April 17, 2018

Item Name: Semi-Annual Health Plan Financial Report

Program: Health Policy Research Division

Item Type: Information

Executive Summary

Starting in 2014, California Public Employees' Retirement System (CalPERS) members had several new Health Maintenance Organization (HMO) health plan options. The enrollment in these plan options has increased from over 22,000 Total Covered Lives (TCL) in 2014 to over 170,000 in 2017.

In addition, Blue Shield with 2 plans, Kaiser, and the Self-Funded Preferred Provider Organization (PPO) health plans are also available. A new funding arrangement, called flex-funding, for all HMO plans except Kaiser was initiated starting in 2014. This report summarizes, as of December 31, 2017, the financial results for the HMO plans and for the PPO plans.

Strategic Plan

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

Background

This report is to provide the Committee with an update on the financial status for the six (6) CalPERS PPO plans, the two (2) EPO plans, and the seven (7) flex-funded HMO health plans.

Analysis

PPO Plans

Attachment 1 summarizes the results for the PPO plans. Actual Reserves, or assets, for the PPO plans are currently $729.6 million, which is an increase of $36.9 million from the assets at the end of 2016. Required reserves for the PPO plans are $609.8 million, which is an increase of $23.0 million over the required reserves at the end of 2016. Actual reserves above the actuarial reserve requirements are $119.8 million. Overall, the Self-Funded PPO health plans have a ratio of assets to reserves of 120 percent.

For 2016 there was an overall gain of $14 million for all six (6) self-funded PPO health plans. The gain or loss evaluates revenue against claims and expenses. Revenue includes premiums, drug rebates, subsidies from the EGWP program, and investment income. This is the second consecutive year of gains, following 2 consecutive years of losses that were driven by high pharmacy claims costs, especially in the Medicare plans.

Medical claims cost trends for the basic plans range from 6.1% to 10.0%. For the Medicare plans, Select is at -4.9%, Care is at 2.1%, and Choice is trending at 10%.

Pharmacy claims cost trends are very favorable, with all of them showing negative for 2017.

Total enrollment in 2017 has increased by 1.3 percent over 2016 enrollment. Enrollment in Care basic continues to increase, from 29,000 to over 31,000, while enrollment in Choice basic dropped by 9,700 (about 6%) and Select basic increased by 5,100 (about 12%). These enrollment changes are still primarily due to risk adjustment, which was implemented in 2014. Enrollment in the Medicare plans increased by almost 5,000 (about 4%) in 2017.

HMO Plans

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

Attachment 2 summarizes the results for the HMO plans. There have been some changes to the HMO plans. With the implementation of a Consolidated Medicare Advantage Program effective January 1, 2016, the flex-funded Medicare plans discontinued operation. The Medicare plan assets displayed in Attachment 2 are for the purpose of paying claims and expenses that have not yet been received. In addition, the Blue Shield Net Value plan discontinued operation effective December 31, 2016. The asset value for each HMO plan is shown on the first 2 pages. The basic plans are shown on the first page and the Medicare plans are shown on the following page.

As of December 31, 2017, the assets for the HMO plans totaled $202.5 million, which is an increase of $109.1 million from the end of 2016. Additional subsidies and rebates received from the Medicare EGWP program and risk transfer payments contributed to this improvement.

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

Enrollments for each plan are shown on page 6. The new plans tripled their enrollment from 2014 to 2015, and then almost doubled the enrollment from 2015 to 2016. Enrollment for 2017 decreased by 28,000.

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

Benefits and Risks
Benefits

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

Risks

- The higher than expected costs in medical and/or pharmacy could lead to larger than expected premium increases

Attachments
Attachment 1 - Key graphical analyses of financial and historical data for the PPO plans.
Attachment 2 - Key graphical analyses of financial and historical data for the HMO plans.

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Gary McCollum
Senior Life Actuary
Actuarial Office

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Liana Bailey-Crimmins
Chief Health Director
Health Policy and Benefits Branch