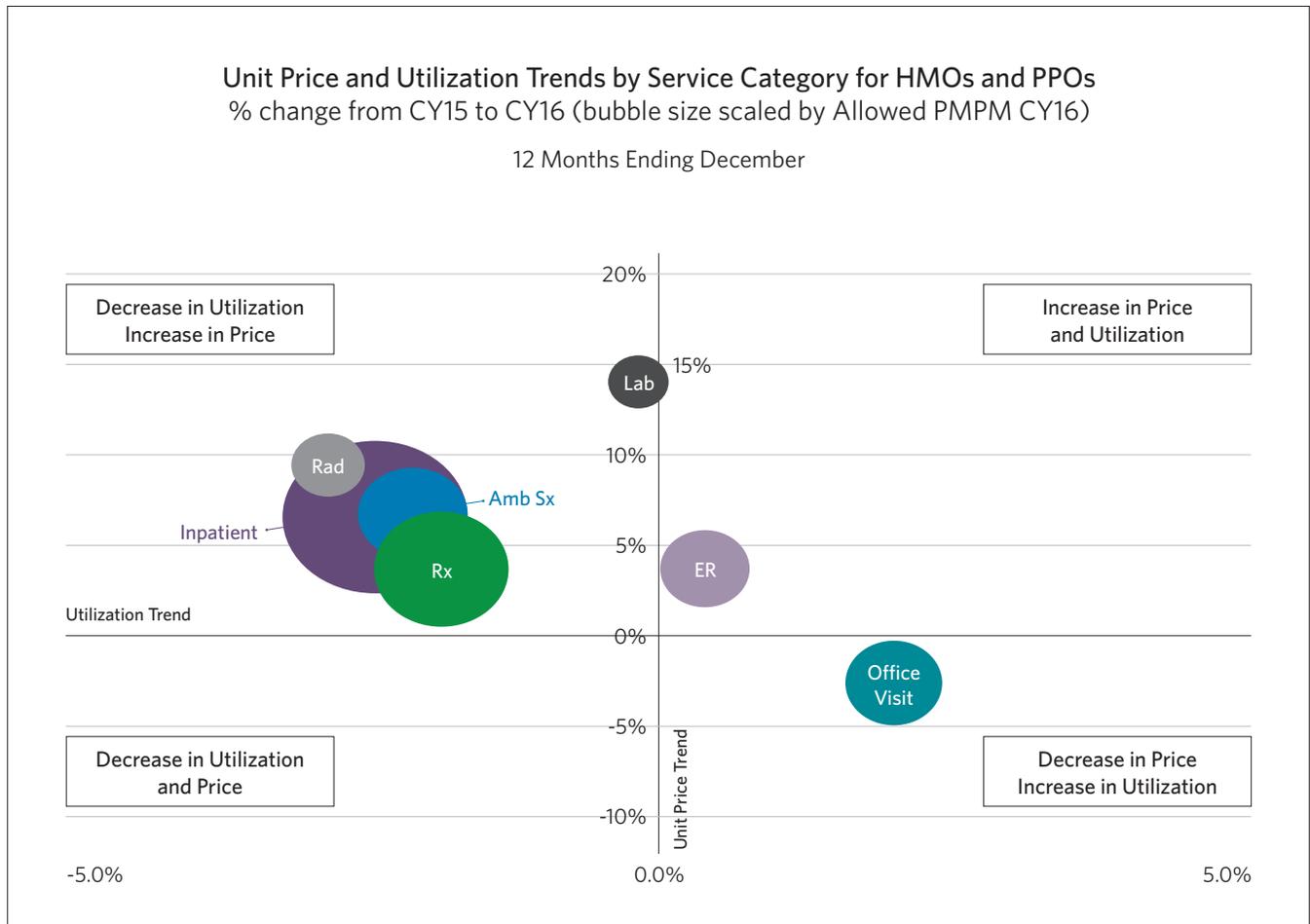
- With the exception of office visits, change in unit price increased across all service categories for calendar year 2016; and laboratory services experienced the largest increase of 14 percent.



## Appendix C – Medical Trends, cont.

### Utilization and Unit Price Trends by Key Service Category

The chart below shows the relationship between changes in utilization and price by key service categories where a single metric can be appropriately used for that category. The size of the bubble is the average cost PMPM for the category.



## Appendix D – Member Satisfaction

Each year, CalPERS conducts a survey to evaluate members' experiences with their health plan during the previous 12-month period. The survey uses a modified version of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey, a standard tool for measuring health plans. The survey covers topics that are important to members and focuses on aspects of quality that members are best qualified to assess, such as their satisfaction with their providers and ease of access to health care services.

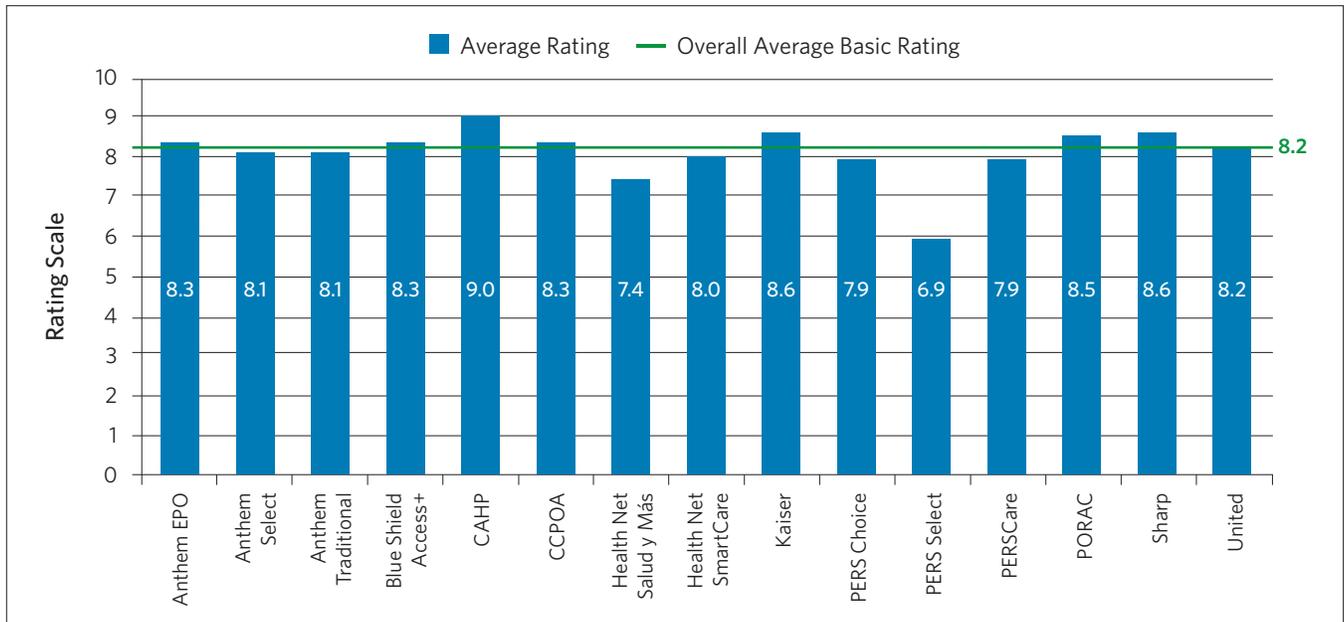
The 2017 CalPERS Health Plan Member Survey that evaluated plan year 2016 experiences began on January 10, 2017, and concluded March 6, 2017. CalPERS randomly selected 1,100 members from each Basic and Medicare plan having at least 2,000 members enrolled. In total, 23,100 members from 15 Basic and 6 Medicare health plans received a survey and 8,159 members responded. As in past years, the response rate for Medicare plans was higher than for Basic plans – 64 percent compared with 25 percent.

The following pages show average ratings for Basic and Medicare plan members.

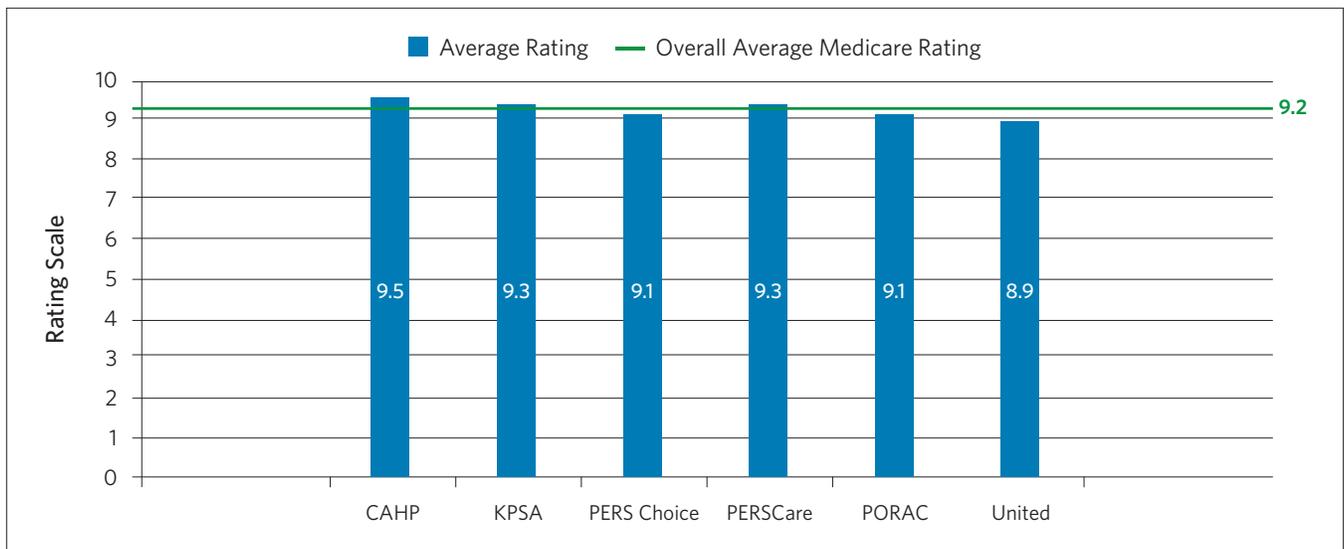
## Appendix D – Member Satisfaction, cont.

Members were asked: Using any number between 0 and 10, where 0 means extremely dissatisfied and 10 means extremely satisfied, what number would you use to rate your health plan?

### Basic: Health Plan Satisfaction Ratings

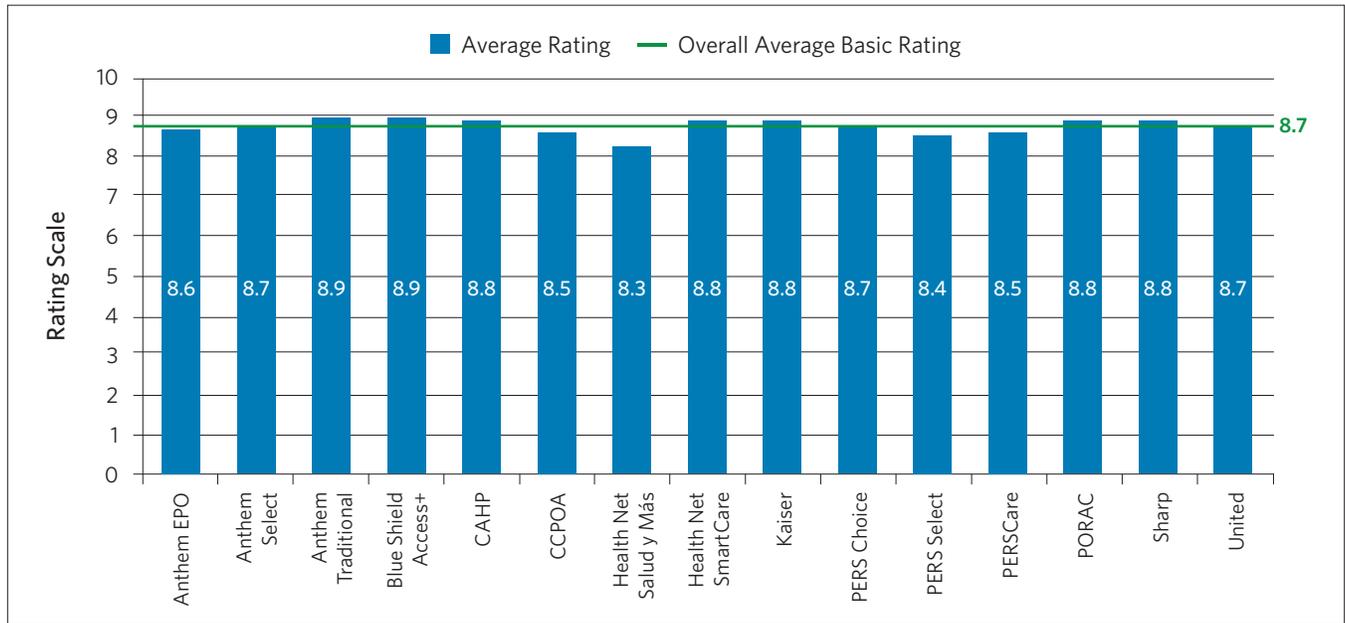


### Medicare: Health Plan Satisfaction Ratings

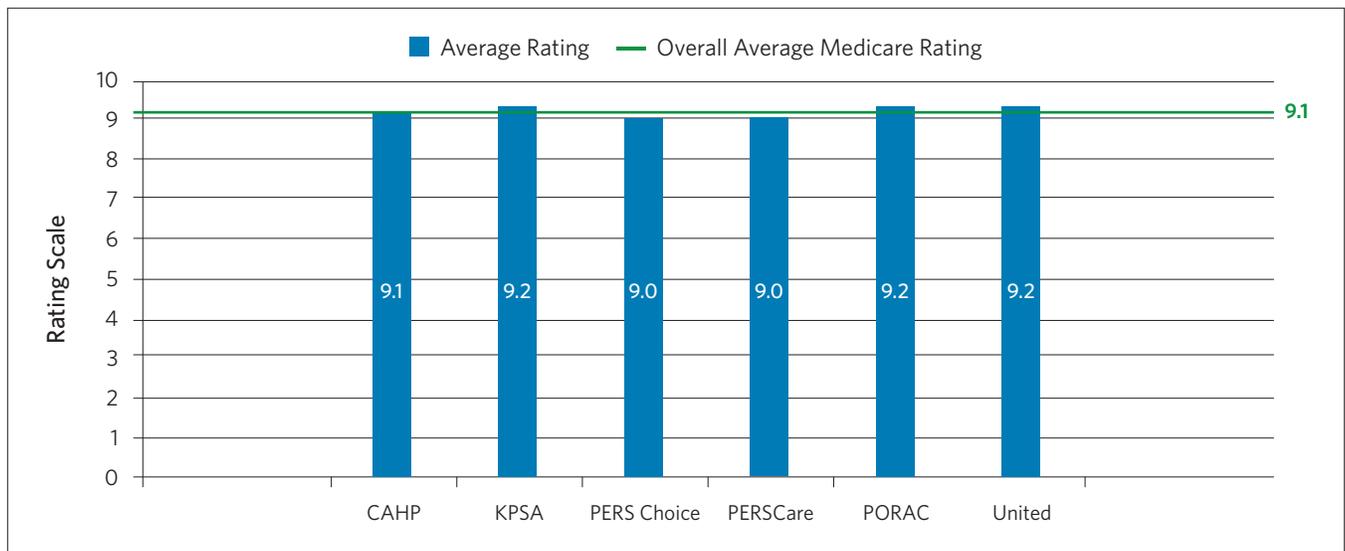


Members were asked: Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?

### Basic: Personal Doctor Satisfaction Ratings



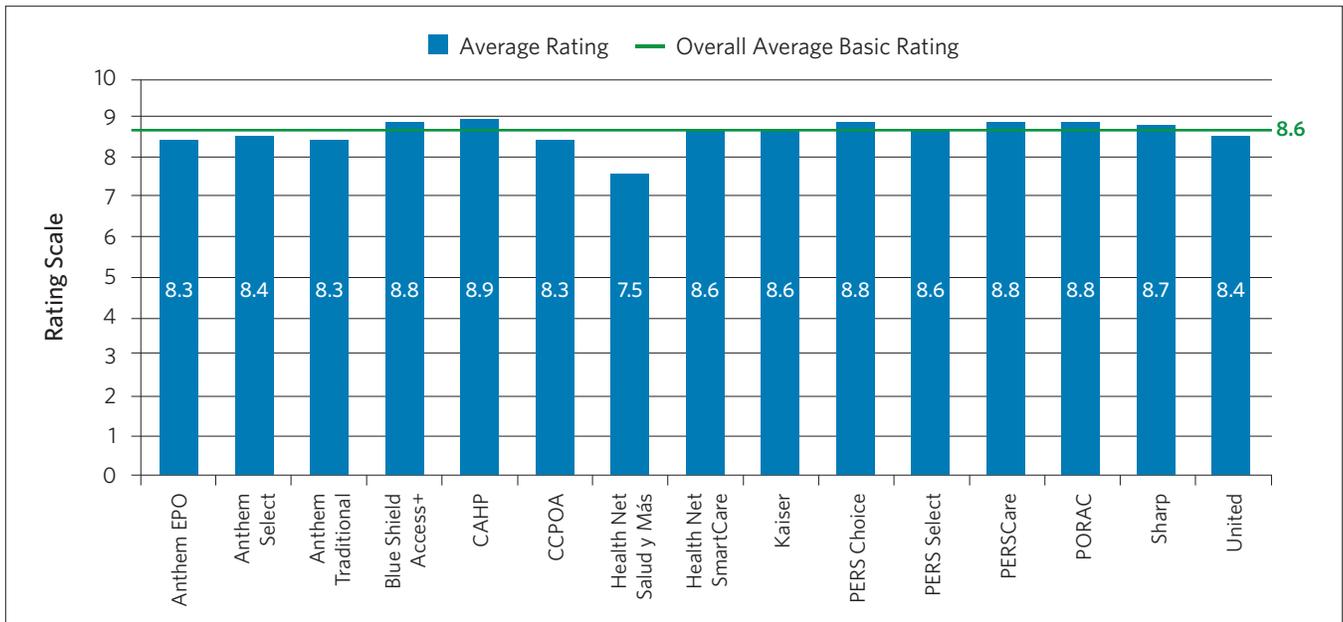
### Medicare: Personal Doctor Satisfaction Ratings



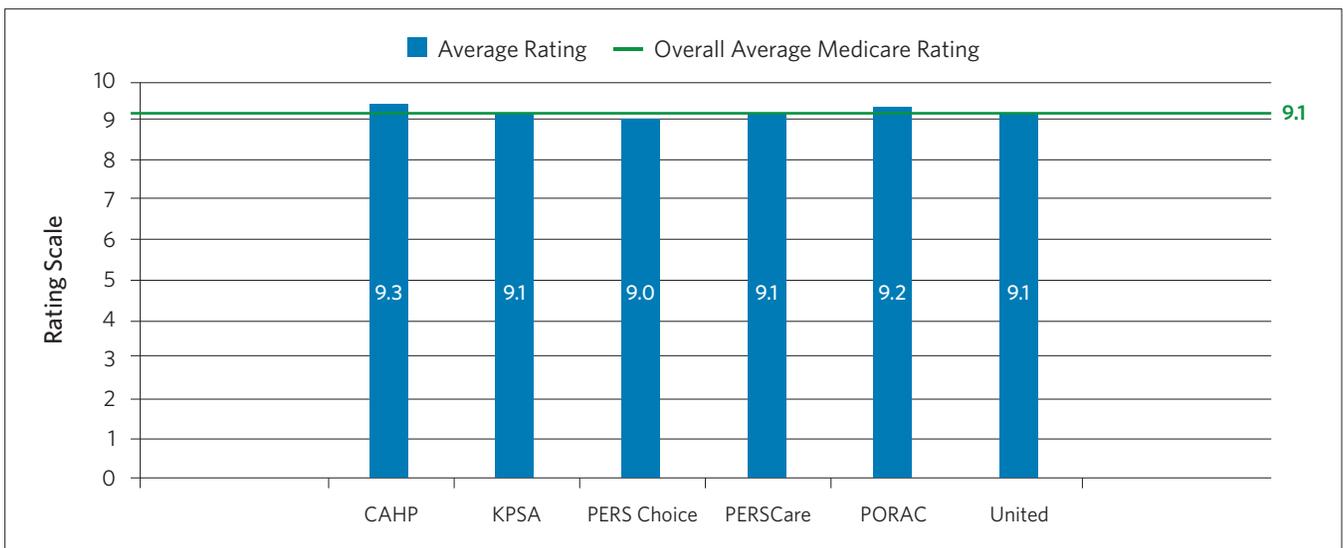
## Appendix D – Member Satisfaction, cont.

Members were asked: We want to know your rating of the specialist you saw most often in the last 12 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate the specialist?

### Basic: Specialist Satisfaction Ratings



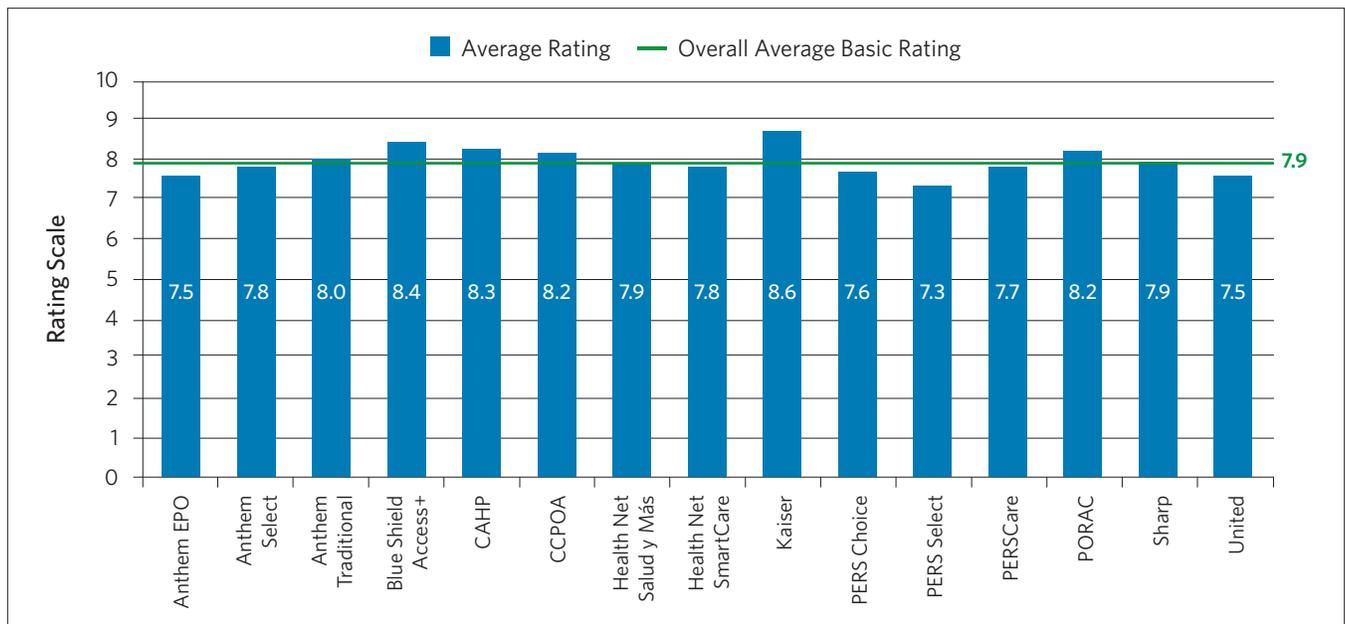
### Medicare: Specialist Satisfaction Ratings



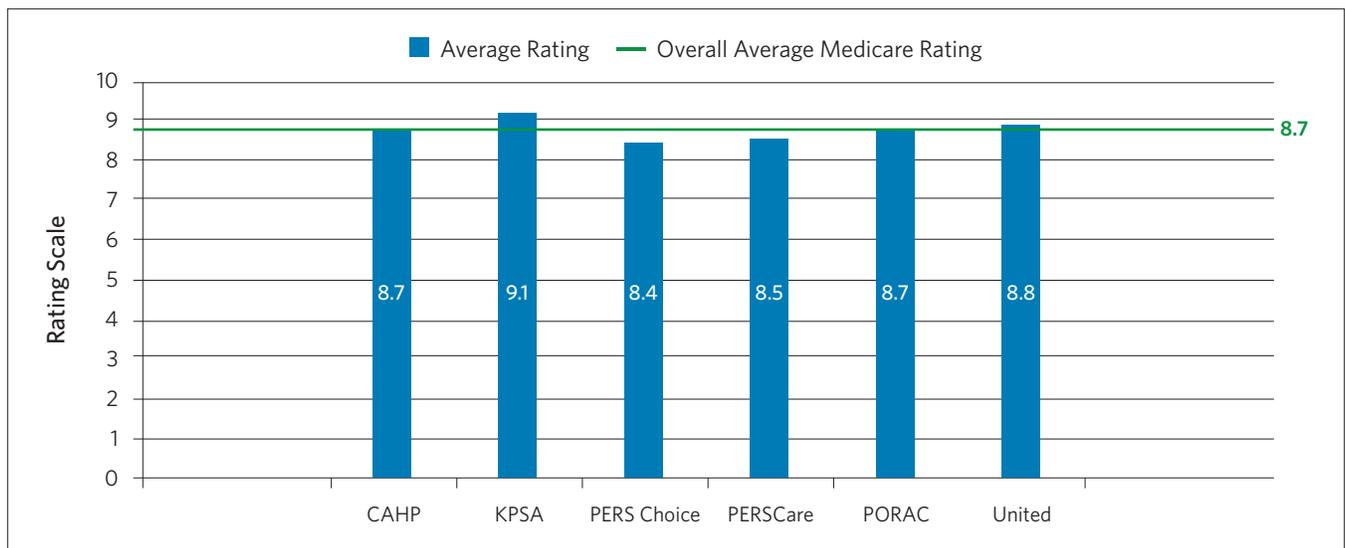
## Pharmacy Services

Members were asked: Using any number from 0 to 10, where 0 is the worst pharmacy services possible and 10 is the best pharmacy services possible, what number would you use to rate your overall satisfaction with your pharmacy services (i.e., your experience with obtaining prescriptions from a retail or mail order pharmacy)?

### Basic: Pharmacy Services Satisfaction Ratings



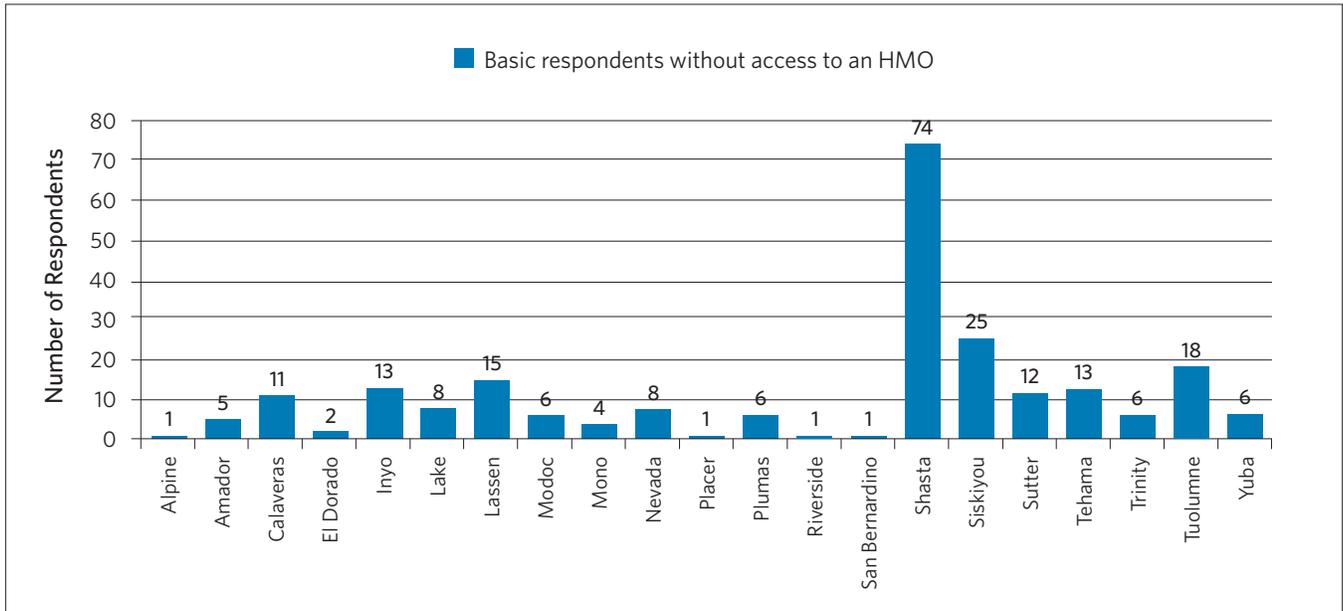
### Medicare: Pharmacy Services Satisfaction Ratings



## Appendix D – Member Satisfaction, cont.

### Rural Area Member Demographics

The table below shows 236 Basic plan respondents living in a rural area without access to an HMO (by county).



### Emergency Room Care: Basic

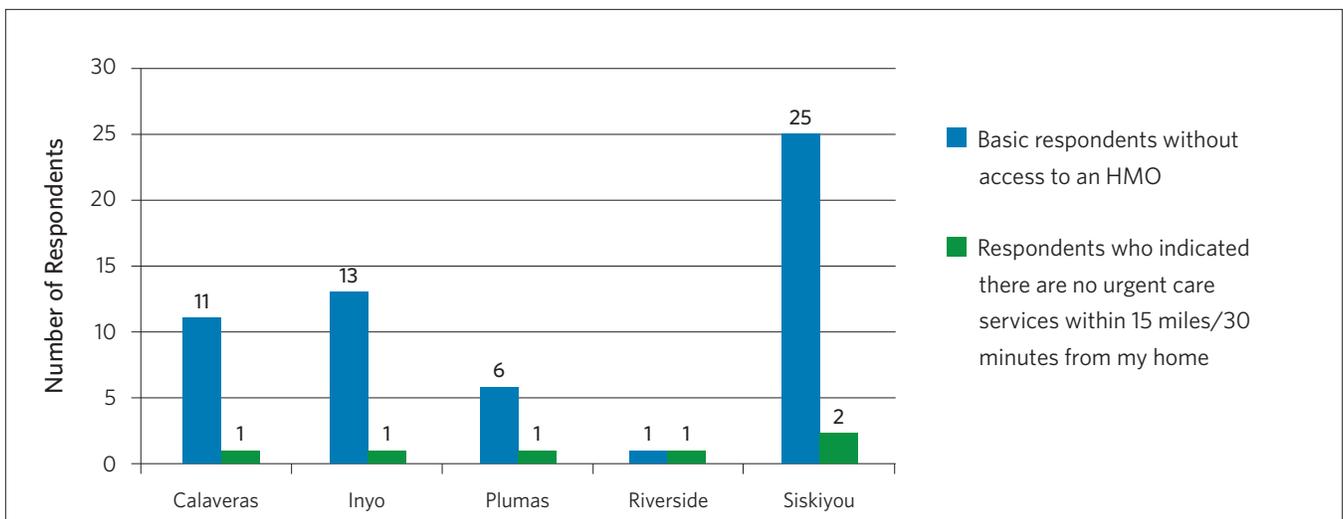
Members were asked:

In the last 12 months, if you went to an emergency room to get care for yourself, why did you go?

Members who responded:

There are no urgent care services within 15 miles/30 minutes of my home.

### Basic Rural Emergency Room Accessibility



### After-Hours Care: Basic

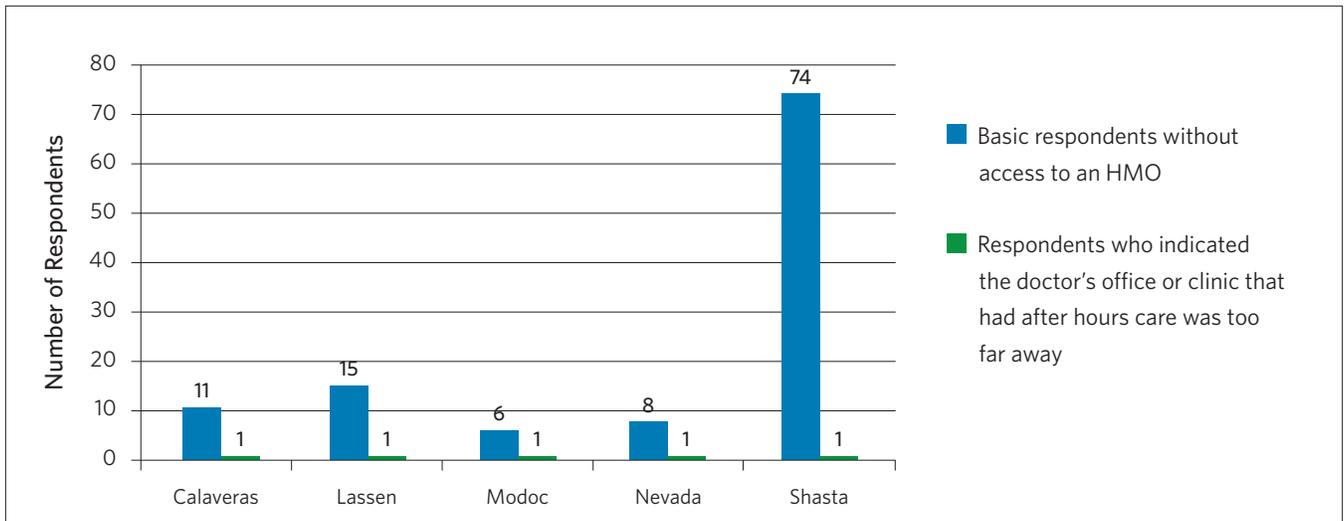
#### Members were asked:

Were any of the following a reason it was not easy to get the after-hours care you thought you needed?

#### Members who responded:

The doctor's office or clinic that had after-hours care was too far away.

### Basic Rural After-Hours Care Accessibility



# Appendix E – Geographic Coverage

## Health Plan Availability by County: Basic Plans

Some health plans are available only in certain counties and/or ZIP Codes. Use the chart below to determine if the health plan you are considering provides services where you reside or work. Contact the plan before enrolling to make sure they cover your ZIP Code and that their provider network is accepting new patients in your area. You may also use our online service, the *Health Plan Search by ZIP Code*, available at [www.calpers.ca.gov](http://www.calpers.ca.gov).

- Health plan covers all or part of county.
- ▲ Available out-of-state for PERS Choice and PERSCare, not available for PERS Select.

County	Anthem Blue Cross EPO	Anthem Blue Cross Select HMO	Anthem Blue Cross Traditional HMO	Blue Shield Access+	Blue Shield Access+ EPO	Blue Shield NetValue	CAHP	CCPOA	Health Net Salud y Más	Health Net SmartCare	Kaiser Permanente	PERS Select, PERS Choice, & PERSCare	PORAC	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance
Alameda		●	●	●			●	●		●	●	●	●		●
Alpine							●					●	●		
Amador							●				●	●	●		
Butte			●	●			●	●				●	●		
Calaveras							●					●	●		
Colusa					●		●					●	●		
Contra Costa		●	●	●		●	●	●		●	●	●	●		●
Del Norte	●						●					●	●		
El Dorado		●	●	●		●	●	●			●	●	●		
Fresno		●	●	●		●	●	●		●	●	●	●		●
Glenn			●	●			●	●				●	●		
Humboldt			●	●			●					●	●		
Imperial		●	●	●		●	●	●				●	●		
Inyo							●					●	●		
Kern		●	●	●		●	●	●	●	●	●	●	●		●
Kings			●	●		●	●	●		●	●	●	●		●
Lake							●					●	●		
Lassen							●					●	●		
Los Angeles		●	●	●		●	●	●	●	●	●	●	●		●
Madera			●	●		●	●	●			●	●	●		●
Marin			●	●		●	●	●			●	●	●		●
Mariposa				●			●	●			●	●	●		
Mendocino			●		●		●					●	●		

County	Anthem Blue Cross EPO	Anthem Blue Cross Select HMO	Anthem Blue Cross Traditional HMO	Blue Shield Access+	Blue Shield Access+ EPO	Blue Shield NetValue	CAHP	CCPOA	Health Net Salud y Más	Health Net SmartCare	Kaiser Permanente	PERS Select, PERS Choice, & PERSCare	PORAC	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance
Merced		●	●	●			●	●				●	●		●
Modoc							●					●	●		
Mono							●					●	●		
Monterey	●						●					●	●		
Napa			●				●			●	●	●	●		
Nevada		●	●	●		●	●	●				●	●		
Orange		●	●	●		●	●	●	●	●	●	●	●		●
Placer		●	●	●		●	●	●			●	●	●		●
Plumas							●					●	●		
Riverside		●	●	●		●	●	●	●	●	●	●	●		●
Sacramento		●	●	●		●	●	●		●	●	●	●		●
San Benito			●				●					●	●		
San Bernardino		●	●	●		●	●	●	●	●	●	●	●		●
San Diego		●		●		●	●	●	●	●	●	●	●	●	●
San Francisco		●	●	●		●	●	●		●	●	●	●		●
San Joaquin		●	●	●		●	●	●		●	●	●	●		●
San Luis Obispo			●	●		●	●	●				●	●		
San Mateo			●	●		●	●	●		●	●	●	●		●
Santa Barbara			●	●			●	●				●	●		
Santa Clara		●	●	●		●	●	●		●	●	●	●		●
Santa Cruz		●	●	●		●	●	●		●		●	●		●
Shasta							●					●	●		
Sierra					●		●					●	●		
Siskiyou							●					●	●		
Solano			●	●			●	●		●	●	●	●		●
Sonoma			●	●		●	●	●		●	●	●	●		●
Stanislaus		●	●	●		●	●	●			●	●	●		●
Sutter							●				●	●	●		
Tehama							●					●	●		
Trinity							●					●	●		
Tulare		●	●	●			●	●		●	●	●	●		
Tuolumne							●					●	●		
Ventura		●	●	●		●	●	●			●	●	●		●
Yolo		●	●	●		●	●	●		●	●	●	●		●
Yuba							●				●	●	●		
Out-of-State											●	▲	●		

## Appendix E – Geographic Coverage, cont.

### Health Plan Availability by County: Medicare Plans

Some health plans are available only in certain counties and/or ZIP Codes. Use the chart below to determine if the health plan you are considering provides services where you reside or work. Contact the plan before enrolling to make sure they cover your ZIP Code and that their provider network is accepting new patients in your area. You may also use our online service, the *Health Plan Search by ZIP Code*, available at [www.calpers.ca.gov](http://www.calpers.ca.gov).

- Health plan covers all or part of county.
- ▲ Available out-of-state for PERS Choice and PERSCare, not available for PERS Select.

County	CAHP Medicare Supplement	CCPOA Medicare Supplement	Kaiser Permanente Senior Advantage	PERS Select, PERS Choice, & PERSCare Medicare Supplement	PORAC Medicare Supplement	UnitedHealthcare Group Medicare Advantage PPO
Alameda	●	●	●	●	●	●
Alpine	●			●	●	●
Amador	●		●	●	●	●
Butte	●	●		●	●	●
Calaveras	●			●	●	●
Colusa	●			●	●	●
Contra Costa	●	●	●	●	●	●
Del Norte	●			●	●	●
El Dorado	●	●	●	●	●	●
Fresno	●	●	●	●	●	●
Glenn	●	●		●	●	●
Humboldt	●			●	●	●
Imperial	●	●		●	●	●
Inyo	●			●	●	●
Kern	●	●	●	●	●	●
Kings	●	●	●	●	●	●
Lake	●			●	●	●
Lassen	●			●	●	●
Los Angeles	●	●	●	●	●	●
Madera	●	●	●	●	●	●
Marin	●	●	●	●	●	●
Mariposa	●	●	●	●	●	●
Mendocino	●			●	●	●

County	CAHP Medicare Supplement	CCPOA Medicare Supplement	Kaiser Permanente Senior Advantage	PERS Select, PERS Choice, & PERS Care Medicare Supplement	PORAC Medicare Supplement	UnitedHealthcare Group Medicare Advantage PPO
Merced	●	●		●	●	●
Modoc	●			●	●	●
Mono	●			●	●	●
Monterey	●			●	●	●
Napa	●		●	●	●	●
Nevada	●	●		●	●	●
Orange	●	●	●	●	●	●
Placer	●	●	●	●	●	●
Plumas	●			●	●	●
Riverside	●	●	●	●	●	●
Sacramento	●	●	●	●	●	●
San Benito	●			●	●	●
San Bernardino	●	●	●	●	●	●
San Diego	●	●	●	●	●	●
San Francisco	●	●	●	●	●	●
San Joaquin	●	●	●	●	●	●
San Luis Obispo	●	●		●	●	●
San Mateo	●	●	●	●	●	●
Santa Barbara	●	●		●	●	●
Santa Clara	●	●	●	●	●	●
Santa Cruz	●	●		●	●	●
Shasta	●			●	●	●
Sierra	●			●	●	●
Siskiyou	●			●	●	●
Solano	●	●	●	●	●	●
Sonoma	●	●	●	●	●	●
Stanislaus	●	●	●	●	●	●
Sutter	●		●	●	●	●
Tehama	●			●	●	●
Trinity	●			●	●	●
Tulare	●	●	●	●	●	●
Tuolumne	●			●	●	●
Ventura	●	●	●	●	●	●
Yolo	●	●	●	●	●	●
Yuba	●		●	●	●	●
Out-of-State			●	▲	●	●

# Appendix F – Historic Enrollment

## Historic Enrollment

Enrollment as of January 1 of Each Reported Year<sup>1</sup>

	2015	2016
<b>Basic HMO Plan</b>		
Anthem HMO Select	22,401	28,707
Anthem HMO Traditional	10,825	15,824
BSC Access+	166,860	150,339
BSC NetValue	147,275	85,910
Health Net Salud y Más	2,483	3,528
Health Net SmartCare	747	13,356
Kaiser	445,527	472,677
Kaiser Out-of-State	565	578
Sharp	7,733	9,555
UnitedHealthcare	19,238	51,842
<b>Basic PPO Plan</b>		
Anthem EPO Del Norte	0	88
Anthem EPO Monterey	1,418	2,592
PERS Choice	177,001	168,492
PERS Select	36,699	40,934
PERSCare	24,314	28,161
<b>Basic ASN Plan</b>		
CAHP	28,247	27,972
CCPOA North	9,341	9,918
CCPOA South	28,575	29,854
PORAC	25,884	25,191
<b>Basic Total</b>	<b>1,155,133</b>	<b>1,165,518</b>
<b>Medicare HMO Plan</b>		
Anthem HMO Select	44	-
Anthem HMO Traditional	167	-
BSC Access+	31,430	-
BSC NetValue	7,139	-
Health Net Salud y Más	33	-
Health Net SmartCare	17	-
Kaiser	81,991	86,665
Kaiser Out-of-State	1,710	1,812
Sharp	87	-
UnitedHealthcare	446	36,419

	2015	2016
<b>Medicare PPO Plan</b>		
PERS Choice	60,425	64,959
PERS Select	1,275	1,601
PERSCare	51,587	56,441
<b>Medicare ASN Plan</b>		
CAHP	4,142	4,204
CCPOA North	327	379
CCPOA South	399	469
PORAC	1,801	1,981
<b>Medicare Total</b>	<b>243,020</b>	<b>254,930</b>
<b>Grand Total</b>	<b>1,398,153</b>	<b>1,420,448</b>
<b>Program</b>		
State	824,168	835,014
Contracting Agency	573,985	585,434
<b>Total</b>	<b>1,398,153</b>	<b>1,420,448</b>
<b>Employment Status</b>		
Active	967,650	979,210
Retired	430,503	441,238
<b>Total</b>	<b>1,398,153</b>	<b>1,420,448</b>
<b>Subscriber and Dependent Tier</b>		
Single	293,872	303,179
2-Party	378,685	386,163
Family	725,596	731,106
<b>Total</b>	<b>1,398,153</b>	<b>1,420,448</b>

<sup>1</sup> This table represents “points-in-time” data which is the best description of enrollment on a typical day.

# Appendix G - Historic Expenditures

## Historic Expenditures

Estimated Expenditures (dollars in thousands)

	2015	2016
<b>Basic HMO Plan</b>		
Anthem HMO Select	\$138,374	\$187,203
Anthem HMO Traditional	83,444	124,164
BSC Access+	1,084,123	1,038,475
BSC NetValue	861,504	576,156
Health Net Salud y Más	12,237	17,390
Health Net SmartCare	4,898	84,865
Kaiser	2,713,433	3,007,829
Kaiser Out-of-State	5,660	5,808
Sharp	42,897	51,472
UnitedHealthcare	110,717	297,670
<b>Basic PPO Plan</b>		
Anthem EPO Del Norte	192	492
Anthem EPO Monterey	9,931	20,116
PERS Choice	1,096,068	1,164,269
PERS Select	214,666	261,112
PERSCare	187,624	231,797
<b>Basic ASN Plan</b>		
CAHP	138,874	138,922
CCPOA North	54,587	58,268
CCPOA South	134,804	141,945
PORAC	143,156	152,540
<b>Basic Total</b>	<b>\$7,037,189</b>	<b>\$7,560,493</b>
<b>Medicare HMO Plan</b>		
Anthem HMO Select	\$326	-
Anthem HMO Traditional	1,008	-
BSC Access+	136,379	-
BSC NetValue	32,823	-
Health Net Salud y Más	123	-
Health Net SmartCare	64	-
Kaiser	297,402	315,764
Kaiser Out-of-State	8,192	6,533
Sharp	417	-
UnitedHealthcare	1,677	144,187

	2015	2016
<b>Medicare PPO Plan</b>		
PERS Choice	252,652	292,047
PERS Select	5,572	7,496
PERSCare	228,699	278,656
<b>Medicare ASN Plan</b>		
CAHP	17,633	17,904
CCPOA North	1,874	2,188
CCPOA South	2,302	2,708
PORAC	9,147	11,014
<b>Medicare Total</b>	<b>\$996,290</b>	<b>\$1,078,497</b>
<b>Grand Total</b>	<b>\$8,033,479</b>	<b>\$8,638,990</b>

<b>Program</b>		
State	\$4,679,368	\$4,999,974
Contracting Agency	3,354,111	3,639,016
<b>Total</b>	<b>\$8,033,479</b>	<b>\$8,638,990</b>

<b>Employment Status</b>		
Active	\$5,735,181	\$6,176,536
Retired	2,298,298	2,462,454
<b>Total</b>	<b>\$8,033,479</b>	<b>\$8,638,990</b>

<b>Subscriber and Dependent Tier</b>		
Single	\$1,932,700	\$2,105,208
2-Party	2,456,350	2,636,508
Family	3,644,429	3,897,274
<b>Total</b>	<b>\$8,033,479</b>	<b>\$8,638,990</b>

# Appendix H - Premium Increases or Decreases from Prior Plan Year

Table 1: 2015 and 2016 State Basic Premiums (HMO, PPO, and ASN)

Basic		2015			2016			Percent Change from 2015
		Single	2-Party	Family	Single	2-Party	Family	
HMO	Anthem Select	\$639.45	\$1,278.90	\$1,662.57	\$695.77	\$1,391.54	\$1,809.00	8.81%
	Anthem Traditional	727.34	1,454.68	1,891.08	752.48	1,504.96	1,956.45	3.46%
	Blue Shield Access+	718.16	1,436.32	1,867.22	767.45	1,534.90	1,995.37	6.85%
	Blue Shield NetValue	670.36	1,340.72	1,742.94	761.20	1,522.40	1,979.12	13.55%
	Health Net Salud y Más	535.97	1,071.94	1,393.52	552.39	1,104.78	1,436.21	3.06%
	Health Net SmartCare	671.47	1,342.94	1,745.82	651.23	1,302.46	1,693.20	-3.01%
	Kaiser	633.04	1,266.08	1,645.90	661.76	1,323.52	1,720.58	4.54%
	Kaiser Out-of-State	922.78	1,845.56	2,399.23	930.29	1,860.58	2,418.75	0.81%
	Sharp	586.38	1,172.76	1,524.59	574.73	1,149.46	1,494.30	-1.99%
	UnitedHealthcare	642.40	1,284.80	1,670.24	625.78	1,251.56	1,627.03	-2.59%
PPO	Anthem EPO Del Norte	640.45	1,280.90	1,665.17	715.70	1,431.40	1,860.82	11.75%
	Anthem EPO Monterey	640.45	1,280.90	1,665.17	715.70	1,431.40	1,860.82	11.75%
	PERS Choice	640.45	1,280.90	1,665.17	715.70	1,431.40	1,860.82	11.75%
	PERS Select	618.22	1,236.44	1,607.37	649.76	1,299.52	1,689.38	5.10%
	PERSCare	718.93	1,437.86	1,869.22	801.58	1,603.16	2,084.11	11.50%
ASN	CAHP	620.79	1,205.17	1,576.26	620.79	1,205.17	1,576.26	0.00%
	CCPOA North	681.33	1,365.26	1,843.13	681.33	1,365.26	1,843.13	0.00%
	CCPOA South	561.88	1,126.30	1,521.82	561.88	1,126.30	1,521.82	0.00%
	PORAC	675.00	1,292.00	1,642.00	699.00	1,399.00	1,789.00	8.03%

Table 2: 2015 and 2016 State Medicare Premiums (HMO, PPO, and ASN)

Medicare		2015			2016			Percent Change from 2015
		Single	2-Party	Family	Single	2-Party	Family	
HMO	Anthem Blue Cross	\$445.38	\$890.76	\$1,336.14	-	-	-	-
	Blue Shield	352.63	705.26	1,057.89	-	-	-	-
	Health Net	276.85	553.70	830.55	-	-	-	-
	Kaiser	295.51	591.02	886.53	297.23	594.46	891.69	0.58%
	Kaiser Out-of-State	390.47	780.94	1,171.41	297.23	594.46	891.69	-23.88%
	Sharp	327.66	655.32	982.98	-	-	-	-
	UnitedHealthcare	267.41	534.82	802.23	320.98	641.96	962.94	-
PPO	PERS Choice	339.47	678.94	1,018.41	366.38	732.76	1,099.14	7.93%
	PERS Select	339.47	678.94	1,018.41	366.38	732.76	1,099.14	7.93%
	PERSCare	368.76	737.52	1,106.28	408.04	816.08	1,224.12	10.65%
ASN	CAHP	372.00	688.00	874.00	372.00	688.00	874.00	0.00%
	CCPOA	447.79	897.61	1,342.41	435.34	872.56	1,304.91	-2.79%
	PORAC	402.00	802.00	1,281.00	442.00	881.00	1,408.00	9.88%

Table 3: Total Percent Change for Basic and Medicare Combined

Total Change	7.10%
Total PPO Change from 2015 to 2016	10.44%
Total HMO Change from 2015 to 2016	6.31%
Total ASN Change from 2015 to 2016	2.52%

## Appendix H – Premium Increases or Decreases from Prior Plan Year, cont.

Table 4: 2015 and 2016 Regional Contracting Agencies Premiums Basic (HMO, PPO, and ASN)

Basic	2015			2016			Percent Change (+/-)
	Single	2-Party	Family	Single	2-Party	Family	

**Basic Premium Rates - Bay Area** — Alameda, Amador, Contra Costa, Marin, Napa, Nevada, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Sutter, and Yuba

HMO	Anthem Select	\$662.41	\$1,324.82	\$1,722.27	\$721.79	\$1,443.58	\$1,876.65	8.96%
	Anthem Traditional	827.57	1,655.14	2,151.68	855.42	1,710.84	2,224.09	3.37%
	Blue Shield Access+	928.87	1,857.74	2,415.06	1,016.18	2,032.36	2,642.07	9.40%
	Blue Shield NetValue	870.60	1,741.20	2,263.56	1,033.86	2,067.72	2,688.04	18.75%
	Health Net SmartCare	-	-	-	808.44	1,616.88	2,101.94	-
	Kaiser	714.45	1,428.90	1,857.57	746.47	1,492.94	1,940.82	4.48%
	UnitedHealthcare	850.67	1,701.34	2,211.74	955.44	1,910.88	2,484.14	12.32%
PPO	PERS Choice	700.84	1,401.68	1,822.18	798.36	1,596.72	2,075.74	13.91%
	PERS Select	690.43	1,380.86	1,795.12	730.07	1,460.14	1,898.18	5.74%
	PERSCare	775.08	1,550.16	2,015.21	889.27	1,778.54	2,312.10	14.73%
ASN	PORAC	675.00	1,292.00	1,642.00	699.00	1,399.00	1,789.00	8.03%

**Basic Premium Rates - Sacramento Area** — El Dorado, Placer, Sacramento, and Yolo

HMO	Anthem Select	\$811.14	\$1,622.28	\$2,108.96	\$902.07	\$1,804.14	\$2,345.38	11.21%
	Anthem Traditional	940.16	1,880.32	2,444.42	1,112.54	2,225.08	2,892.60	18.34%
	Blue Shield Access+	809.22	1,618.44	2,103.97	885.33	1,770.66	2,301.86	9.41%
	Blue Shield NetValue	758.45	1,516.90	1,971.97	900.73	1,801.46	2,341.90	18.76%
	Health Net SmartCare	-	-	-	747.55	1,495.10	1,943.63	-
	Kaiser	660.96	1,321.92	1,718.50	695.11	1,390.22	1,807.29	5.17%
	UnitedHealthcare	623.45	1,246.90	1,620.97	686.36	1,372.72	1,784.54	10.09%
PPO	PERS Choice	679.26	1,358.52	1,766.08	727.58	1,455.16	1,891.71	7.11%
	PERS Select	669.16	1,338.32	1,739.82	665.35	1,330.70	1,729.91	-0.57%
	PERSCare	751.21	1,502.42	1,953.15	810.40	1,620.80	2,107.04	7.88%
ASN	PORAC	675.00	1,292.00	1,642.00	699.00	1,399.00	1,789.00	8.03%

Basic	2015			2016			Percent Change (+/-)
	Single	2-Party	Family	Single	2-Party	Family	

**Basic Premium Rates - Los Angeles Area — Los Angeles, San Bernardino, and Ventura**

		2015	2015	2015	2016	2016	2016	Percent Change (+/-)
HMO	Anthem Select	\$493.40	\$986.80	\$1,282.84	\$543.47	\$1,086.94	\$1,413.02	10.15%
	Anthem Traditional	631.62	1,263.24	1,642.21	610.64	1,221.28	1,587.66	-3.32%
	Blue Shield Access+	517.87	1,035.74	1,346.46	566.53	1,133.06	1,472.98	9.40%
	Blue Shield NetValue	485.41	970.82	1,262.07	576.46	1,152.92	1,498.80	18.76%
	Health Net Salud y Más	430.71	861.42	1,119.85	466.11	932.22	1,211.89	8.22%
	Health Net SmartCare	568.47	1,136.94	1,478.02	585.39	1,170.78	1,522.01	2.98%
	Kaiser	521.18	1,042.36	1,355.07	543.83	1,087.66	1,413.96	4.35%
	UnitedHealthcare	458.74	917.48	1,192.72	492.24	984.48	1,279.82	7.30%
PPO	PERS Choice	585.18	1,170.36	1,521.47	598.75	1,197.50	1,556.75	2.32%
	PERS Select	576.49	1,152.98	1,498.87	547.55	1,095.10	1,423.63	-5.02%
	PERSCare	647.11	1,294.22	1,682.49	666.91	1,333.82	1,733.97	3.06%
ASN	PORAC	675.00	1,292.00	1,642.00	699.00	1,399.00	1,789.00	8.03%

**Basic Premium Rates - Other Southern California — Fresno, Imperial, Inyo, Kern, Kings, Madera, Orange, Riverside, San Diego, San Luis Obispo, Santa Barbara, and Tulare**

		2015	2015	2015	2016	2016	2016	Percent Change (+/-)
HMO	Anthem Select	\$653.97	\$1,307.94	\$1,700.32	\$634.75	\$1,269.50	\$1,650.35	-2.94%
	Anthem Traditional	743.12	1,486.24	1,932.11	710.79	1,421.58	1,848.05	-4.35%
	Blue Shield Access+	598.66	1,197.32	1,556.52	654.87	1,309.74	1,702.66	9.39%
	Blue Shield NetValue	561.09	1,122.18	1,458.83	666.35	1,332.70	1,732.51	18.76%
	Health Net Salud y Más	520.59	1,041.18	1,353.53	535.98	1,071.96	1,393.55	2.96%
	Health Net SmartCare	579.88	1,159.76	1,507.69	596.98	1,193.96	1,552.15	2.95%
	Kaiser	579.80	1,159.60	1,507.48	605.05	1,210.10	1,573.13	4.35%
	Sharp	564.57	1,129.14	1,467.88	561.34	1,122.68	1,459.48	-0.57%
	UnitedHealthcare	449.10	898.20	1,167.66	493.99	987.98	1,284.37	10.00%
PPO	PERS Choice	594.40	1,188.80	1,545.44	683.71	1,367.42	1,777.65	15.03%
	PERS Select	585.58	1,171.16	1,522.51	625.20	1,250.40	1,625.52	6.77%
	PERSCare	657.32	1,314.64	1,709.03	761.50	1,523.00	1,979.90	15.85%
ASN	PORAC	675.00	1,292.00	1,642.00	699.00	1,399.00	1,789.00	8.03%

## Appendix H – Premium Increases or Decreases from Prior Plan Year, cont.

Table 4: 2015 and 2016 Regional Contracting Agencies Premiums Basic (HMO, PPO, and ASN), cont.

Basic	2015			2016			Percent Change (+/-)
	Single	2-Party	Family	Single	2-Party	Family	

**Basic Premium Rates - Other Northern California** — Alpine, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Plumas, San Benito, Shasta, Sierra, Siskiyou, Stanislaus, Tehama, Trinity, and Tuolumne

HMO	Anthem Select	\$728.65	\$1,457.30	\$1,894.49	\$839.10	\$1,678.20	\$2,181.66	15.16%
	Anthem Traditional	838.48	1,676.96	2,180.05	964.91	1,929.82	2,508.77	15.08%
	Blue Shield Access+	804.34	1,608.68	2,091.28	879.96	1,759.92	2,287.90	9.40%
	Blue Shield NetValue	753.82	1,507.64	1,959.93	895.17	1,790.34	2,327.44	18.75%
	Kaiser	716.98	1,433.96	1,864.15	755.27	1,510.54	1,963.70	5.34%
	UnitedHealthcare	677.35	1,354.70	1,761.11	794.80	1,589.60	2,066.48	17.34%
PPO	Anthem EPO Del Norte	656.08	1,312.16	1,705.81	795.57	1,591.14	2,068.48	21.26%
	Anthem EPO Monterey	656.08	1,312.16	1,705.81	795.57	1,591.14	2,068.48	21.26%
	PERS Choice	656.08	1,312.16	1,705.81	795.57	1,591.14	2,068.48	21.26%
	PERS Select	646.35	1,292.70	1,680.51	727.47	1,454.94	1,891.42	12.55%
	PERSCare	725.54	1,451.08	1,886.40	886.15	1,772.30	2,303.99	22.14%
ASN	PORAC	675.00	1,292.00	1,642.00	699.00	1,399.00	1,789.00	8.03%

### Basic Premium Rates - Out-of-State

HMO	Kaiser	\$922.78	\$1,845.56	\$2,399.23	\$930.29	\$1,860.58	\$2,418.75	0.81%
PPO	PERS Choice	653.58	1,307.16	1,699.31	625.31	1,250.62	1,625.81	-4.33%
	PERSCare	722.74	1,445.48	1,879.12	696.49	1,392.98	1,810.87	-3.63%
ASN	PORAC	675.00	1,292.00	1,642.00	699.00	1,399.00	1,789.00	8.03%

Table 5: 2015 and 2016 Regional Contracting Agency Premiums Medicare (HMO, PPO, and ASN)

Medicare		2015			2016			Percent Change (+/-)
		Single	2-Party	Family	Single	2-Party	Family	
HMO	Anthem Blue Cross	\$445.38	\$890.76	\$1,336.14	-	-	-	-
	Blue Shield	352.63	705.26	1,057.89	-	-	-	-
	Health Net	276.85	553.70	830.55	-	-	-	-
	Kaiser	295.51	591.02	886.53	297.23	594.46	891.69	0.58%
	Kaiser Out-of-State	390.47	780.94	1,171.41	297.23	594.46	891.69	-23.88%
	Sharp	327.66	655.32	982.98	-	-	-	-
	UnitedHealthcare	267.41	534.82	802.23	320.98	641.96	962.94	-
PPO	PERS Choice	339.47	678.94	1,018.41	366.38	732.76	1,099.14	7.93%
	PERS Select	339.47	678.94	1,018.41	366.38	732.76	1,099.14	7.93%
	PERSCare	368.76	737.52	1,106.28	408.04	816.08	1,224.12	10.65%
ASN	PORAC	402.00	802.00	1,281.00	442.00	881.00	1,408.00	9.88%

## Appendix I – Basic HMO Plan HEDIS-Like Measures

Measure	Anthem HMO	BSC	KP North	KP South
<b>Prevention and Screening</b>				
Adult BMI Assessment*	23.6%	41.6%	94.0%	97.1%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)*	5.9%	7.3%	97.5%	99.1%
Childhood Immunization Status - Combination 3*	28.7%	43.4%	88.9%	87.0%
Childhood Immunization Status - Combination 10*	18.6%	26.0%	64.7%	57.9%
Immunizations for Adolescents - Meningococcal*	58.0%	71.2%	89.8%	88.2%
Immunizations for Adolescents - Tdap/Td*	66.2%	80.9%	93.5%	92.6%
Immunizations for Adolescents - Combination 1*	50.5%	63.2%	88.2%	87.1%
Breast Cancer Screening - Total	77.5%	76.5%	88.5%	
Cervical Cancer Screening*	72.6%	68.1%	90.3%	
Colorectal Cancer Screening*	47.2%	64.1%	82.7%	
Chlamydia Screening in Women - Total	49.2%	49.0%	69.0%	73.1%
<b>Respiratory Conditions</b>				
Appropriate Testing for Children With Pharyngitis	75.9%	70.3%	93.4%	92.3%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	29.4%	27.0%	42.5%	74.0%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	40.0%	33.3%	45.5%	72.1%
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	60.0%	72.6%	82.6%	82.6%
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	73.3%	85.4%	92.0%	93.7%
<b>Cardiovascular Conditions</b>				
Persistence of Beta-Blocker Treatment after a Heart Attack	86.4%	80.5%	92.3%	
<b>Diabetes</b>				
Comprehensive Diabetes Care - HbA1c Testing*	87.6%	87.0%	95.5%	
Comprehensive Diabetes Care - HbA1c Control (<8%)*	57.8%	56.0%	67.5%	
Comprehensive Diabetes Care - Eye Exams*	31.4%	43.7%	74.2%	
Comprehensive Diabetes Care - Medical Attention for Nephropathy*	89.6%	90.4%	94.1%	
<b>Musculoskeletal Conditions</b>				
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	89.2%	86.6%	90.2%	97.0%
<b>Overuse/Appropriateness</b>				
Appropriate Treatment for Children With Upper Respiratory Infection	94.4%	89.2%	98.4%	99.0%
Use of Imaging Studies for Low Back Pain	78.5%	77.6%	86.6%	

Measure	Anthem HMO	BSC	KP North	KP South
<b>Behavioral Health</b>				
Antidepressant Medication Management - Effective Acute Phase Treatment	63.7%	62.0%	76.1%	
Antidepressant Medication Management - Effective Continuation Phase Treatment	50.6%	47.8%	54.0%	
Follow Up Care for Children Prescribed ADHD Medication - Initiation Phase	33.9%	34.8%	57.6%	48.0%
Follow Up Care for Children Prescribed ADHD Medication - Continuation & Maintenance Phase	42.9%	39.8%	58.8%	51.6%
Follow Up After Hospitalization For Mental Illness - 7 days	52.4%	79.7%	73.4%	76.6%
Follow Up After Hospitalization For Mental Illness - 30 days	70.5%	66.2%	84.2%	83.8%
<b>Medication Management</b>				
Annual Monitoring for Patients on Persistent Medications - ACEIs or ARBs	82.4%	83.6%	87.6%	88.0%
Annual Monitoring for Patients on Persistent Medications - Digoxin	35.0%	54.0%	49.3%	65.7%
Annual Monitoring for Patients on Persistent Medications - Diuretics	80.4%	82.3%	85.7%	86.3%
Annual Monitoring for Patients on Persistent Medications - Total	81.5%	83.0%	86.6%	87.2%
<b>Access/Availability of Care</b>				
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Initiation - Total	28.9%	28.1%	56.7%	40.2%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Engagement - Total	10.6%	6.8%	29.0%	19.4%
Prenatal and Postpartum Care - Timeliness of Prenatal Care*	56.7%	51.8%	96.5%	95.4%
Prenatal and Postpartum Care - Postpartum Care*	36.4%	35.0%	91.3%	92.9%

\* "Hybrid measure" for which HMOs gather additional information from patients' medical records for HEDIS measures for accreditation purposes; however, for CalPERS-specific HEDIS-like measures, HMOs report only administrative data.

**Notes:**

- The measures presented are from HEDIS® 2016 Volume 2: Technical Specifications for Health Plans.
- Due to space limitations, measures focusing on specific age groups (e.g., "16-20 Years" vs "21-24 Years" for "Chlamydia Screening in Women"), as well as measures unavailable for all HMO and PPO plans, are excluded from this table.
- Plan Abbreviations and Acronyms: Anthem = Anthem Blue Cross, BSC = Blue Shield of California, KP = Kaiser Permanente. For measurement year 2016, Health Net, Sharp, and UnitedHealthcare HMOs did not provide CalPERS-specific HEDIS-like data.
- In the immunization measures, "Combination 3," "Combination 10," and "Combination 1" refer to different sets of recommended vaccines; see National Committee for Quality Assurance (NCQA) website for details.
- Acronyms used in measures: ACEIs = Angiotensin-Converting Enzyme Inhibitors; ADHD = Attention Deficit Hyperactivity Disorder; ARBs = Angiotensin Receptor Blockers; BMI = Body Mass Index; COPD = Chronic Obstructive Pulmonary Disease; HbA1c = Hemoglobin A1c; Tdap/Td = Tetanus, Diphtheria, and Pertussis / Tetanus and Diphtheria.

## Appendix J – Basic PPO Plan HEDIS Measures

Measure	PERSCare	PERS Choice	PERS Select
<b>Prevention and Screening</b>			
Adult BMI Assessment*	12.4%	9.8%	8.9%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)*	6.2%	5.7%	5.0%
Childhood Immunization Status - Combination 3*	36.4%	40.4%	37.9%
Childhood Immunization Status - Combination 10*	21.5%	22.5%	19.5%
Immunizations for Adolescents - Meningococcal*	64.7%	60.9%	50.5%
Immunizations for Adolescents - Tdap/Td*	75.3%	81.1%	76.5%
Immunizations for Adolescents - Combination 1*	61.1%	58.0%	47.0%
Breast Cancer Screening - Total	74.1%	70.3%	65.8%
Cervical Cancer Screening*	72.5%	70.7%	71.0%
Colorectal Cancer Screening*	60.7%	62.2%	53.1%
Chlamydia Screening in Women - Total	43.3%	43.0%	42.5%
<b>Respiratory Conditions</b>			
Appropriate Testing for Children With Pharyngitis	66.7%	69.1%	64.8%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	24.3%	22.7%	24.5%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	42.1%	34.9%	18.4%
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	48.4%	62.7%	56.3%
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	67.7%	73.3%	37.5%
<b>Cardiovascular Conditions</b>			
Persistence of Beta-Blocker Treatment after a Heart Attack	79.2%	88.8%	70.6%
<b>Diabetes</b>			
Comprehensive Diabetes Care - HbA1c Testing*	88.4%	87.1%	83.9%
Comprehensive Diabetes Care - HbA1c Control (<8%)*	34.6%	30.7%	31.3%
Comprehensive Diabetes Care - Eye Exams*	40.5%	35.6%	33.6%
Comprehensive Diabetes Care - Medical Attention for Nephropathy*	87.8%	87.2%	83.4%
<b>Musculoskeletal Conditions</b>			
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	85.8%	85.3%	84.1%
<b>Overuse/Appropriateness</b>			
Appropriate Treatment for Children With Upper Respiratory Infection	88.6%	87.5%	88.2%
Use of Imaging Studies for Low Back Pain	81.6%	80.4%	82.4%

Measure	PERSCare	PERS Choice	PERS Select
<b>Behavioral Health</b>			
Antidepressant Medication Management - Effective Acute Phase Treatment	72.0%	70.4%	73.5%
Antidepressant Medication Management - Effective Continuation Phase Treatment	55.9%	55.3%	53.4%
Follow Up Care for Children Prescribed ADHD Medication - Initiation Phase	45.5%	34.0%	53.4%
Follow Up Care for Children Prescribed ADHD Medication - Continuation & Maintenance Phase	28.6%	46.5%	35.0%
Follow Up After Hospitalization For Mental Illness - 7 days	57.6%	48.9%	32.8%
Follow Up After Hospitalization For Mental Illness - 30 days	78.8%	70.5%	55.7%
<b>Medication Management</b>			
Annual Monitoring for Patients on Persistent Medications - ACEIs or ARBs	84.5%	82.3%	75.8%
Annual Monitoring for Patients on Persistent Medications - Digoxin	40.0%	36.3%	36.4%
Annual Monitoring for Patients on Persistent Medications - Diuretics	84.9%	81.8%	74.6%
Annual Monitoring for Patients on Persistent Medications - Total	84.3%	81.8%	75.2%
<b>Access/Availability of Care</b>			
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Initiation - Total	29.8%	30.0%	28.7%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Engagement - Total	10.5%	10.4%	12.1%
Prenatal and Postpartum Care - Timeliness of Prenatal Care*	72.6%	66.5%	65.8%
Prenatal and Postpartum Care - Postpartum Care*	35.0%	34.5%	37.4%

\* "Hybrid measure" for which additional information is gathered from patients' medical records.

**Notes:**

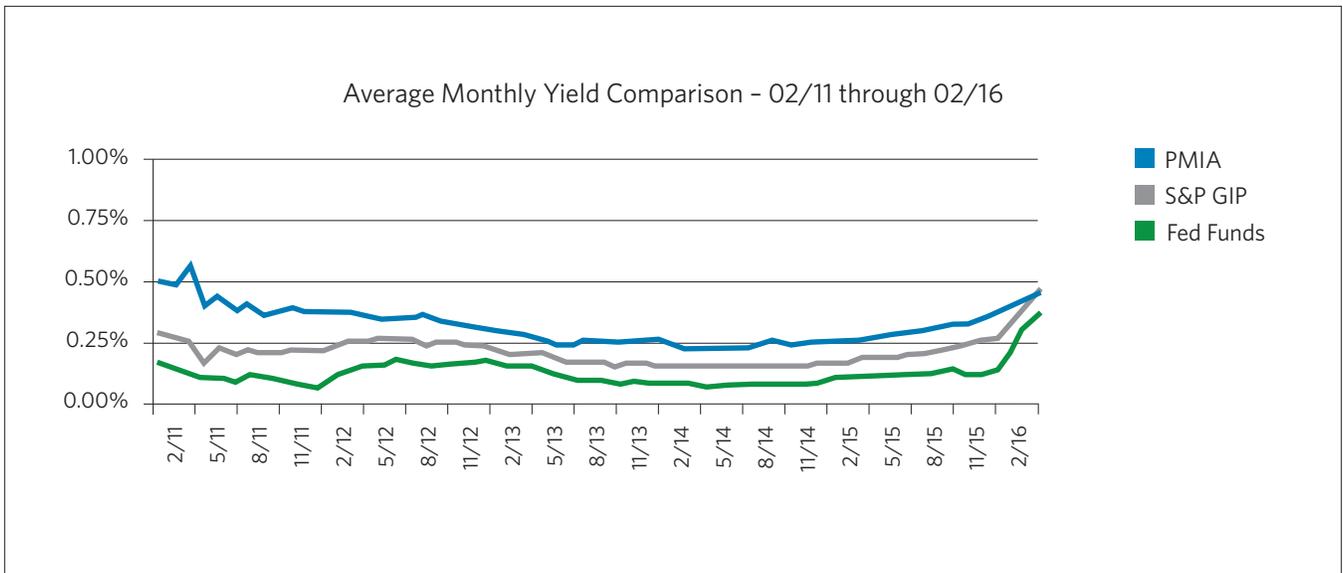
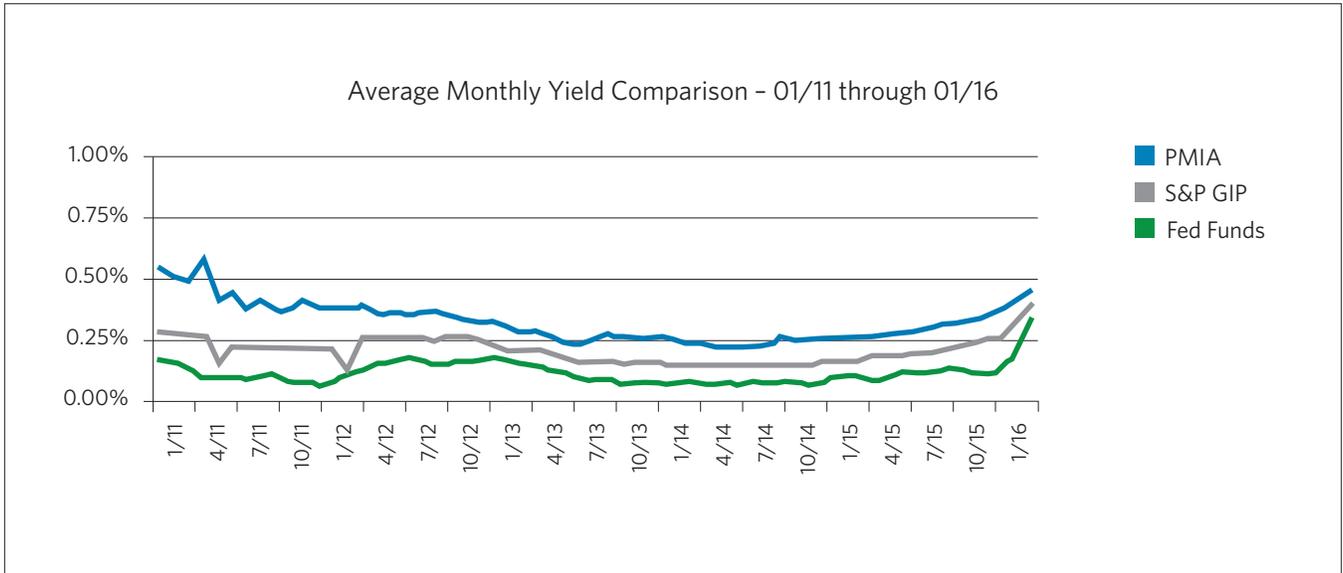
- Unlike the HMO "HEDIS-like" measures, the PPO measures are audited and therefore satisfy HEDIS requirements.
- The measures presented are from HEDIS® 2016 Volume 2: Technical Specifications for Health Plans.
- Due to space limitations, measures focusing on specific age groups (e.g., "16-20 Years" vs "21-24 Years" for "Chlamydia Screening in Women"), as well as measures unavailable for all HMO and PPO plans, are excluded from this table.
- In the immunization measures, "Combination 3," "Combination 10," and "Combination 1" refer to different sets of recommended vaccines; see National Committee for Quality Assurance (NCQA) website for details.
- Acronyms used in measures: ACEIs = Angiotensin-Converting Enzyme Inhibitors; ADHD = Attention Deficit Hyperactivity Disorder; ARBs = Angiotensin Receptor Blockers; BMI = Body Mass Index; COPD = Chronic Obstructive Pulmonary Disease; HbA1c = Hemoglobin A1c; Tdap/Td = Tetanus, Diphtheria, and Pertussis / Tetanus and Diphtheria.

# Appendix K – Surplus Money Investment Fund

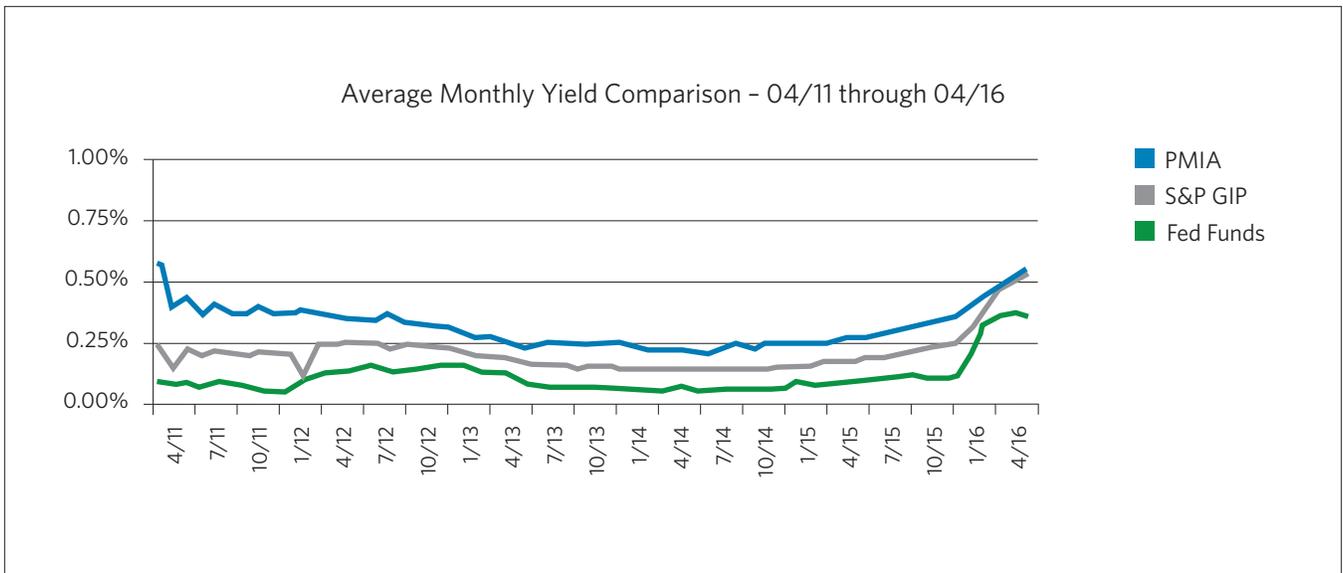
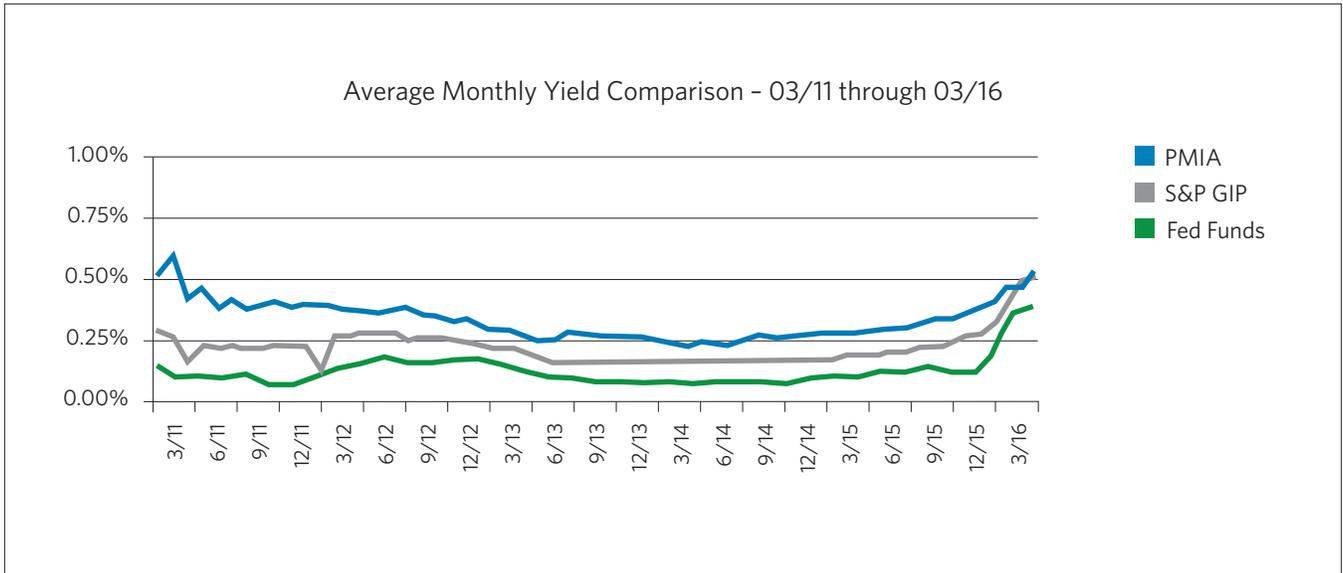
State Controller’s Office  
 Division of Accounting and Reporting  
 Surplus Money Investment Fund  
 Apportionment Yield Rate

Period Ending	Rate	Period Ending	Rate
3/31/2006	4.032%	3/31/2012	0.374%
6/30/2006	4.529%	6/30/2012	0.361%
9/30/2006	4.926%	9/30/2012	0.349%
12/31/2006	5.106%	12/31/2012	0.316%
3/31/2007	5.172%	3/31/2013	0.275%
6/30/2007	5.235%	6/30/2013	0.246%
9/30/2007	5.236%	9/30/2013	0.249%
12/31/2007	4.955%	12/31/2013	0.248%
3/31/2008	4.174%	3/31/2014	0.222%
6/30/2008	3.108%	6/30/2014	0.228%
9/30/2008	2.769%	9/30/2014	0.234%
12/31/2008	2.533%	12/31/2014	0.249%
3/31/2009	1.903%	3/31/2015	0.254%
6/30/2009	1.512%	6/30/2015	0.283%
9/30/2009	0.889%	9/30/2015	0.316%
12/31/2009	0.594%	12/31/2015	0.364%
3/31/2010	0.551%	3/31/2016	0.460%
6/30/2010	0.559%	6/30/2016	0.543%
9/30/2010	0.503%	9/30/2016	0.599%
12/31/2010	0.456%	12/31/2016	0.672%
3/31/2011	0.508%	3/31/2017	0.769%
6/30/2011	0.480%	6/30/2017	0.922%
9/30/2011	0.377%		
12/31/2011	0.378%		

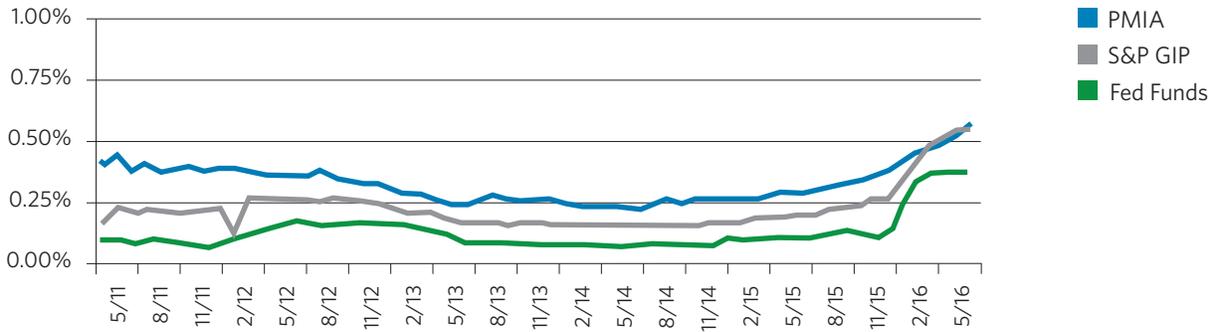
# Appendix L - PMIA, S&P GIP, and Federal Funds Average Monthly Yield Comparison



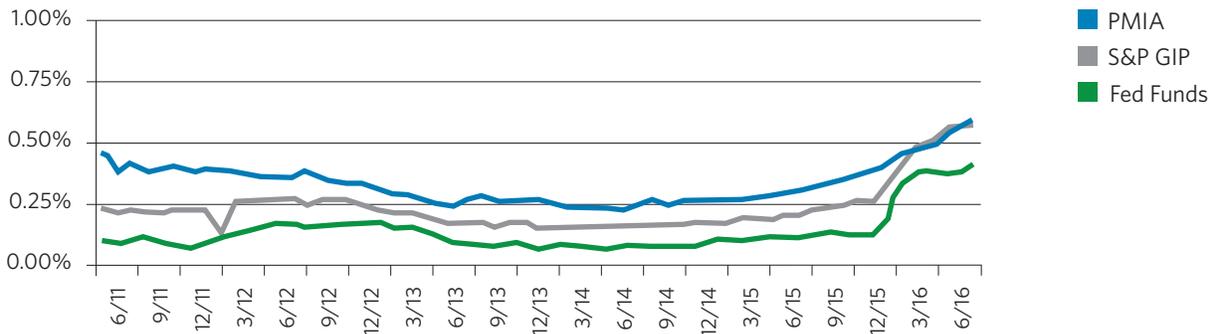
## Appendix L - PMIA, S&P GIP, and Federal Funds Average Monthly Yield Comparison, cont.



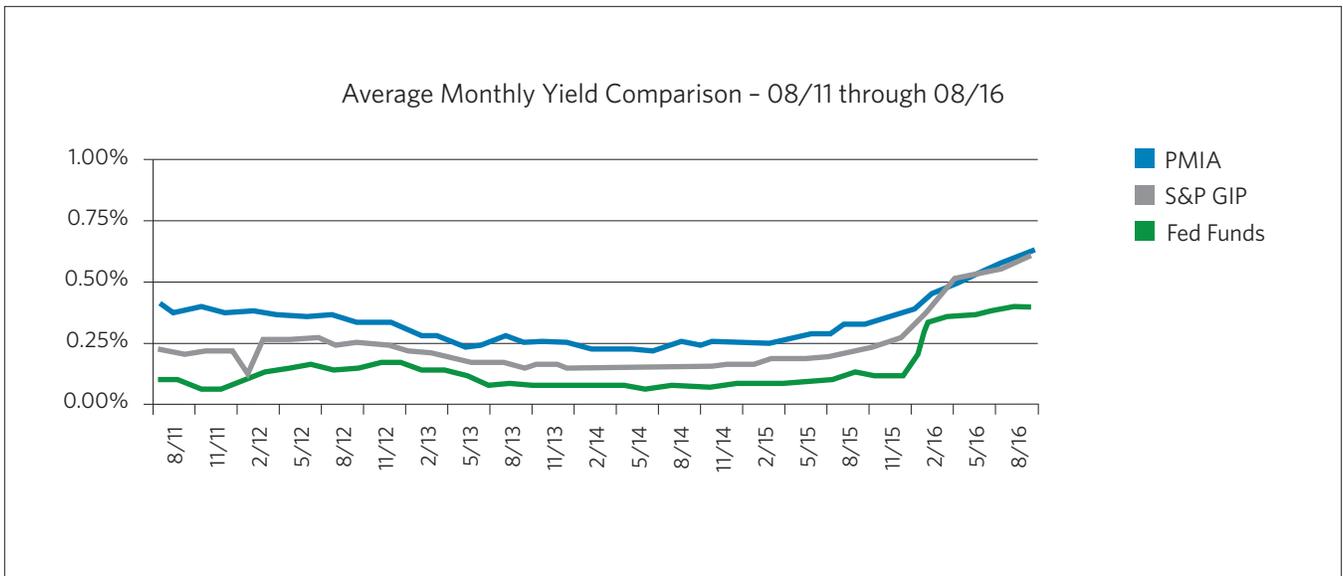
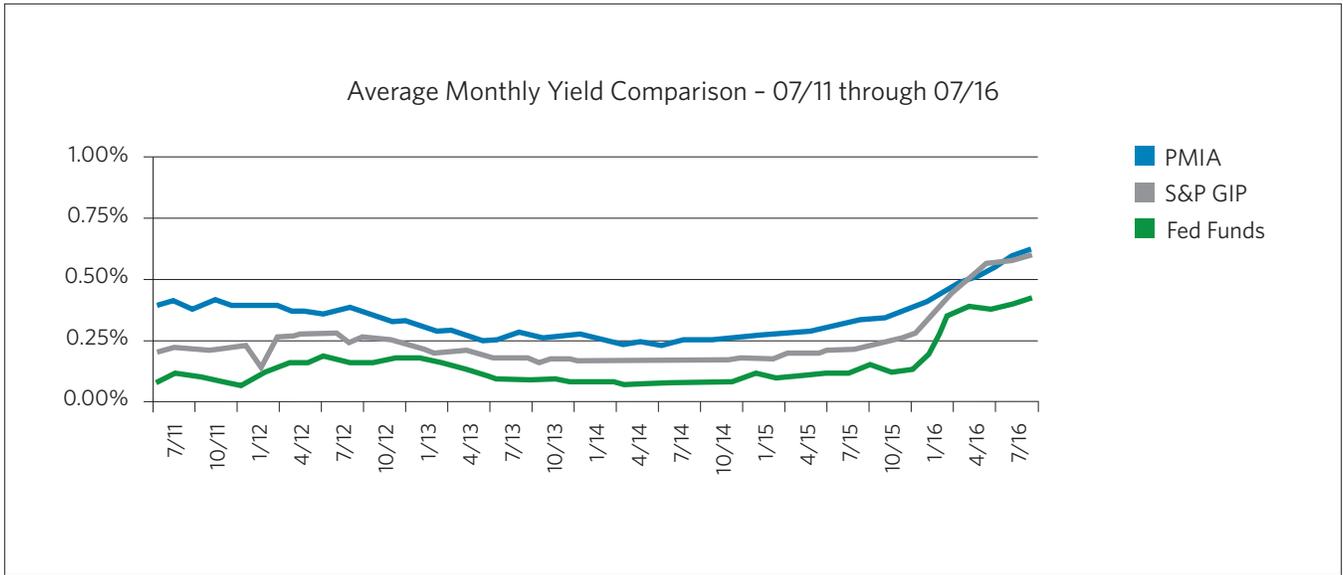
Average Monthly Yield Comparison - 05/11 through 05/16



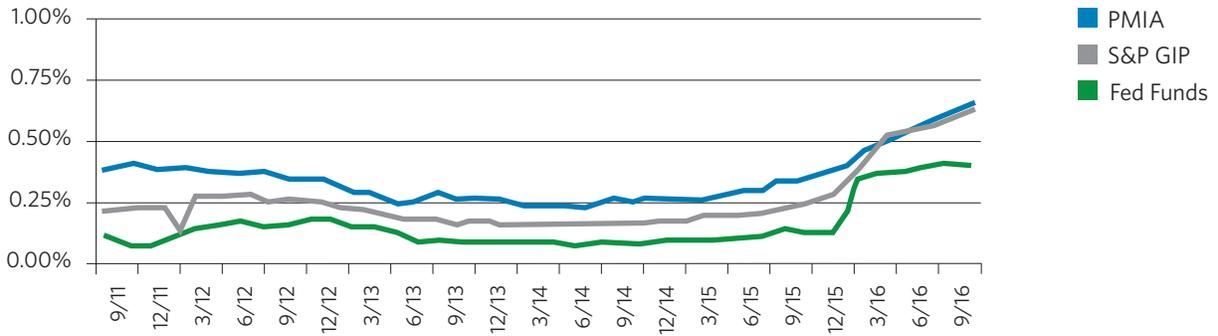
Average Monthly Yield Comparison - 06/11 through 06/16



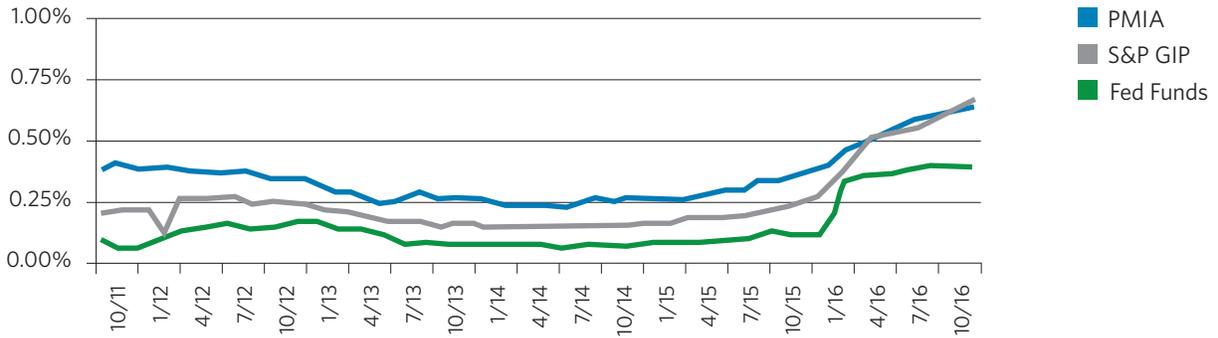
## Appendix L - PMIA, S&P GIP, and Federal Funds Average Monthly Yield Comparison, cont.



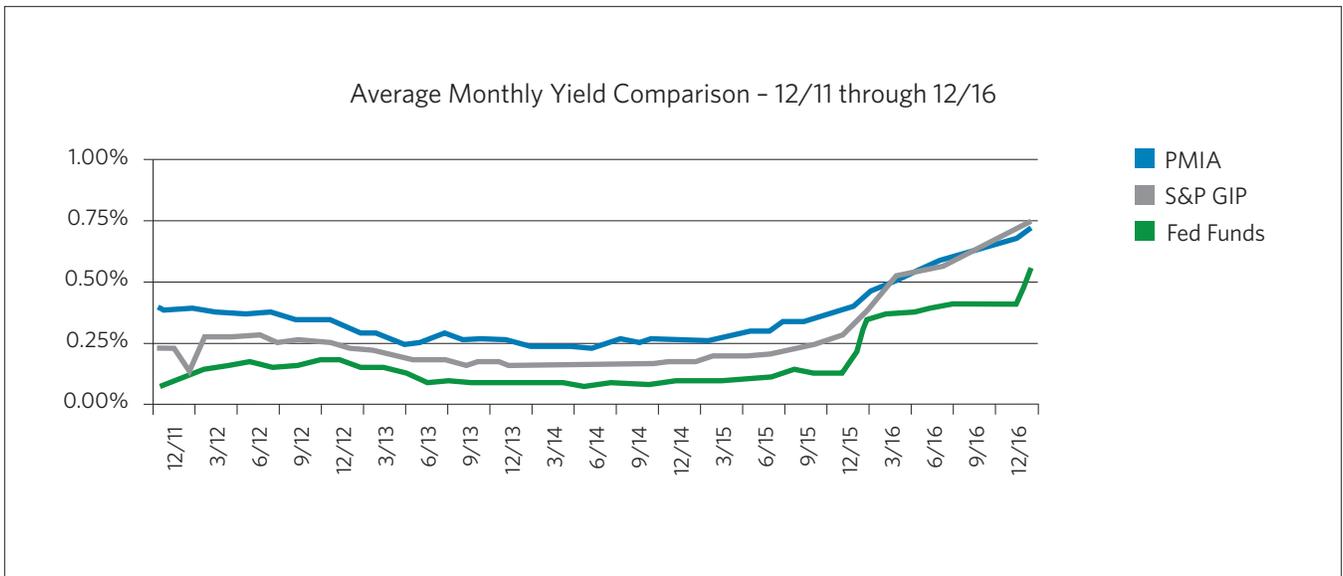
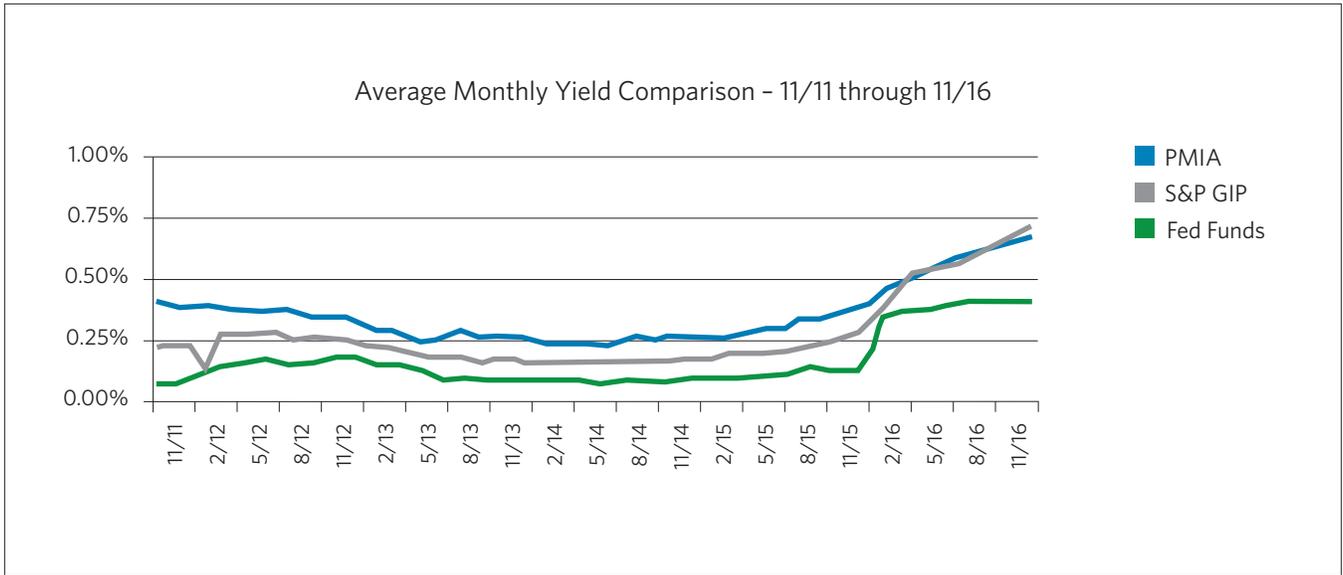
Average Monthly Yield Comparison - 09/11 through 09/16



Average Monthly Yield Comparison - 10/11 through 10/16



## Appendix L - PMIA, S&P GIP, and Federal Funds Average Monthly Yield Comparison, cont.







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