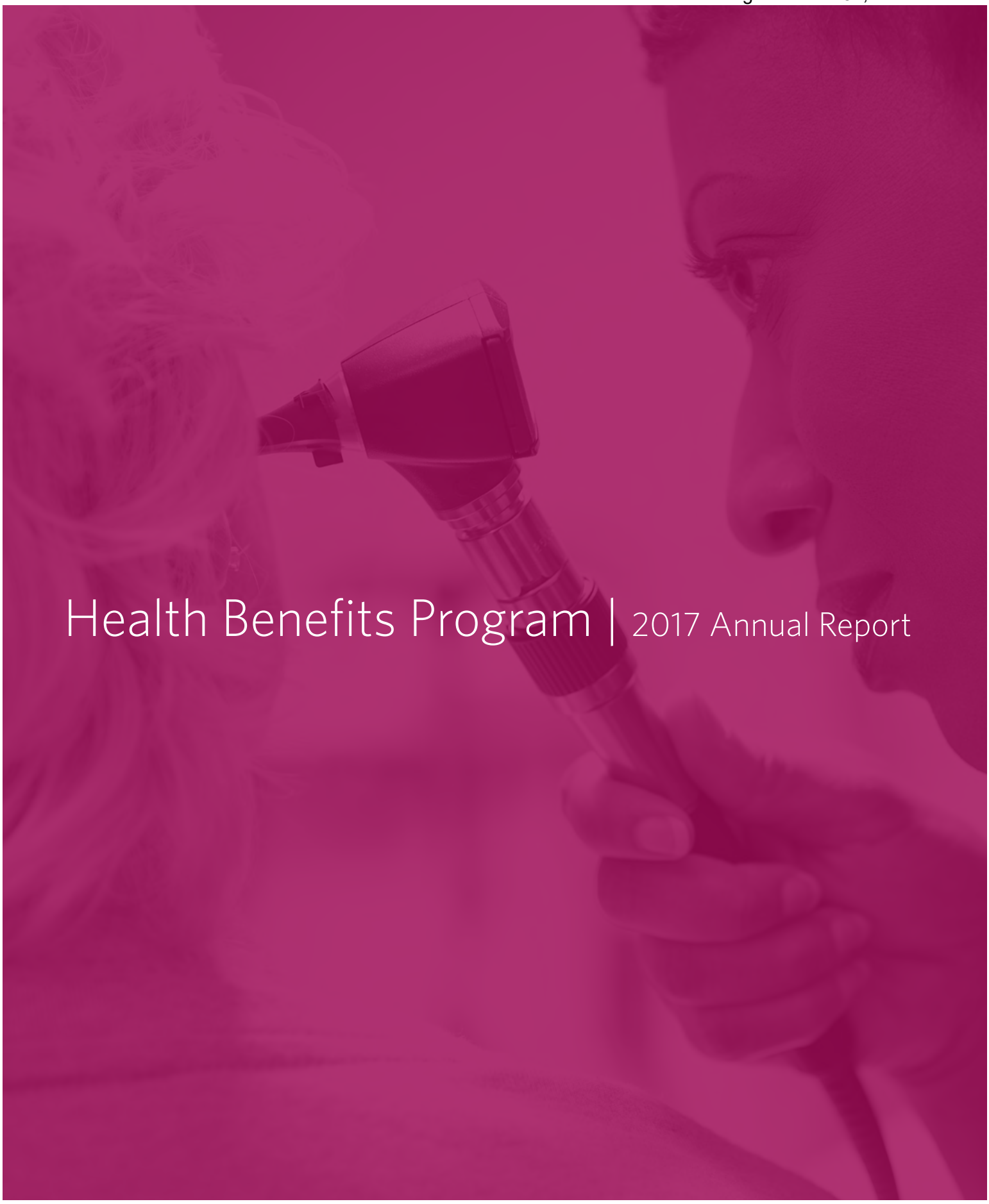

Health Benefits Program | 2017 Annual Report

Published November 1, 2018

CalPERS

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Executive Summary

Members of the California Legislature and Director of Finance:

I am pleased to present the CalPERS Health Benefits Program Annual Report (HBPAR) for plan year 2017. The HBPAR fulfills our annual requirement to provide information about the CalPERS Health Benefits Program, pursuant to California Government Code Section 22866 (see Appendix A).

The HBPAR provides you with information on state and federal benefit requirements, health benefit designs offered to enrollees, medical trends by aggregate service category, member health characteristics, historic enrollment and expenditure data, health plan premium information, federal Medicare subsidies information, and member health plan survey data relative to satisfaction and quality.

The report captures geographic coverage areas, premium changes from the prior plan year, and health plan quality measures. Additionally, the HBPAR provides 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.

We continue to be the largest purchaser of health benefits in California, and second largest in the nation behind the federal government, covering more than 1.4 million employees, retirees, and their families. During 2017, we took a number of important steps to continue our mission to provide superior customer service in the delivery of affordable, quality health care. Our Board of Administration approved the new 2017-2022 Strategic Plan. The plan serves as our guide to transform health care purchasing and delivery, to make it affordable while providing the best value in health care to our members. To that end, 2018 and 2019 saw our lowest overall health plan rate increases in over 20 years at 2.3 and 1.16 percent, respectively. In addition, the board awarded a five-year Pharmacy Benefit Manager contract, beginning January 2018, expected to save our members more than $63 million in the first year.

Amid increasingly volatile health care markets across the industry, CalPERS continues to maintain competitive prices on behalf of our members. We proudly serve those who serve California.

Marcie Frost
Chief Executive Officer

Chief Health Director Message

The CalPERS Health Benefits Program is a nationally recognized leader and influencer in the health care industry. We provide quality healthcare to the employees, retirees, and dependents of the State of California (including California State University), and nearly 1,200 public agencies and schools that contract with us. Our mission is to provide superior service in the delivery of quality, affordable health care for all our members.

Through innovative benefit designs, competitive negotiations, and advanced business strategies, we hold the line to protect our members from uncertainty associated with market increases in medical and pharmaceutical costs and the ever-changing political environment. Our proven ability to maintain a competitive edge in the public agency and school employer health insurance marketplace has led to the retention of 99 percent of our contracting agencies. Over the last decade, we gained more than 177,000 total covered lives, despite significant changes in the health insurance landscape.

As we continue to build on our successes, we know that there is still more work to be done. Offering exemplary employer health benefits to our members requires constant tuning and innovation.

Over the past year and a half, the CalPERS Health Benefits Program has achieved short-term goals, while maintaining long-term focus on providing high quality, affordable, and accessible health care. We created a set of Health Beliefs to accompany CalPERS' Investment and Pension Beliefs. We reached out to stakeholders, hosted CalPERS Board and executive team workshops, and presented a final set of Health Beliefs that was adopted by the board. Our Health Beliefs will provide a basis for the strategic management of the program, as well as, a framework for assessing new health benefit strategies and engagement on legislative, regulatory, and policy issues. The Beliefs will also help guide future benefit design decisions.

CalPERS will offer a value-based insurance design (VBID) option through the PERS Select Basic plan. This lower-cost plan option aims to improve the health of enrollees by offering economic incentives to encourage the use of preventive health services and high-value coordinated care.

Moving forward, we will focus on the cost of care across all 58 California counties. In conjunction with our stakeholders and board, we will examine the public agency and school regions for health premium rates. In order to retain and attract public agencies and schools, we must ensure that we maintain stable risk pools that reflect the cost of health care regionally. Additionally, we are focusing on recruitment and retention of contracting agencies to ensure the sustainability of the program.

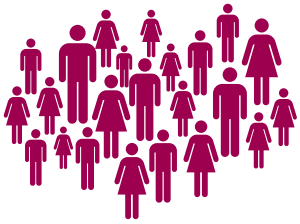
We will continue to pursue unparalleled customer service as we address the health care needs of our members and their families.

Liana Bailey-Crimmins
Chief Health Director

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 participating public agencies and schools. 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. In 2017, we spent approximately $8.88 billion to purchase health benefits for more than 1.4 million active and retired members and their families on behalf of the State of California (including the California State University), and nearly 1,200 public agencies and schools. The 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 purchases health benefits for more than 1.4 million active and retired members and their families on behalf of the state and nearly 1,200 public agencies and schools.

2017-22 Strategic Plan

The CalPERS 2017-22 Strategic Plan is the roadmap that guides the enterprise to meet the investment, retirement, and health benefit needs of our members and their families. It is a result of a year-long collaborative process between our board and executive team that gives us a fresh look at the next five years. CalPERS' Strategic Plan includes the following vision and mission statements and goals and objectives:

Our Vision

A respected partner, providing a sustainable retirement system and health care program for those who serve California.

Our Mission

Deliver retirement and health care benefits to members and their beneficiaries.

CalPERS Health Benefits Program's mission is to provide superior service in the delivery of affordable, quality health care.

Goals and Objectives

Fund Sustainability: Strengthen the long-term sustainability of the pension fund

- Fund the System through an integrated view of pension assets and liabilities.
- Mitigate the risk of significant investment loss.
- Deliver target risk-adjusted investment returns.
- Educate employers, members, and stakeholders on system risks and mitigation strategies.
- Integrate environmental, social, and governance (ESG) considerations into investment decision making.

Health Care Affordability: Transform health care purchasing and delivery to achieve affordability

- Restructure benefit design to promote high-value care.
- Improve the health status of our employees, members and their families, and the communities where they live.
- Reduce the overuse of ineffective or unnecessary medical care.

Reduce Complexity: Reduce complexity across the enterprise

- Simplify programs to improve service and/or reduce cost.
- Streamline operations to gain efficiencies, improve productivity, and reduce costs.

Risk Management: Cultivate a risk-intelligent organization

- Enhance compliance and risk functions throughout the enterprise.
- Continue to evolve cyber security program.

Talent Management: Promote a high-performing and diverse workforce

- Recruit and empower a broad range of talents to meet organization priorities.
- Cultivate leadership competencies and develop succession plans across the enterprise.

Accompanying the Strategic Plan, CalPERS develops annual business plan objectives, strategic plan measures and key performance indicators to monitor specific items that will achieve overarching goals.

Strategic Direction and Policy Initiatives for the Health Benefits Program

CalPERS had a transitional year in 2017 in terms of strategic planning. It included the completion of 2012-2017 initiatives,[1] as well as new initiatives listed in the 2017-2022 CalPERS Strategic Plan[2] and 2017-2018 Business Plan.[3]

The CalPERS 2012-17 Strategic Plan had three goals:

- Improve long-term pension and health benefit sustainability
- Cultivate a high-performing, risk-intelligent, and innovative organization
- Engage in state and national policy development to enhance the long-term sustainability and effectiveness of our programs

The following page provides a description of changes in strategic direction and major policy initiatives for the 2017 health plan year. It includes content from the CalPERS Strategic Plan, CalPERS Business Plans, and CalPERS Finance and Administration Committee agenda items. These plans and agenda items are interrelated, complement each other, and focus on cost, quality, and accessibility.

The table on the next page shows the status of health-related 2017 Business Plan Initiatives.

[1] CalPERS Annual and Final Report of the 2012-2017 Strategic Plan, September 2017. https://www.calpers.ca.gov/docs/forms-publications/2016-17-strategic-plan-annual-report.pdf

[2] *CalPERS Board of Administration Agenda Item 12, Attachment C. November 15, 2017.* https://www.calpers.ca.gov/docs/board-agendas/201711/full/item12-03.pdf

[3] CalPERS 2017-2018 Business Plan. https://www.calpers.ca.gov/docs/forms-publications/2017-18-business-plan.pdf

2017 Business Plan Initiatives: Health Benefits

Initiative Title	Description	Status
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.	Completed[4]
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.	Completed[5]
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.	Deferred[6]
Value-Based Insurance Design: Feasibility	Research and develop health benefit design strategies to improve member health, and value of care, while decreasing costs in PPO plans.	New
Site of Care Management	Leverage current Integrated Health Care and Population Health delivery models to contain health care costs in PPO plans for possible expansion to health maintenance organizations (HMO).	New
Pharmacy Benefit Design Pilot	Develop and implement strategies to align our pharmacy benefit manager with our reference pricing model.	New
Reference Pricing Expansion	Leverage existing efforts to reduce health care costs by expanding the use of reference pricing for routine non-emergency procedures with price variation in the PPOs.	New
Population Health Alignment with Let's Get Healthy California Taskforce Report Dashboard	Provide employers with aggregate health care data to identify major health care costs and enhance Population Health Management.	New
Partner with Health Plans to Engage in Community Activities	Collaborate with health plans to positively impact the health of our members by engaging in community activities which create a culture of good health.	New
Statewide Collaboration Through Smart Care California	Partner with Covered California and Department of Health Care Services through the Smart Care California coalition to promote safe, affordable care in the areas of opioid use, caesarean sections, and spinal/back disorders.	New
Review and Update Shared Savings Accountable Care Organization Cost and Quality Targets	Research, analyze, and update shared savings cost and quality targets and expand the use of evidence - based medicine in improving outcomes while decreasing costs.	New
Research and Expand Evidence-Based Medicine	Apply outcome-based medical strategies to provide affordable and high value care.	New

[4] *CalPERS Pension and Health Benefits Committee Agenda Item 8, December 19, 2017.* https://www.calpers.ca.gov/docs/board-agendas/201712/pension/item-8.pdf

[5] This project ended in March 2016 and the final report on pilot findings was published. *CalPERS Pension and Health Benefits Committee Agenda Item 11,* June 20, 2017. https://www.calpers.ca.gov/docs/board-agendas/201706/pension/item-11.pdf

[6] On January 22, 2018, the President signed into law a two-year delay on the Affordable Care Act's excise tax on high-cost employer-sponsored health coverage, postponing the effective date from 2020 to 2022. This initiative is deferred until it becomes apparent that the tax will take effect and regulations will be promulgated.

Health Beliefs: Look Ahead

In addition to the already established Investment and Pension Beliefs, in April 2018, the board adopted a set of six Health Beliefs to help guide the management of the CalPERS Health Benefits Program.

CalPERS Core Values are engrained in the work we do every day. These values drive us to be transparent, accountable, and ethical to achieve our goals. As a leader, we shall engage in activities that influence the state and federal policy landscape, and align with other entities who share our values. We believe:

Health Program Sustainability

The sustainability of the Health Program is the foremost consideration when reviewing proposed changes to benefits, coverage areas, and costs.

High Quality Care

Health benefit plan designs should improve member health outcomes, maximize quality, and reduce unwarranted care.

Affordability

Health premiums and out-of-pocket costs must be affordable and sustainable for members and employers.

Comprehensive Care

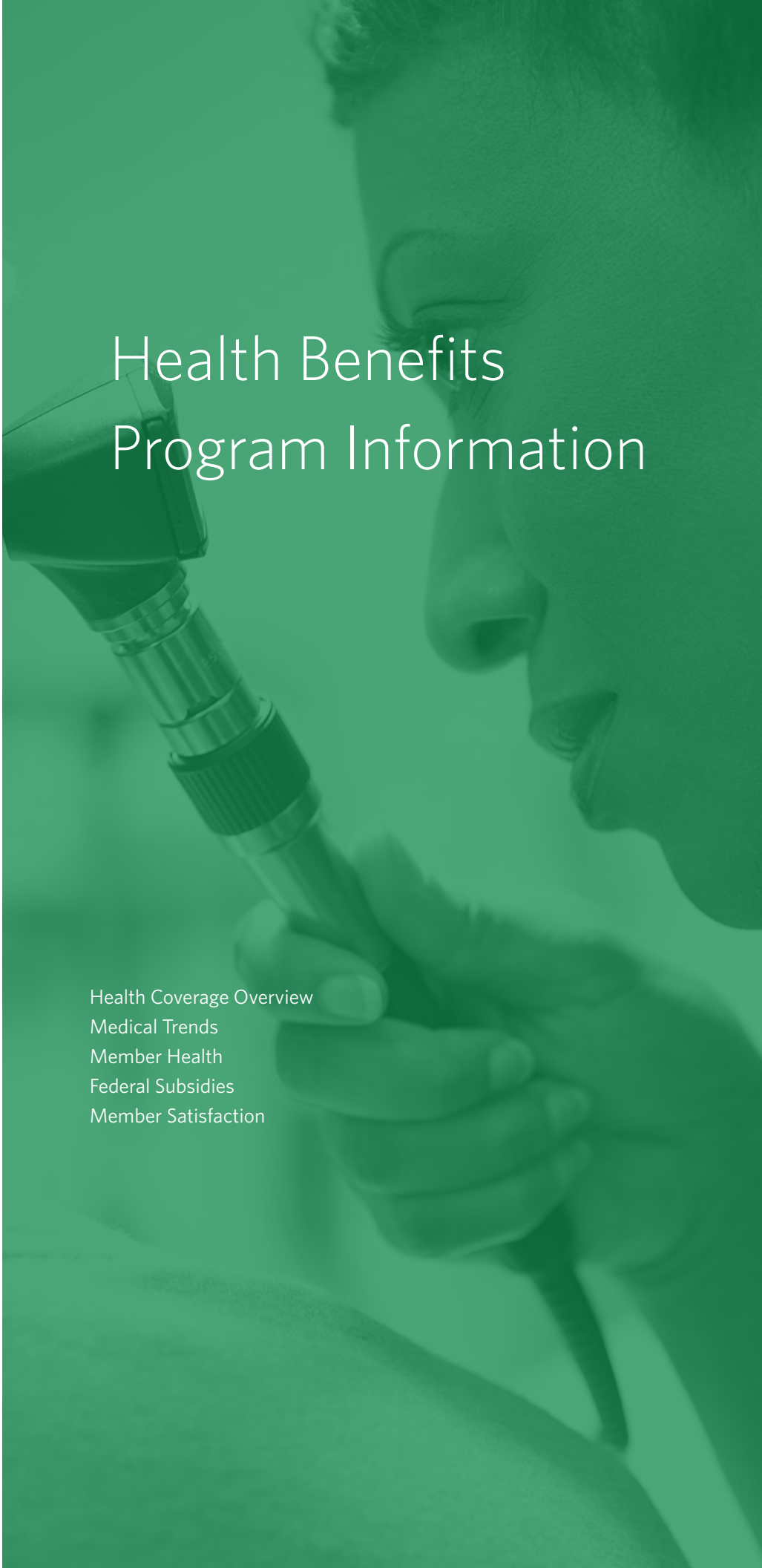
Health plans shall encourage healthy life choices and provide access to essential health care and evidence-based health services.

Competitive Plan Choice

CalPERS shall manage competition among health plans to help drive cost containment and give members access to options among health plans, benefits, and providers.

Quality Program Administration

CalPERS shall meet the needs of its many stakeholders with responsiveness, accuracy, and respectful service.



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 2017 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. CalPERS contracted with Kaiser Permanente and UnitedHealthcare to offer the following Medicare Advantage plans:

- Kaiser Permanente Senior Advantage (HMO)
- UnitedHealthcare Group Medicare Advantage (PPO)

In addition, CalPERS contracted with Anthem Blue Cross to administer the following Medicare Supplemental plans:

- PERS Select
- PERS Choice
- PERSCare

Three Association plans (ASN) are also available to members who pay applicable dues to the following employee associations:

- California Association of Highway Patrolmen (CAHP)
- California Correctional Peace Officers Association (CCPOA)
- Peace Officers Research Association of California (PORAC)

CalPERS does not negotiate rates and is not responsible for the benefit administration of these three plans.

For the 2017 plan year, OptumRx was selected as the Pharmacy Benefit Manager (PBM), replacing CVS Caremark. The five-year contract took effect January 1, 2017, and ends December 31, 2021. OptumRx will administer prescription drug benefits for members in PERS Select, PERS Choice, and PERSCare PPO health plans, as well as Anthem Blue Cross, Health Net, Sharp, and UnitedHealthcare Basic HMO plans.

CalPERS' HMO and PPO Basic health plans provide benefits in all of the Essential Health Benefit categories[1] under the Affordable Care Act.

[1] 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.

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, including consultation and referral
- 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.[2]

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

[2] See footnote 1 on page 10.

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 CalPERS Board of Administration. Benefit designs for CalPERS' health plans, including covered benefits and cost-sharing requirements, are summarized in Appendix B.

In June 2016, the board adopted the following five benefit changes for the 2017 health plan year:

Diabetes Prevention

The board elected to require all CalPERS contracted health plans to implement diabetes prevention programs that meet the Centers for Disease Control and Prevention "Diabetes Prevention Recognition Program Standards and Operating Procedures," at no additional cost to members. This benefit is designed to reach pre-diabetic plan members to prevent or reduce the onset of Type 2 diabetes.

Welvie

The board elected to discontinue the Welvie program for Blue Shield and Anthem Traditional HMO and Anthem Select HMO plans. The board continued the Welvie program for CalPERS Basic PPO plans - PERS Choice, PERS Select, and PERSCare. Welvie is an online tool that helps educate members on unnecessary and inappropriate surgeries.

Kaiser Permanente Dental Benefit Rider

The board elected to authorize Kaiser to offer a dental rider for contracting agency members enrolled in its Medicare plan. The dental rider will be at the member's option to purchase directly from Kaiser. CalPERS will not be responsible for enrollment and will not have any financial obligation for this benefit.

Kaiser Permanente Silver&Fit Benefit

The board elected to add the Silver&Fit benefit to Kaiser's Medicare plan at a proposed cost of $2.45 Per Member Per Month (PMPM). The addition of the Silver&Fit benefit to the Kaiser Medicare plan is expected to contribute to improved health of CalPERS members and long-term cost moderation. Both CalPERS' Medicare Advantage plans will now offer a health and wellness program.

Castlight

The board elected to continue the Castlight tool for CalPERS Basic PPO plans. Castlight is an online health care price transparency tool available to members enrolled in PERS Choice, PERS Select, and PERSCare.

All CalPERS health plans offer diabetes prevention programs at no additional cost to members.

Actuarial Value by Metal Tier

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 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 and EPO health plans fall in the platinum tier, and its Basic PPO plans in the gold tier. The Basic ASN health plans include a combination of platinum and gold tier ratings.

The following tables show the Metal Tiers for the 2017 Basic Health Plans.

HMO Plans	Actuarial Value	Metal Tier
Anthem HMO Select	97%	Platinum
Anthem HMO Tradtional	97%	Platinum
Blue Shield Access+	92%	Platinum
Health Net Salud y Más	90%	Platinum
Health Net SmartCare	91%	Platinum
Kaiser	98%	Platinum
Sharp	97%	Platinum
UnitedHealthcare	98%	Platinum

PPO Plans	Actuarial Value	Metal Tier
Anthem EPO Del Norte	98%	Platinum
Anthem EPO Monterey	96%	Platinum
PERS Choice	86%	Gold
PERS Select	84%	Gold
PERSCare	89%	Gold

ASN Plans	Actuarial Value	Metal Tier
CAHP	90%	Platinum
CCPOA	88%	Gold
PORAC	88%	Gold

Look Ahead

Beginning in 2019, CalPERS Basic PPO plans will change some co-pays. A new value-based insurance design (VBID) option is available for those enrolled in the PERS Select Basic plan. This plan will provide members and their families a lower-cost option and encourage enrollees to be more engaged in their health care. By adjusting co-pays for some services and, more specifically, by introducing the VBID option, CalPERS is offering a lower-cost premium plan with a slightly different cost-sharing structure and lower actuarial value.

Member Out-of-Pocket Costs

Member out-of-pocket costs are members' expenses for medical care that are not reimbursed by insurance. These costs include deductibles, co-insurance, co-payments, and other out-of-pocket costs as specified in CalPERS' health plans' Evidence of Coverage (EOC) booklets.

In 2017, a typical co-payment for a physician office visit for members enrolled in a Basic HMO plan was $15, and $20 for members enrolled in a Basic PPO plan. In 2017, a typical deductible for members enrolled in a Basic PPO plan was $500 for individuals and $1,000 for a family. CalPERS' members paid on average $309 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 2017 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 $135 in out-of-pocket costs, while a member in a Medicare Advantage plan paid $290. On average, a member in a Basic PPO plan paid $938 in out-of-pocket costs, while a member in a Medicare PPO plan paid on average $239. The average out-of-pocket costs are based on submitted health claims data. 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. A 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.

Medical Trends

The overall cost trend for CalPERS' HMO and PPO Basic health plans increased 2.8 percent in calendar year 2017, compared to 2.4[3] percent between calendar years' 2015 and 2016. 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

Analysis of trends allow a better understanding of the factors that impact healthcare premiums. The 2017 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 visits, ambulatory surgery, and laboratory services, while all other service categories had a decreasing trend in utilization for calendar year 2017. See Appendix C for graphs displaying these medical trend changes.

We have made methodology changes for the information presented in the Medical Trends and Chronic Conditions sections. The methodologies used have evolved and were developed in coordination with industry experts. Readers will continue to see changes and improvements to these sections. We will seek to align with best practices to group and present the data.

[3] Report reflects corrections to data reported in the November 1, 2017, Health Benefits Program Annual Report including corrections to claims data and reporting methodologies.

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 2017, approximately 41 percent of members enrolled in a CalPERS health benefit plan had an existing chronic condition and 30 percent had one or more of the major most prevalent chronic conditions. In 2017, seven of the major chronic conditions, affecting between 0.5 and 10.5 percent of CalPERS' California population, were:

- Hypertension
- Diabetes
- Depression
- Asthma
- Coronary Artery Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure

The prevalence of chronic conditions seems to be increasing. In CalPERS' Medicare plans, conditions such as hypertension and diabetes are highly prevalent.

The CalPERS population, on average, is older and has 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, heart failure, and asthma are all higher among members enrolled in CalPERS' plans.

The table on the next page provides a breakdown of chronic conditions prevalence in Northern and Southern California counties, and statewide, based on information from CalPERS' Health Care Decision Support System (HCDSS) for 2017. Note that some members may have had more than one chronic condition.

2017 Chronic Conditions Prevalence Among CalPERS Members*

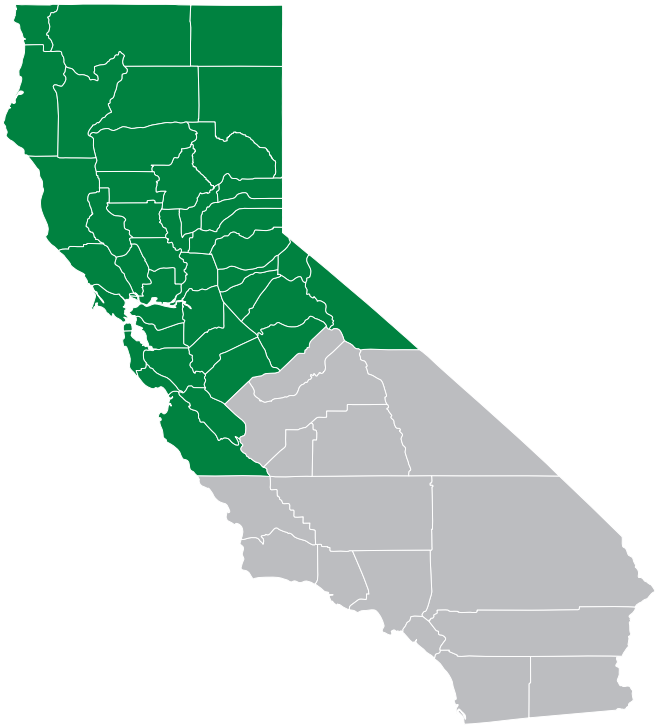
	Northern California		Southern California		Total California	
	Percentages based on 752,839 members		Percentages based on 620,305 members		Percentages based on 1,373,144 members	
Chronic Condition	Population	Prevalence (%)	Population	Prevalence (%)	Population	Prevalence (%)
Hypertension	76,888	10.2	67,697	10.9	144,585	10.5
Diabetes	56,696	7.5	49,187	7.9	105,883	7.7
Depression	29,147	3.9	23,558	3.8	52,705	3.8
Asthma	25,512	3.4	19,454	3.1	44,966	3.3
Coronary artery disease	15,577	2.1	14,451	2.3	30,028	2.2
COPD	13,500	1.8	16,867	2.7	30,367	2.2
Congestive heart failure	3,569	0.5	3,192	0.5	6,761	0.5

* The CalPERS HCDSS 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



The table below provides a breakdown of chronic conditions prevalence for Basic members in Northern and Southern California counties, and statewide, based on information from CalPERS' HCDSS for 2017. Note that some members may have had more than one chronic condition.

2017 Chronic Conditions Prevalence Among CalPERS Basic Members*

	Northern California		Southern California		Total California	
	Percentages based on 617,705 members		Percentages based on 527,064 members		Percentages based on 1,144,769 members	
Chronic Condition	Population	Prevalence (%)	Population	Prevalence (%)	Population	Prevalence (%)
Hypertension	39,462	6.4	36,117	6.9	75,579	6.6
Diabetes	30,646	5.0	28,848	5.5	59,494	5.2
Depression	23,947	3.9	19,567	3.7	43,514	3.8
Asthma	20,634	3.3	15,740	3.0	36,374	3.2
Coronary artery disease	4,900	0.8	4,915	0.9	9,815	0.9
COPD	5,976	1.0	9,715	1.8	15,691	1.4
Congestive heart failure	788	0.1	838	0.2	1,626	0.1

* The CalPERS HCDSS medical episode grouper was used to measure prevalence of chronic conditions.

The table below provides a breakdown of chronic conditions prevalence for Medicare members in Northern and Southern California counties, and statewide, based on information from CalPERS' HCDSS for 2017. Note that some members may have had more than one chronic condition.

2017 Chronic Conditions Prevalence Among CalPERS Medicare Members*

	Northern California		Southern California		Total California	
	Percentages based on 135,134 members		Percentages based on 93,241 members		Percentages based on 228,375 members	
Chronic Condition	Population	Prevalence (%)	Population	Prevalence (%)	Population	Prevalence (%)
Hypertension	37,426	28.0	31,580	33.9	69,006	30.2
Diabetes	26,050	19.3	20,339	22.0	46,389	20.1
Depression	5,200	3.8	3,991	4.3	9,191	4.0
Asthma	4,878	3.6	3,714	4.0	8,592	3.8
Coronary artery disease	10,677	8.0	9,536	10.0	20,213	8.8
COPD	7,524	5.6	7,152	7.7	14,676	6.4
Congestive heart failure	2,781	2.1	2,354	2.5	5,135	2.2

* The CalPERS HCDSS medical episode grouper was used to measure prevalence of chronic conditions.

Population Risk

CalPERS periodically conducts a population risk analysis to determine the overall risk of the Health Benefits Program. 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 historically had similar risk profiles, and because of its size the Health Benefits Program as a whole is not greatly affected by the addition or departure of any single contracting agency.

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 53 percent female and 47 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 effect 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 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.

Look Ahead

CalPERS strives to keep health premium increases low. For 2018 and 2019, aggregate premiums increased 2.33 and 1.16 percent, respectively. These mark the lowest health premium increases in over two decades.

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 2017, CalPERS collected $29,534,000 in federal subsides, 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 PERS Select, PERS Choice, and PERSCare 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.

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 2017 plan year, launched on January 9, 2018, and concluded on March 5, 2018.

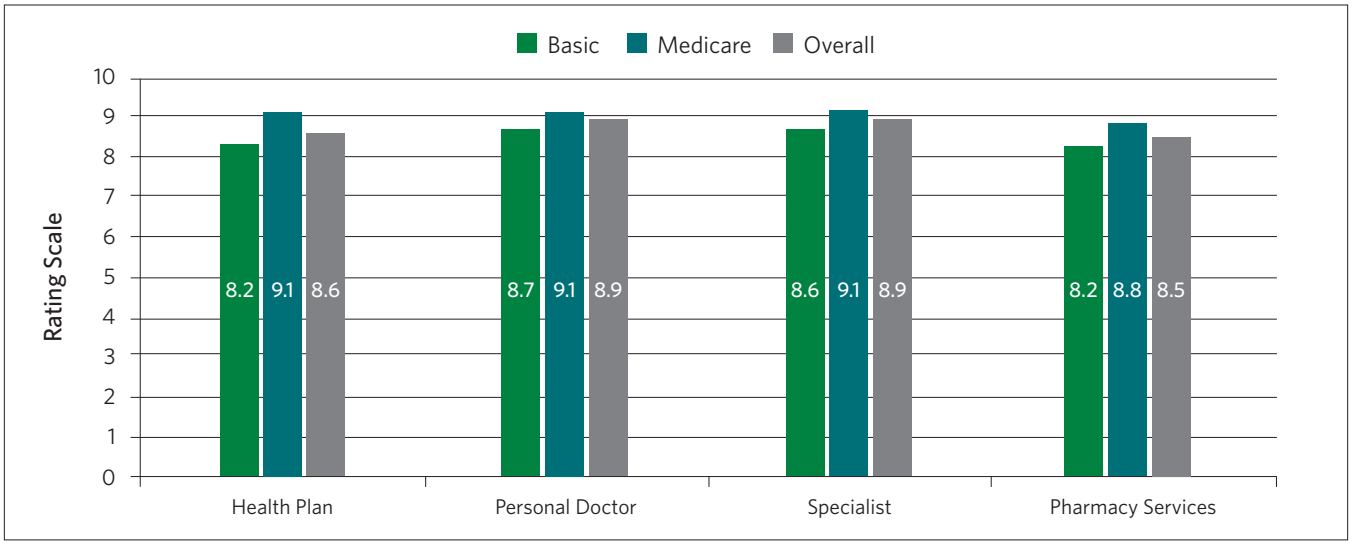
The survey asked members to rate certain aspects of their health care experience using any number from 0 to 10 where 0 is the lowest possible rating and 10 is the highest possible rating. The overall rating is the average rating of total respondents on the 10-point scale. Appendix D includes graphical data on specific responses.

Members were asked to rate their satisfaction with their:

- Health Plan
- Personal Doctor
- Specialist
- Pharmacy Service

The Member Satisfaction Ratings chart below summarizes the survey responses.

Member Satisfaction Ratings



Rural Healthcare Accessibility

The annual survey asked Basic plan members to report their level of accessibility. According to survey data, 224 respondents did not have access to an HMO in their area. These respondents lived in rural coverage areas and were enrolled in a Basic PPO Plan. This section is specific to Basic plan members, as CalPERS' Medicare plan subscribers had access to Medicare Advantage in all 58 counties in California. Appendix D includes graphical data on specific responses.

Emergency Room Care

Out of the 224 respondents living in a rural area, 36 utilized the emergency room to get care for themselves.

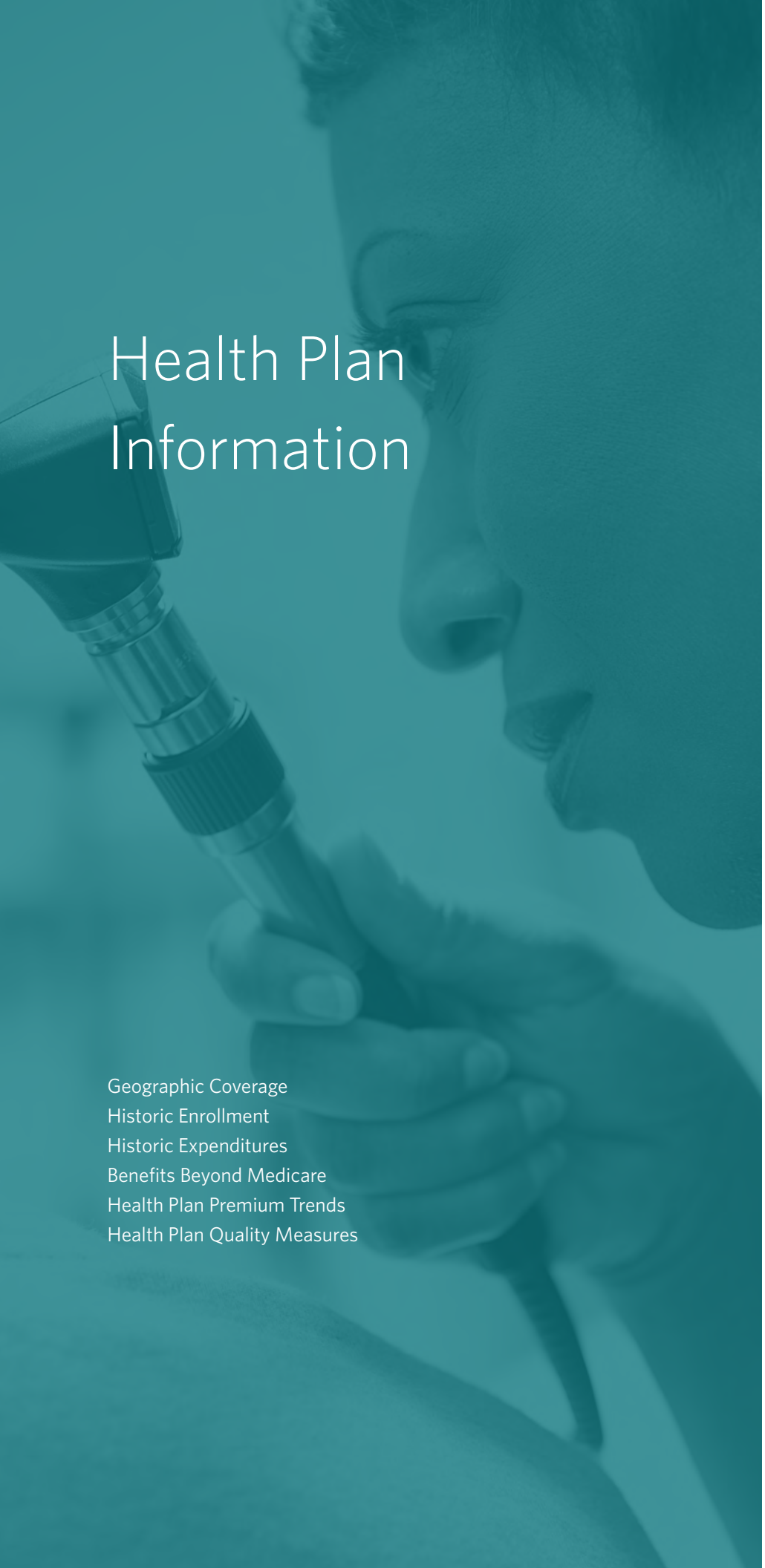
Of these 36 respondents, five responded that they went to the emergency room because there were no urgent care services within 15 miles/30 minutes of their homes. These individuals resided in Amador, Inyo, Plumas, Shasta, and Trinity counties.

After-Hours Care

Out of the 224 Basic plan respondents living in a rural area, six responded that it was not easy to get after-hours care.

Of these six respondents, four 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 Inyo, Lake, Shasta, and Trinity counties.

CalPERS members report high satisfaction with their health plans. On a scale of 1-10, Basic members rate their health plans 8.2. Medicare members rate their plans 9.1.



Health Plan Information

Geographic Coverage
Historic Enrollment
Historic Expenditures
Benefits Beyond Medicare
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 almost 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. 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. Refer to Appendix E for a comprehensive view of health plan availability by county.

Look Ahead

In 2018, CalPERS expanded Basic HMO coverage options for members in Placer, El Dorado, Sacramento, Yolo, Colusa, Solano, Napa, Sonoma, and Marin counties.

CalPERS offers health benefit options for members located throughout the state, out-of-state, and worldwide.

Historic Enrollment

CalPERS has seen its health plan enrollment grow over the past ten years. Between 2008 and 2017, CalPERS' total enrollment has increased by over 14 percent.

Throughout the year, we engage our employer community through conferences, workshops, health fairs, and the annual CalPERS Educational Forum. These outreach efforts help raise awareness of the Health Benefits Program and attract new public agency and school employers. In 2017, we were successful in retaining 99 percent of our contracting public agency and school employers.

Basic and Medicare

The table to the right displays ten years (2008-2017) 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.

Other Enrollment Information

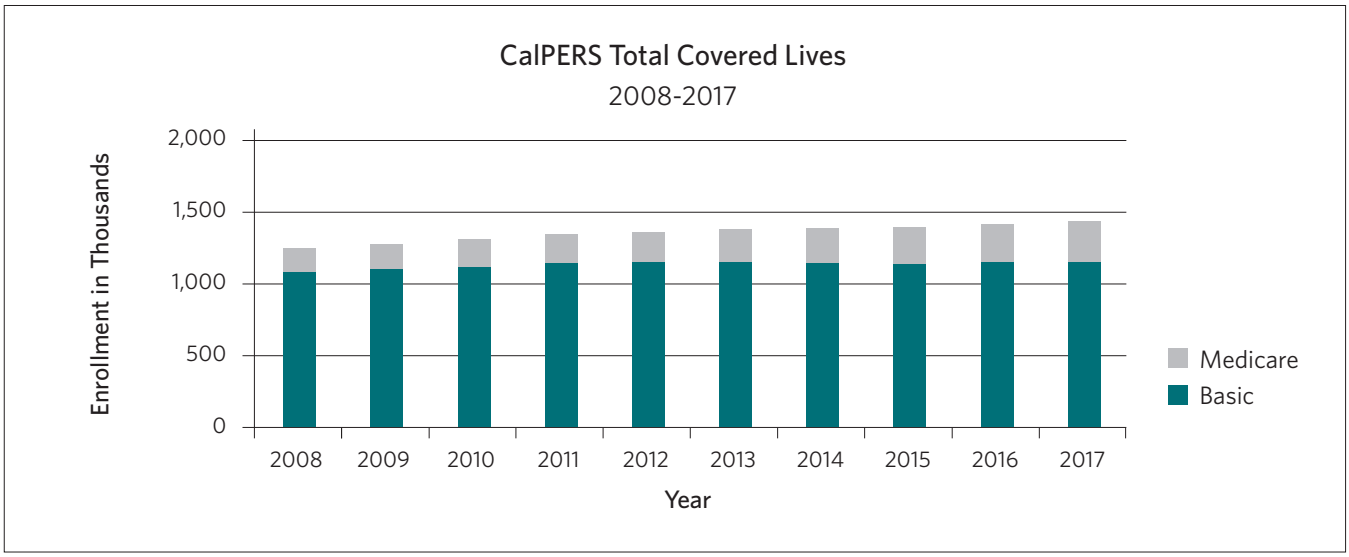
In addition to the Basic and Medicare enrollment information in this section, the CalPERS Historic Enrollment tables (see Appendix F) provide enrollment data for plan years 2015, 2016, and 2017. The CalPERS total enrollment count includes state, public agency, and school members, excluding individuals 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).

Estimated Basic and Medicare Enrollment
(Enrollment in Thousands)

	Basic	Medicare	Total*
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
2017	1,172	266	1,437

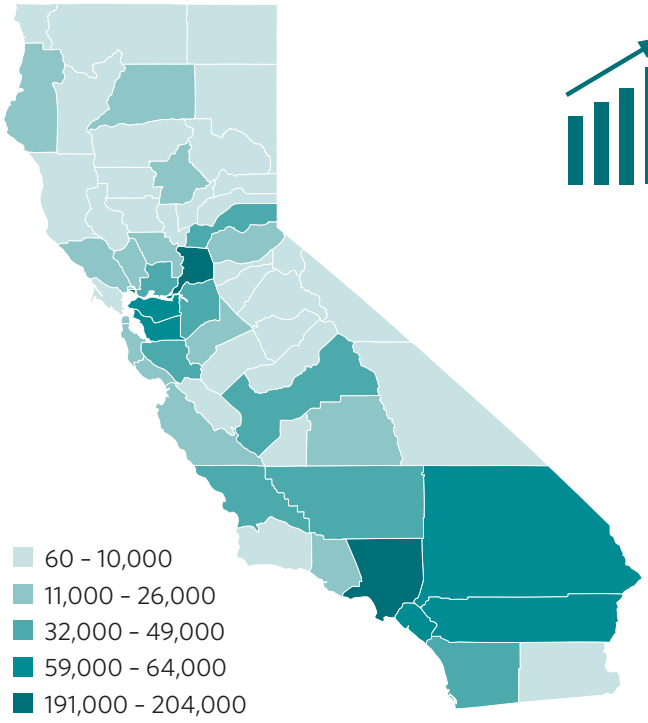
* Total Program may not equal the sum of Basic and Medicare totals due to rounding.

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



The California map below displays CalPERS' estimated enrollments for all 58 counties.

2017 Enrollment by County



The CalPERS Health Benefits Program continues to grow. Over the past 10 years, total enrollment increased by 14 percent.

Notes:

- There are approximately 64,000 members residing outside of California.
- Data is based on January 2017 Enrollment Report

Historic Expenditures

The CalPERS Health Benefits Program total estimated expenditure in 2017 was $8.88 billion.

Basic and Medicare

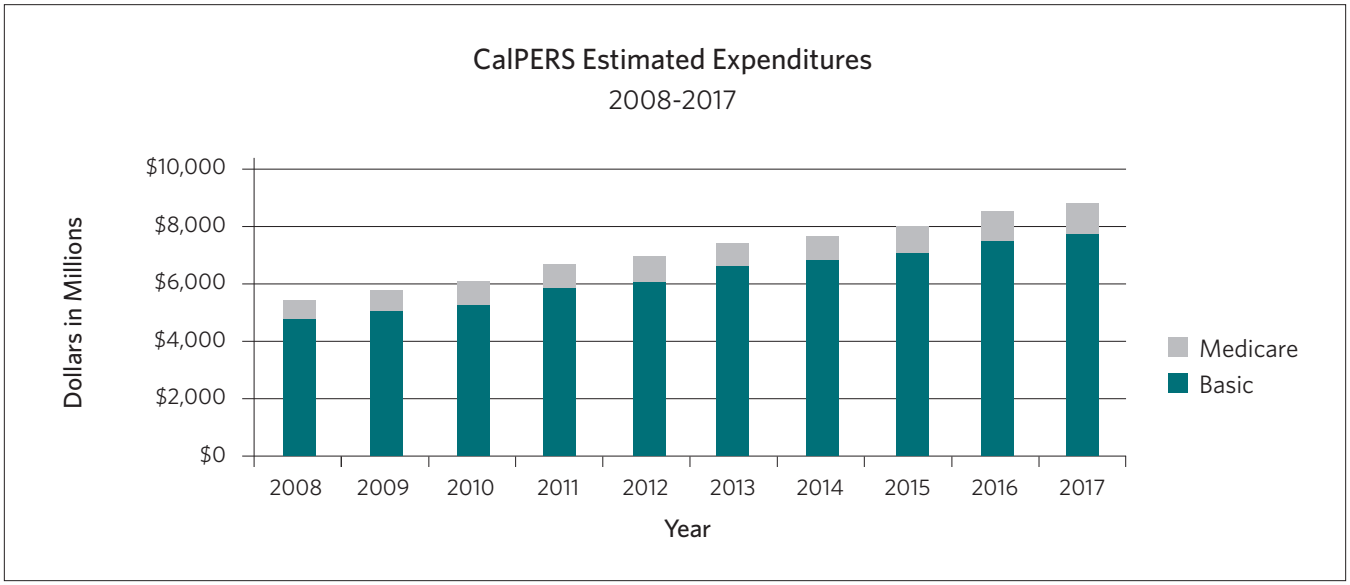
The table to the right displays ten years (2008-2017) of CalPERS' total estimated expenditures by Basic and Medicare. Since actual membership fluctuates during any given month, the numbers presented in the table are estimated expenditures, not actual. Estimates are determined by applying the corresponding year's premium amounts to the annualized January subscriber enrollment counts (e.g., 2017 expenditures were calculated based on 2017 premium rates and January 2017 enrollment counts).

Estimated Basic and Medicare Expenditures
(Dollars in Millions)

	Basic	Medicare	Total*	Year Over Year
2008	$4,820	$662	$5,482	9.4%
2009	5,137	697	5,833	6.4%
2010	5,363	753	6,116	4.9%
2011	5,929	825	6,754	10.4%
2012	6,156	867	7,022	4.0%
2013	6,678	833	7,511	7.0%
2014	6,864	858	7,722	2.8%
2015	7,045	975	8,020	3.9%
2016	7,573	1,058	8,631	7.6%
2017	7,795	1,084	8,879	2.9%

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

In 2017, the Health Benefits Program spent an estimated $8.88 billion on health benefits for active employees, retirees, and their dependents.



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

The average annual increase for the program's total estimated expenditures was approximately 5.9 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 in this section, the Historic Expenditures tables (see Appendix G) provide estimated expenditures for 2015–2017. 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).

Basic health plans represent about 88 percent of the total program's expenditures, while Medicare represents 12 percent.

Benefits Beyond Medicare

In 2017, 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 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: Up to 20 visits per calendar year
- 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
- Smoking Cessation Programs: Up to $100 per calendar year
- Speech Therapy: Up to a lifetime maximum of $5,000 per member
- 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 continue to explore 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 2017.

2017 Benefits Beyond Medicare

(Dollars in Thousands)

Benefit	Aggregated Cost
Acupuncture or acupressure services	$1,944
Blood replacement	6
Christian Science nurse or practitioner	0
Hearing aid	5,353
Hospital services and supplies (inpatient and outpatient)	53,996
Immunizations	62
Lancets	64
Mental health services and supplies (inpatient and outpatient)	2,219
Physical or occupational therapy	1,841
Skilled nursing services	1,825
Smoking cessation programs	2
Speech therapy	12
Vision care	128
Total	$67,452

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 2017 plan year premiums started in 2016, using data from 2015.

The Health Care Decision Support System (HCDSS) 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.

Look Ahead

As an active purchaser, CalPERS' HCDSS claims data is crucial to our rate development process. In 2018, CalPERS was successful in negotiating a five-year contract to provide actuarial and analytical services.

Trend Factors

CalPERS has been successful in moderating premium trend increases without compromising quality health care. The CalPERS Board of Administration 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 2017, premiums increased by 3.24 percent for all Basic and Medicare plans combined. Basic HMO plans increased by an average of 4.14 percent, Basic PPO plans increased by an average of 3.76 percent, and Medicare

plans decreased by an average of 1.63 percent. For the HMO and PPO plans, there was an increase in medical costs and a decrease in pharmacy and ACA costs.

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 five public agency and school (contracting agencies) regions across California. Appendix H shows tables reflecting premium increases or decreases between plan years 2016 and 2017 for state and contracting agency HMO, PPO, and ASN. CalPERS is not responsible for the benefit administration of ASN's and does not negotiate ASN premiums.

Look Ahead

Ensuring that CalPERS health plan rates appropriately reflect the actual cost of care is crucial to the long-term sustainability of the program. Throughout 2018, CalPERS has engaged with stakeholders and industry experts to re-evaluate public agency and school regions and regional factors. The board expects to make decisions on these topics in December 2018.

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 premium table below is derived from information from my|CalPERS that originated at the subscriber enrollment level by coverage month, plan code, and health plan. It reflects the amount owed to each carrier from January through December 2017. The premium information was extracted from a point in time from my|CalPERS as of June 9, 2018.

Health Premium Management Report for Calendar Year 2017
(Dollars in Thousands)

Health Plan Carriers	Health Premiums Amount
Anthem Blue Cross	$2,625,090
ASNs (CAHP, CCPOA, and PORAC)	548,783*
Blue Shield of California	1,237,907
Health Net of California	252,734
Kaiser Permanente	3,560,496*
Sharp Health Plan	59,815
UnitedHealthcare	598,442
Total	**$8,883,267**

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

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.[1] The current set of HEDIS® measures addresses "preventive services, chronic disease management, behavioral health care, appropriateness/overuse of services, and value."[2]

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.[3] 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[4] data specific to CalPERS members on an annual basis. Data analysis and reporting during the reporting year[5] is based on data collected from health plans during the measurement year.[6]

This report includes HEDIS® and HEDIS-like data for reporting year 2018 based on data collected during measurement year 2017. 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.

[1] https://www.ncqa.org/hedis/

[2] https://www.ncqa.org/hedis/measures/

[3] http://healthinsuranceratings.ncqa.org/2017/Default.aspx

[4] True HEDIS measures must be audited. Unaudited CalPERS-specific measures that follow HEDIS specifications are classified as "HEDIS-like."

[5] The calendar year in which data are analyzed and reported.

[6] 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.[7] 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:

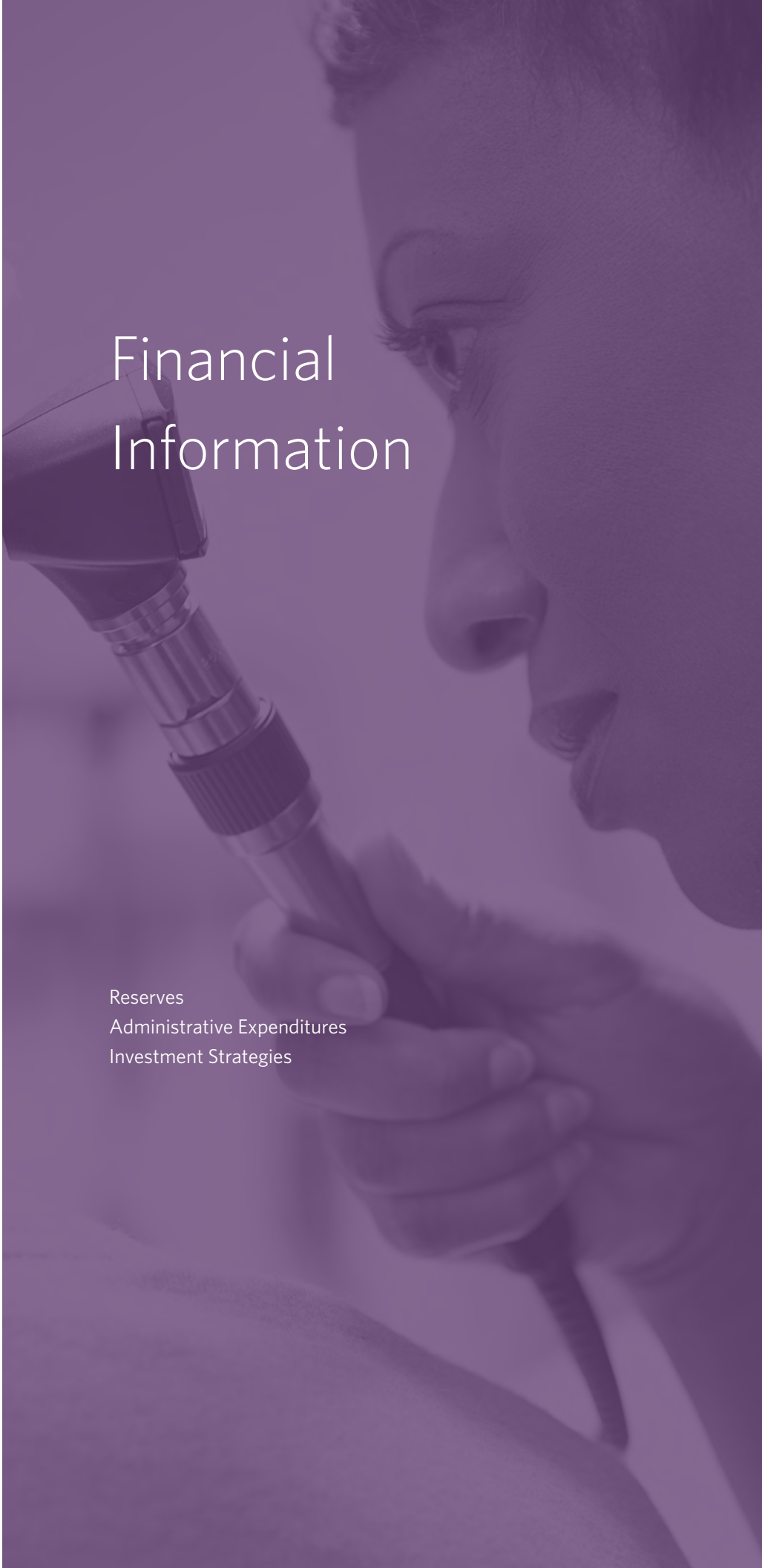
2017 Health Plan Contract Quality Measures

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.

[7] https://www.medicareinteractive.org/get-answers/medicare-health-coverage-options/changing-medicare-coverage/how-to-compare-plans-using-the-medicare-star-rating-system

2017 Health Plan Contract Quality Measures, cont.

Item	Health Plan Contractor Requirements
Quality Management and Improvement	Review, measure, and improve the quality of services provided and the clinical practices of its participating providers and provide reports to CalPERS. 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. 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.
Reporting and Public Regulatory Studies	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).



Financial Information

Reserves
Administrative Expenditures
Investment Strategies

Reserves

Reserve Levels/Adequacy

As of December 31, 2017, the required actuarial reserve level for the PPO plans was $609.8 million, and the total reserve level was $729.6 million (i.e., $119.8 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 2017, 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[1]), 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, 2017, the assets for the self-funded portion of CalPERS' HMO plans totaled $24.8 million.

Look Ahead

In September 2018, the CalPERS Board of Administration adopted a new Health Care Fund Reserve Policy. This Policy establishes a strategy for developing, reviewing, updating, and handling fund surpluses or deficits related to the CalPERS PPO and Flex-Funded HMO health benefit plans.

[1] At the December 2017 Closed Session (Item 2), the board approved to not risk adjust the Health Maintenance Organization and Preferred Provider Organization health plan premiums beginning with plan year 2019.

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 2017-18 fiscal year.

The Health Benefits Program staffs 445.2 positions out of the total organization of 2,875 positions. The direct positions are located in the Health Policy and Benefits Branch, the Actuarial Office, the Legal Office, and the Customer Service and Outreach Division. Enterprise Support Operation positions are throughout the organization, including the Operations and Technology Branch.

Staff Levels

Direct	254.6
Enterprise Support Operations	190.6
Total Staffing Levels	**445.2**

Personnel Services

(Dollars in Thousands)

Salary and Wages	$32,304
Staff Benefits	16,096
Total Personnel Services	**$48,400**

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	$9,128
Consultant and Professional Services – Internal	195
Consultant and Professional Services – External	7,024
Statewide Administrative Cost (Pro Rata)	3,825
Total Operating Expenses & Equipment	**$20,172**

The funding sources for the 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	$28,665
Public Employees' HCF	39,907
Total Funding Sources	**$68,572**

Look Ahead

Beginning July 1, 2018, all state employees contribute toward other post-employment benefit (OPEB) liabilities, by pre-funding their retiree health care benefits. In addition, CalPERS offers the California Employers' Retiree Benefit Trust (CERBT) to help public agencies and schools fund retiree health care benefits.

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, shall be managed as follows:

- The pool will ensure 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 will be managed to ensure that normal cash needs, as well as scheduled extraordinary cash needs can be met.
- Pooled investments and deposits shall be 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
13/14	Surplus Money Investment Fund (SMIF)	$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%
17/18		658,269,063	1.45%

* 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.

The Health Benefits Program has two funding sources: the Public Employees' Contingency Reserve Fund and the Public Employees' Health Care Fund.

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
13/14	State Street Global Advisors (SSGA) U.S. Aggregate Bond Index Fund	$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%)
17/18		443,267,916	(0.33%)
13/14	Surplus Money Investment Fund (SMIF)	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%
17/18		583,267,337	1.45%

*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, 2018, is 3.72 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

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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 Law111-152).

(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 EPO Select HMO Traditional HMO	Blue Shield Access+ & Access+ EPO	Health Net Salud y Más & SmartCare	Kaiser Permanente	Sharp Performance Plus	UnitedHealthCare SignatureValue Alliance	CCPOA (Association Plan)
Calendar Year Deductible							
Individual	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Maximum Calendar Year Co-pay or Co-insurance (excluding pharmacy)							
Individual	$1,500 (co-pay)	$1,500 (co-pay)	$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)	$3,000 (co-pay)	$3,000 (co-pay)	$3,000 (co-pay)	$3,000 (co-pay)	$4,500 (co-pay)
Hospital (including Mental Health and Substance Abuse)							
Deductible (per Admission)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Inpatient	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	$100/ admission
Outpatient Facility/ Surgery Service	No Charge	No Charge	No Charge	$15	No Charge	No Charge	$50

Continued on next page

Benefits	PPO Basic Plans									
	PERS Select		PERS Choice		PERSCare		CAHP (Association Plan)		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Calendar Year Deductible										
Individual	$500 (not transferable between plans)		$500 (not transferable between plans)		$500 (not transferable between plans)		N/A		$300	$600
Family	$1,000 (not transferable between plans)		$1,000 (not transferable between plans)		$1,000 (not transferable between plans)		N/A		$900	$1,800
Maximum Calendar Year Co-pay or Co-insurance (excluding pharmacy)										
Individual	$3,000 (co-insurance)	N/A	$3,000 (co-insurance)	N/A	$2,000 (co-insurance)	N/A	$2,000 (co-insurance)	N/A	$3,000	N/A
Family	$6,000 (co-insurance)	N/A	$6,000 (co-insurance)	N/A	$4,000 (co-insurance)	N/A	$4,000 (co-insurance)	N/A	$6,600	N/A
Hospital (including Mental Health and Substance Abuse)										
Deductible (per Admission)	N/A		N/A		$250		N/A		N/A	
Inpatient	20-30% (hospital tiers)	40%	20%	40%	10%	40%	10%	Varies	10%	
Outpatient Facility/ Surgery Service	20-30% (hospital tiers)	40%	20%	40%	10%	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 EPO Select HMO Traditional HMO	Blue Shield Access+ & Access+ EPO	Health Net Salud y Más & SmartCare	Kaiser Permanente	Sharp Performance Plus	UnitedHealthCare SignatureValue Alliance	CCPOA (Association Plan)
Emergency Services							
Emergency Room Deductible	N/A	N/A	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	$50	$50	$50	$50	$75
Non-Emergency (co-pay waived if admitted as an inpatient or for observation as an outpatient)	$50	$50	$50	$50	$50	$50	$75
Physician Services (including Mental Health and Substance Abuse)							
Office Visits (co-pay for each service provided)	$15	$15	$15	$15	$15	$15	$15
Inpatient Visits	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Outpatient Visits	$15	$15	$15	$15	$15	$15	$15
Urgent Care Visits	$15	$15	$15	$15	$15	$15	$15
Preventive Services	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Surgery/Anesthesia	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Diagnostic X-Ray/Lab							
	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge

Continued on next page

Benefits	PPO Basic Plans									
	PERS Select		PERS Choice		PERSCare		CAHP (Association Plan)		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Emergency Services										
Emergency Room Deductible	$50 (applies to hospital emergency room charges only)		$50 (applies to hospital emergency room charges only)		$50 (applies to hospital emergency room charges only)		$50 (co-pay reduced to $25 if admitted on an inpatient basis)		N/A	
Emergency (co-pay waived if admitted as an inpatient or for observation as an outpatient)	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% (applies to other services such as physician, x-ray, lab, etc.)		10%	
Non-Emergency (co-pay waived if admitted as an inpatient or for observation as an outpatient)	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+10%	$50+40% (co-pay reduced to $25 if admitted on an inpatient basis)	50% (for non-emergency services provided by hospital emergency room)	
Physician Services (including Mental Health and Substance Abuse)										
Office Visits (co-pay for each service provided)	$20	40%	$20	40%	$20	40%	$15	40%	$20	10%
Inpatient Visits	20%	40%	20%	40%	10%	40%	10%	40%	10%	10%
Outpatient Visits	$20	40%	$20	40%	$20	40%	10%	40%	10%	10%
Urgent Care Visits	$20	40%	$20	40%	$20	40%	$15	40%	10%	10%
Preventive Services	No Charge	40%	No Charge	40%	No Charge	40%	No Charge	40%	No Charge	
Surgery/Anesthesia	20%	40%	20%	40%	10%	40%	10%	40%	10%	10%
Diagnostic X-Ray/Lab										
	20%	40%	20%	40%	10%	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 EPO Select HMO Traditional HMO	Blue Shield Access+ & Access+ EPO	Health Net Salud y Más & SmartCare	Kaiser Permanente	Sharp Performance Plus	UnitedHealthCare SignatureValue Alliance	CCPOA (Association Plan)
Prescription Drugs							
Deductible	N/A	N/A	N/A	N/A	N/A	N/A	Brand Formulary: $50 (not to exceed $150/family)
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: $5 Brand Formulary: $20 Non-Formulary: $50	Generic: $5 Brand: $20	Generic: $5 Brand Formulary: $20 Non-Formulary: $50	Generic: $5 Brand Formulary: $20 Non-Formulary: $50	Generic: $10 Brand Formulary: $25 Non-Formulary: $50
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: $40 Non-Formulary: $100	N/A	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	Generic: $10 Brand Formulary: $25 Non-Formulary: $50
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: $10 Brand Formulary: $40 Non-Formulary: $100	Generic: $10 Brand: $40 (31-100 day supply)	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	Generic: $20 Brand Formulary: $50 Non-Formulary: $100
Mail order maximum co-payment per person per calendar year	$1,000	$1,000	$1,000	N/A	$1,000	$1,000	N/A
Durable Medical Equipment							
	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge

Continued on next page

Benefits	PPO Basic Plans									
	PERS Select		PERS Choice		PERSCare		CAHP (Association Plan)		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Prescription Drugs										
Deductible	N/A		N/A		N/A		N/A		N/A	
Retail Pharmacy (not to exceed 30-day supply)	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: $5 Single Source: $20 Multi Source: $25		Generic: $10 Brand Formulary: $25 Non-Formulary: $45 Compound: $45	
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 Preferred: $40 Non-Preferred: $100		Generic: $10 Preferred: $40 Non-Preferred: $100		Generic: $10 Preferred: $40 Non-Preferred: $100 (not to exceed 34-day supply)		Generic: $10 Single Source: $40 Multi Source: $50		N/A	
Mail Order Pharmacy Program (not to exceed 90-day supply for maintenance drugs)	Generic: $10 Preferred: $40 Non-Preferred: $100		Generic: $10 Preferred: $40 Non-Preferred: $100		Generic: $10 Preferred: $40 Non-Preferred: $100		Generic: $10 Single Source: $40 Multi Source: $50		Generic: $20 Brand Formulary: $40 Non-Formulary: $75	N/A
Mail order maximum co-payment per person per calendar year	$1,000		$1,000		$1,000		N/A		N/A	
Durable Medical Equipment										
	20%	40%	20%	40%	10%	40%	10%	40%	20%	20%
	(pre-certification required for equipment)		(pre-certification required for equipment)		(pre-certification required for equipment $1,000 or more)					

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 EPO Select HMO Traditional HMO	Blue Shield Access+ & Access+ EPO	Health Net Salud y Más & SmartCare	Kaiser Permanente	Sharp Performance Plus	UnitedHealthCare SignatureValue Alliance	CCPOA (Association Plan)
Infertility Testing/Treatment							
	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Allowed Charges
Occupational/Physical/Speech Therapy							
Inpatient (hospital or skilled nursing facility)	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Outpatient (office and home visits)	$15	$15	$15	$15	$15	$15	No Charge
Diabetes Services							
Glucose monitors	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Self-management training	$15	$15	$15	$15	$15	$15	$15
Acupuncture							
	$15/visit (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)	$15/visit (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)	N/A
Chiropractic							
	$15/visit (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)	$15/visit (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)	$15 exam (up to 20 visits) No Charge diagnostic services; chiropractic appliances (up to $50)

Benefits	PPO Basic Plans									
	PERS Select		PERS Choice		PERSCare		CAHP (Association Plan)		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Infertility Testing/Treatment										
	Not Covered		Not Covered		Not Covered		Not Covered		50%	
Occupational/Physical/Speech Therapy										
Inpatient (hospital or skilled nursing facility)	No Charge		No Charge		No Charge		10%	40%	10%	10%
Outpatient (office and home visits)	20% (pre-certification required for more than 24 visits)	40%; Occupational therapy: 20% (pre-certification required for more than 24 visits)	20% (pre-certification required for more than 24 visits)	40%; Occupational therapy: 20% (pre-certification required for more than 24 visits)	10% (pre-certification required for more than 24 visits)	40%; Occupational therapy: 10% (pre-certification required for more than 24 visits)	10% (pre-certification required for more than 24 visits)	40% (pre-certification required for more than 24 visits)	$20	10%
Diabetes Services										
Glucose monitors	Coverage Varies		Coverage Varies		Coverage Varies		Coverage Varies		Coverage Varies	
Self-management training	$20		$20		$20		$15		$20	
Acupuncture										
	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40% (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40% (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40% (acupuncture/chiropractic; combined 20 visits per calendar year)	10% (acupuncture/chiropractic; combined 20 visits per calendar year)	40% (acupuncture/chiropractic; combined 20 visits per calendar year)	$20 (10% for all other services)	10%
Chiropractic										
	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40% (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40% (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40% (acupuncture/chiropractic; combined 20 visits per calendar year)	10% (acupuncture/chiropractic; combined 20 visits per calendar year)	40% (acupuncture/chiropractic; combined 20 visits per calendar year)	$20/up to 20 visits	$35/visit

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

Continued on next page

Benefits	Medicare Plans							
	PERS Select		PERS Choice		PERSCare		CAHP Medicare Supplement (Association Plan)	PORAC (Association Plan)
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO		
Calendar Year Deductible								
Individual	N/A		N/A		N/A		N/A	N/A
Family	N/A		N/A		N/A		N/A	N/A
Maximum Calendar Year Co-pay or Co-insurance (excluding pharmacy)								
Individual	N/A		N/A		$3,000 (co-insurance)	N/A	N/A	$15,000 calendar year stop-loss
Family	N/A		N/A		N/A		N/A	N/A
Hospital (including Mental Health and Substance Abuse)								
Inpatient	No Charge		No Charge		No Charge		No Charge	No Charge
Outpatient Facility/ Surgery Services	No Charge		No Charge		No Charge		No Charge	No Charge
Skilled Nursing Facility								
Medicare (up to 100 days/ benefit period)	No Charge		No Charge		No Charge		No Charge	No Charge
Home Health Services								
Medicare	No Charge		No Charge		No Charge		No Charge	No Charge
Hospice								
Medicare	No Charge		No Charge		No Charge		No Charge	No Charge
Emergency Services								
Medicare (waived if admitted or kept for observation)	No Charge		No Charge		No Charge		No Charge	No Charge
Ambulance Services								
Medicare	No Charge		No Charge		No Charge		No Charge	No Charge
Surgery/Anesthesia								
	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		
	Kaiser Permanente Senior Advantage	UnitedHealthcare Group Medicare Advantage (PPO)	CCPOA Medicare Supplement (Association Plan)
Physician Services (including Mental Health and Substance Abuse)			
Office Visits	$10	$10	$10
Inpatient Visits	No Charge	No Charge	No Charge
Outpatient Visits	$10	$10	$10
Urgent Care Visits	$10	$25	$10
Preventive Services	No Charge	No Charge	No Charge
Diagnostic X-Ray/Lab			
	No Charge	No Charge	No Charge
Durable Medical Equipment			
Medicare	No Charge	No Charge	No Charge
Prescription Drugs			
Deductible	N/A	N/A	N/A
Retail Pharmacy (not to exceed 30-day supply)	Generic: $5 Preferred: $20	Generic: $5 Preferred: $20 Non-Preferred: $50	Generic: $5 Preferred: $20 Non-Preferred: $35
Retail Pharmacy Long-Term Prescription Medications filled after 2nd fill (i.e. 90-day supply)	N/A	Generic: $10 Preferred: $40 Non-Preferred $100	Generic: $5 Preferred: $20 Non-Preferred: $35
Mail Order Pharmacy Program (not to exceed 90-day supply)	Generic: $10 Preferred: $40 (31-100 day supply)	Generic: $10 Preferred: $40 Non-Preferred $100	Generic: $10 Preferred: $40 Non-Preferred $70
Mail order maximum co-payment per person per calendar year	N/A	$1,000	N/A
Occupational/Physical/Speech Therapy			
Inpatient (hospital or skilled nursing facility)	No Charge	No Charge	No Charge
Outpatient (office and home visits)	$10	$10	No Charge

Continued on next page

Benefits	Medicare Plans							
	PERS Select		PERS Choice		PERSCare		CAHP Medicare Supplement (Association Plan)	PORAC (Association Plan)
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO		
Physician Services (including Mental Health and Substance Abuse)								
Office Visits	No Charge		No Charge		No Charge		$10	No Charge
Inpatient Visits	No Charge		No Charge		No Charge		No Charge	No Charge
Outpatient Visits	No Charge		No Charge		No Charge		No Charge	No Charge
Urgent Care Visits	No Charge		No Charge		No Charge		No Charge	No Charge
Preventive Services	No Charge		No Charge		No Charge		No Charge	No Charge
Diagnostic X-Ray/Lab								
	No Charge		No Charge		No Charge		No Charge	No Charge
Durable Medical Equipment								
Medicare	No Charge		No Charge		No Charge		No Charge	No Charge
Prescription Drugs								
Deductible	N/A		N/A		N/A		N/A	$100
Retail Pharmacy (not to exceed 30-day supply)	Generic: $5 Preferred: $20 Non-Preferred: $50		Generic: $5 Preferred: $20 Non-Preferred: $50		Generic: $5 Preferred: $20 Non-Preferred: $50		Generic: $5 Single Source: $20 Multi Source: $25	Generic: $10 Preferred: $25 Non-Preferred: $45
Retail Pharmacy Long-Term Prescription Medications filled after 2nd fill (i.e. 90-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 90 day supply)		Generic: $10 Preferred: $40 Non-Preferred: $100 (not to exceed 90 day supply)		Generic: $10 Single Source: $40 Multi Source: $50	N/A
Mail Order Pharmacy Program (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 Single Source: $40 Multi Source: $50	Generic: $20 Preferred: $40 Non-Preferred: $75
Mail order maximum co-payment per person per calendar year	$1,000		$1,000		$1,000		N/A	N/A
Occupational/Physical/Speech Therapy								
Inpatient (hospital or skilled nursing facility)	No Charge		No Charge		No Charge		No Charge	No Charge
Outpatient (office and home visits)	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		
	Kaiser Permanente Senior Advantage	UnitedHealthcare Group Medicare Advantage (PPO)	CCPOA Medicare Supplement (Association Plan)
Diabetes Services			
Glucose monitors, test strips	No Charge	No Charge	No Charge
Self-management training	$10	$10	$10
Hearing Services			
Routine Hearing Exam	$10	No Charge	No Charge
Physician Services	$10	$10	$15
Hearing Aids	$1,000 max/36 months	$1,000 max/36 months	$500 max/member
Vision Care			
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
More Benefits Beyond Medicare (Services covered beyond Medicare coverage)			
Acupuncture	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	N/A
Chiropractic	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (up to 20 visits per calendar year)

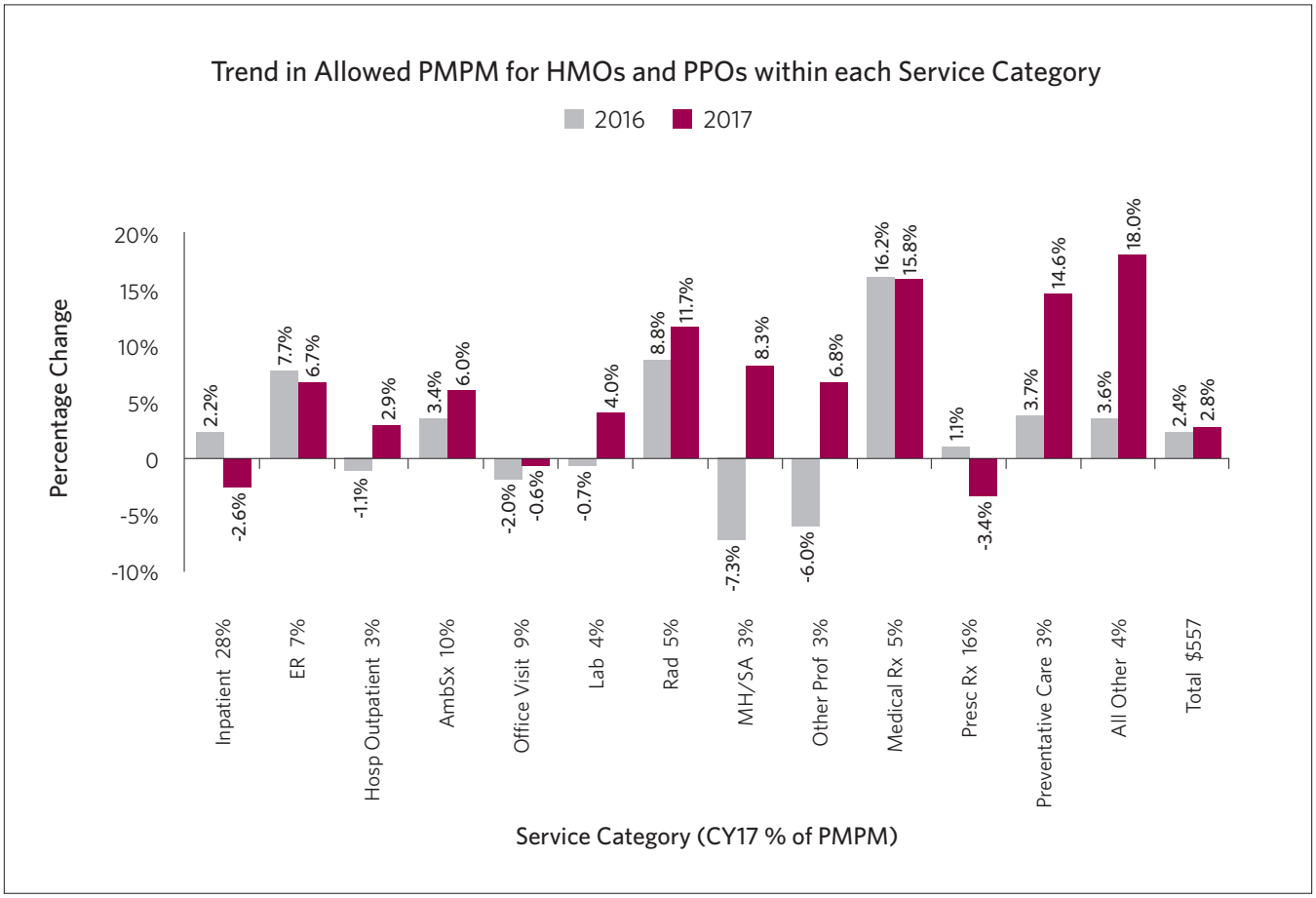
Benefits	Medicare Plans							
	PERS Select		PERS Choice		PERSCare		CAHP Medicare Supplement (Association Plan)	PORAC (Association Plan)
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO		
Diabetes Services								
Glucose monitors, test strips	No Charge		No Charge		No Charge		No Charge	No Charge
Self-management training	No Charge		No Charge		No Charge		No Charge	No Charge
Hearing Services								
Routine Hearing Exam	No Charge		No Charge		No Charge		No Charge	20%
Physician Services	No Charge		No Charge		No Charge		No Charge	20%
Hearing Aids	20% ($1,000 max/ 36 months)		20% ($1,000 max/ 36 months)		20% ($2,000 max/ 24 months)		20% ($1,000 max/ 36 months)	20% ($900 max/ 36 months)
Vision Care								
Vision Exam	N/A		N/A		N/A		N/A	20%
Eyeglasses (following cataract surgery)	No Charge		No Charge		No Charge		No Charge	20%
Contact Lenses (following cataract surgery)	No Charge		No Charge		No Charge		No Charge	20%
More Benefits Beyond Medicare (Services covered beyond Medicare coverage)								
Acupuncture	$15/visit (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)		20%	20%
Chiropractic	$15/visit (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)		20%	20%

Appendix C – Medical Trends

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

The trend in allowed PMPM[1] cost[2] is examined across 13 service categories, revealing the key drivers of medical trend changes for the last two years.

The chart below shows the three major drivers that account for 54 percent of the total allowed PMPM are inpatient (28 percent), prescription drugs (Presc Rx) (16 percent), and ambulatory surgery (AmbSx) (10 percent). For individual categories, the largest change was in Medical Rx for a total percent differential of 15.8 percent.



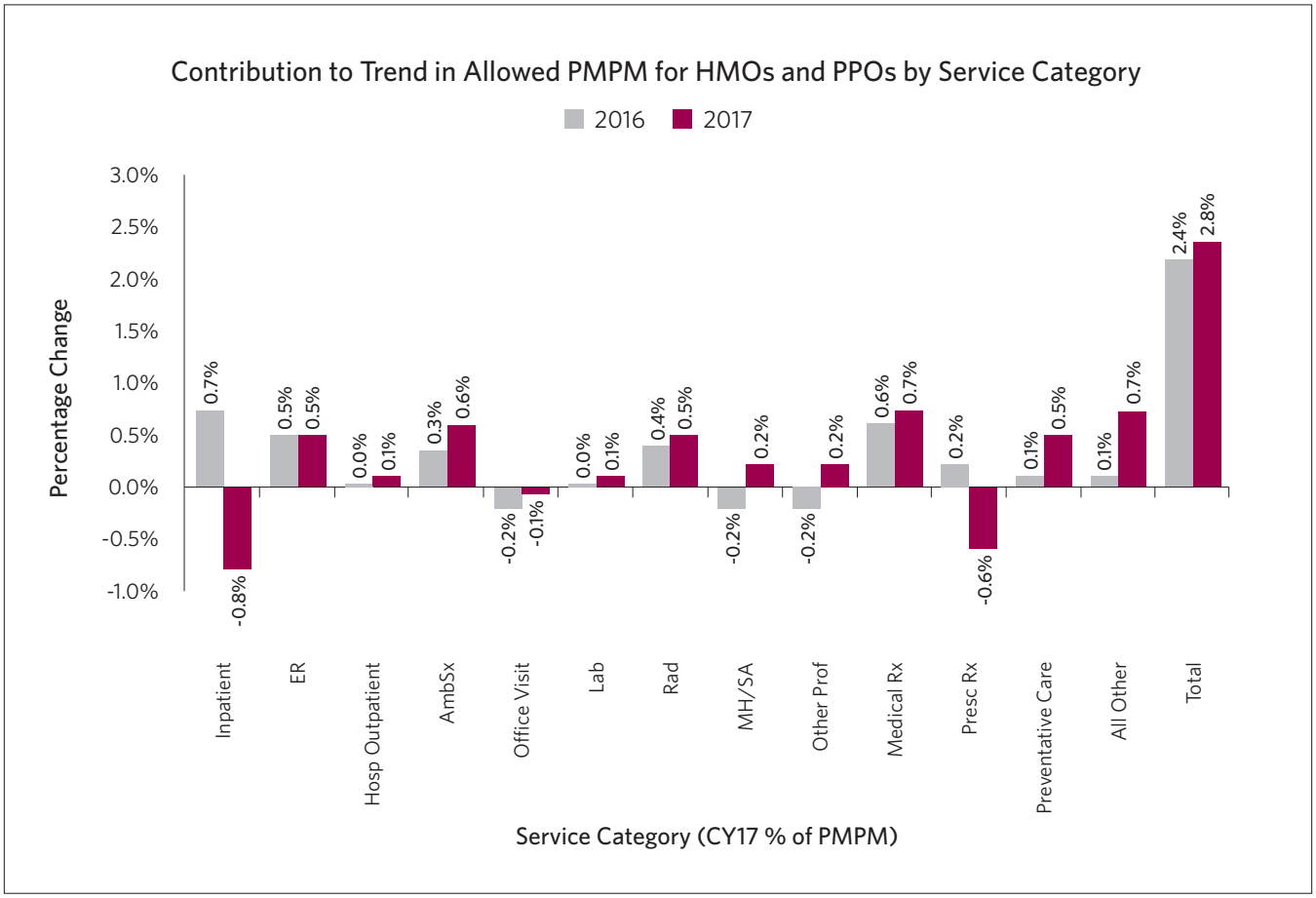
[1] Allowed cost divided by sum of member months in period, adjusted for population size.

[2] Contractual "allowed amounts" due to providers inclusive of member out-of-pocket obligations such as co-insurance, co-pays, 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).

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

In calendar year 2017, the total allowed PMPM increased 2.8 percent across all service categories compared to 2.4 percent in 2016.

The chart below shows the major drivers that contributed to trend in allowed PMPM for calendar year 2017. Inpatient accounted for -0.8 percent, prescription drug (Presc Rx) was -0.6 percent, and ambulatory surgery (AmbSx) was 0.6 percent.

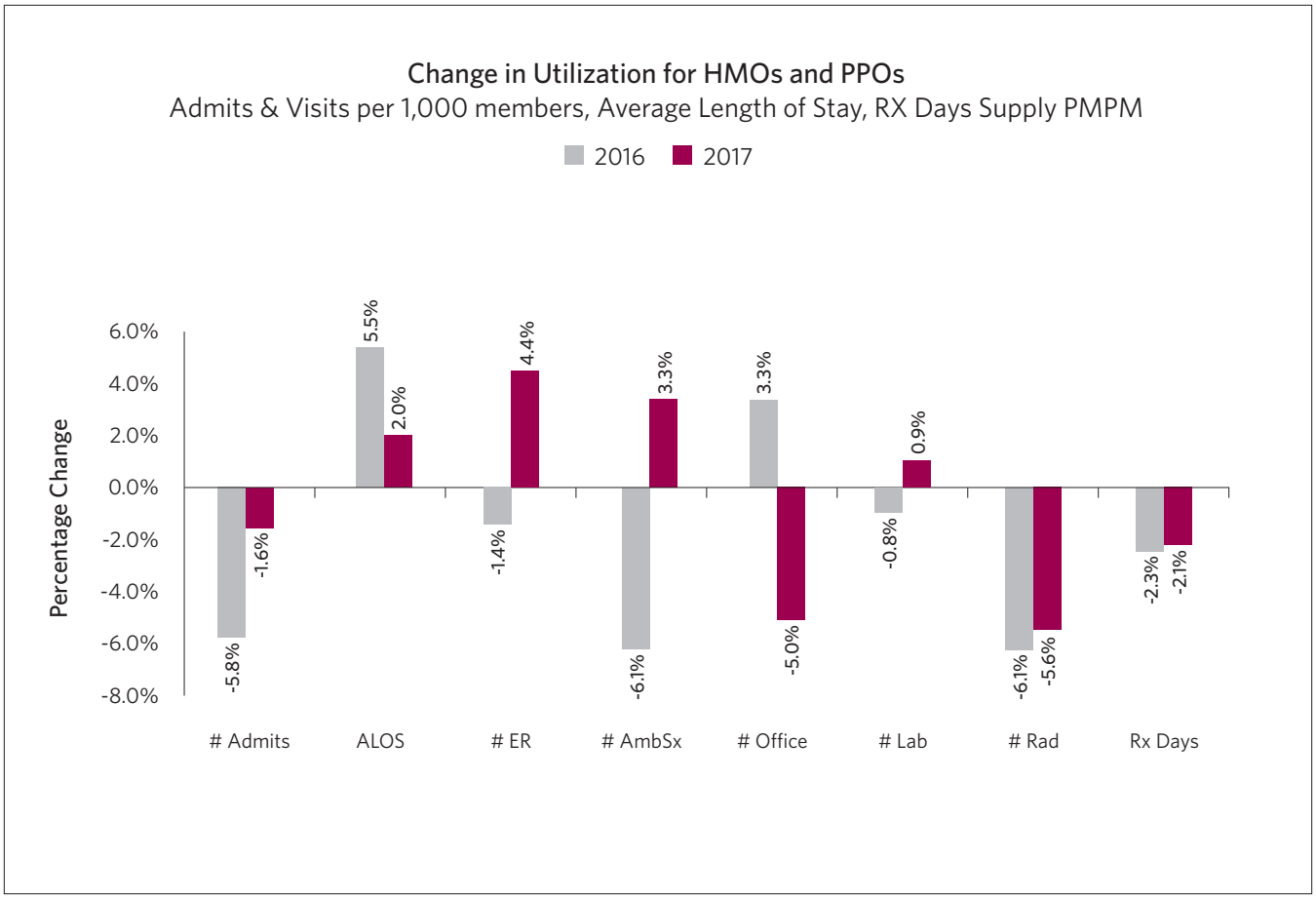


Appendix C – Medical Trends, cont.

Change in Utilization by Key Service Categories

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

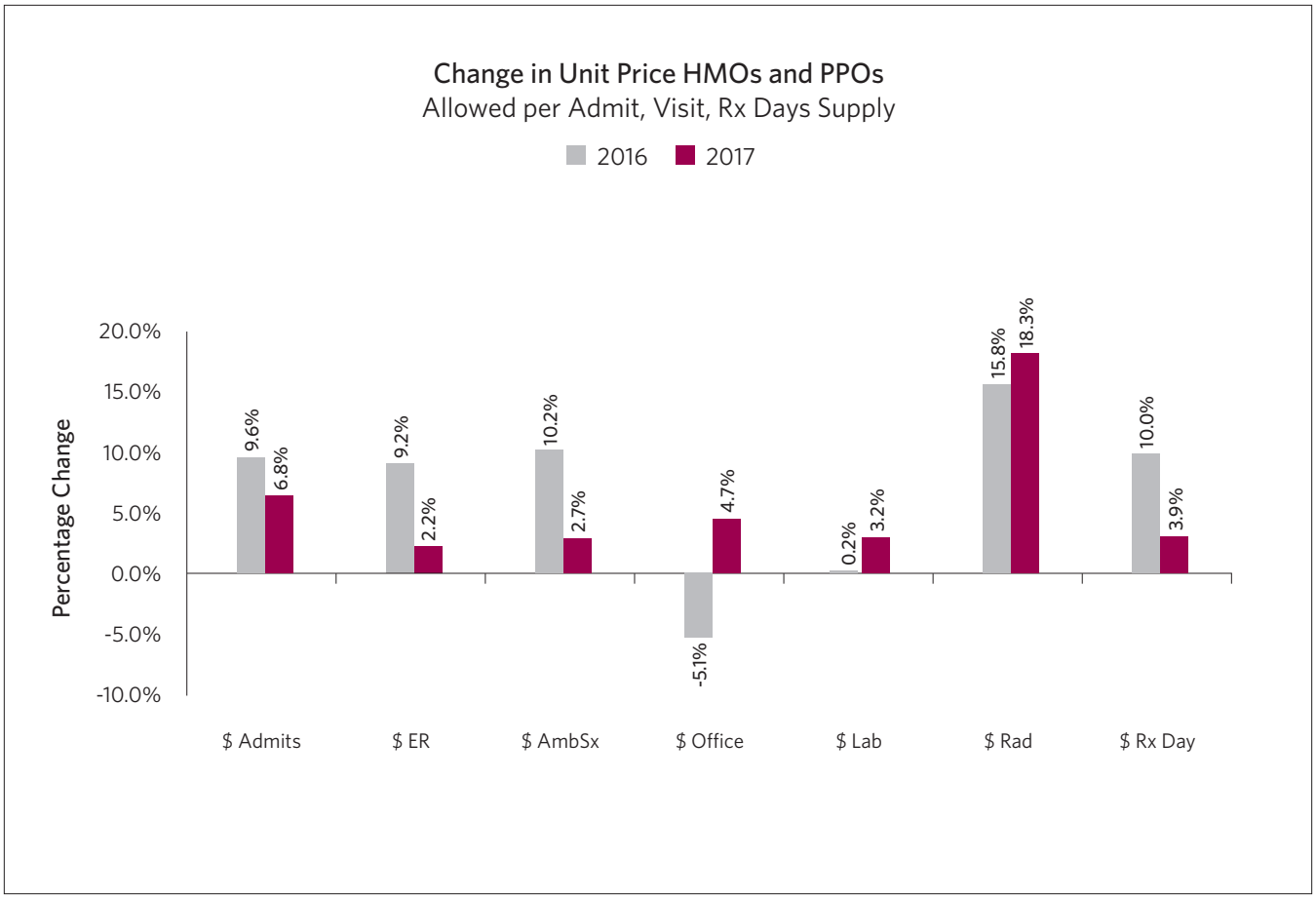
- Increases in utilization occurred in number of emergency room visits (# ER) by 4.4 percent, number of ambulatory surgery (# AmbSx) by 3.3 percent, average length of stay (ALOS) by 2.0 percent, and number of laboratory services (# Lab) by 0.9 percent.
- Decreases in utilization occurred in number of radiology services (# Rad) by 5.6 percent, number of office visits (# Office) by 5.0 percent, number of prescription drug days (Rx Days) by 2.1 percent, and number of admits (# Admits) by 1.6 percent.



Change in Unit Price by Key Service Categories

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

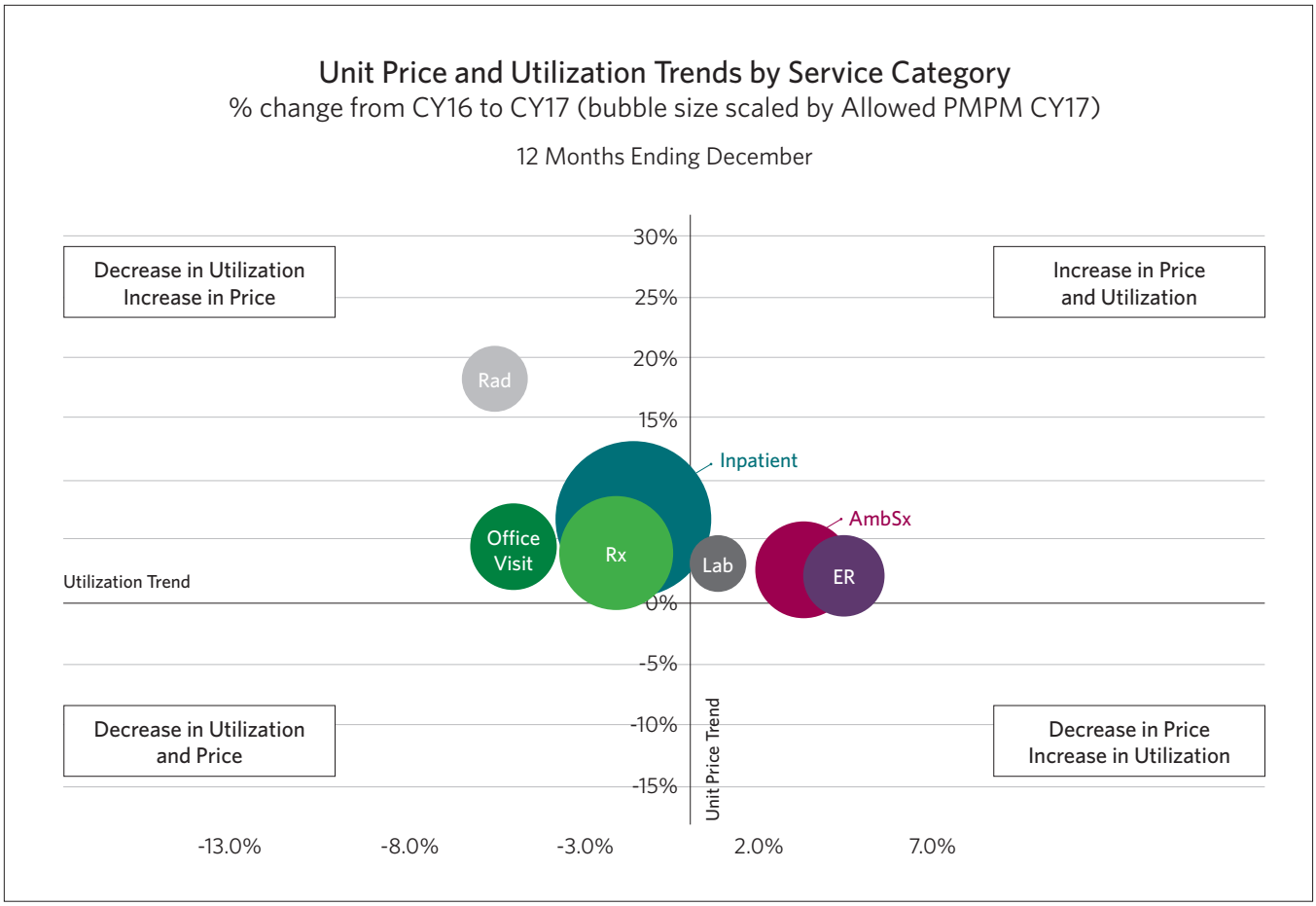
- Change in unit price increased across all service categories for calendar year 2017. Emergency room visits ($ ER) experienced the smallest increase of 2.2 percent, while radiology services ($ Rad) experienced the largest increase of 18.3 percent.



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.

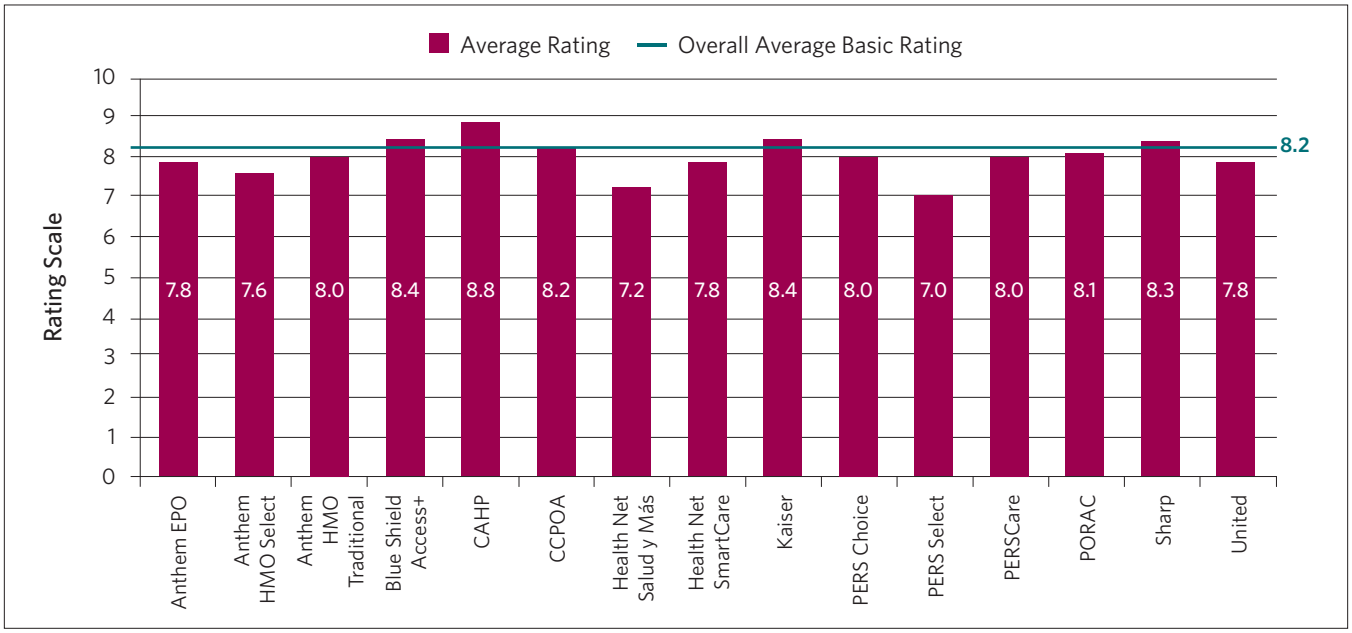
The 2018 CalPERS Health Plan Member Survey that evaluated plan year 2017 experiences began on January 9, 2018, and concluded March 5, 2018. Health plans with an enrollment of at least 2,000 eligible members had 1,100 randomly selected from each plan. In total, 22,701 members from 15 Basic and six Medicare health plans received a survey and 7,654 members responded. As in previous years, the response rate for Medicare plans was higher than for Basic plans – 62 percent compared with 24 percent.

The following pages show average ratings of health plan, personal doctor, specialist, and pharmacy satisfaction for Basic and Medicare plan members, and level of accessibility in rural coverage areas for Basic PPO plan members.

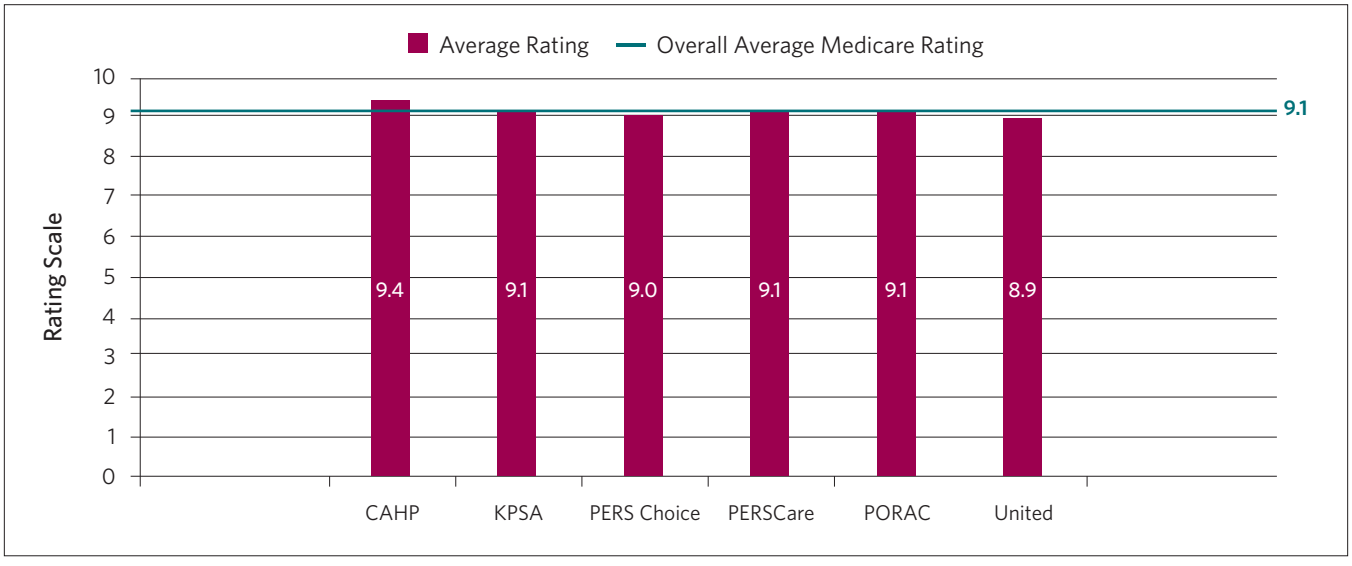
Appendix D – Member Satisfaction, cont.

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

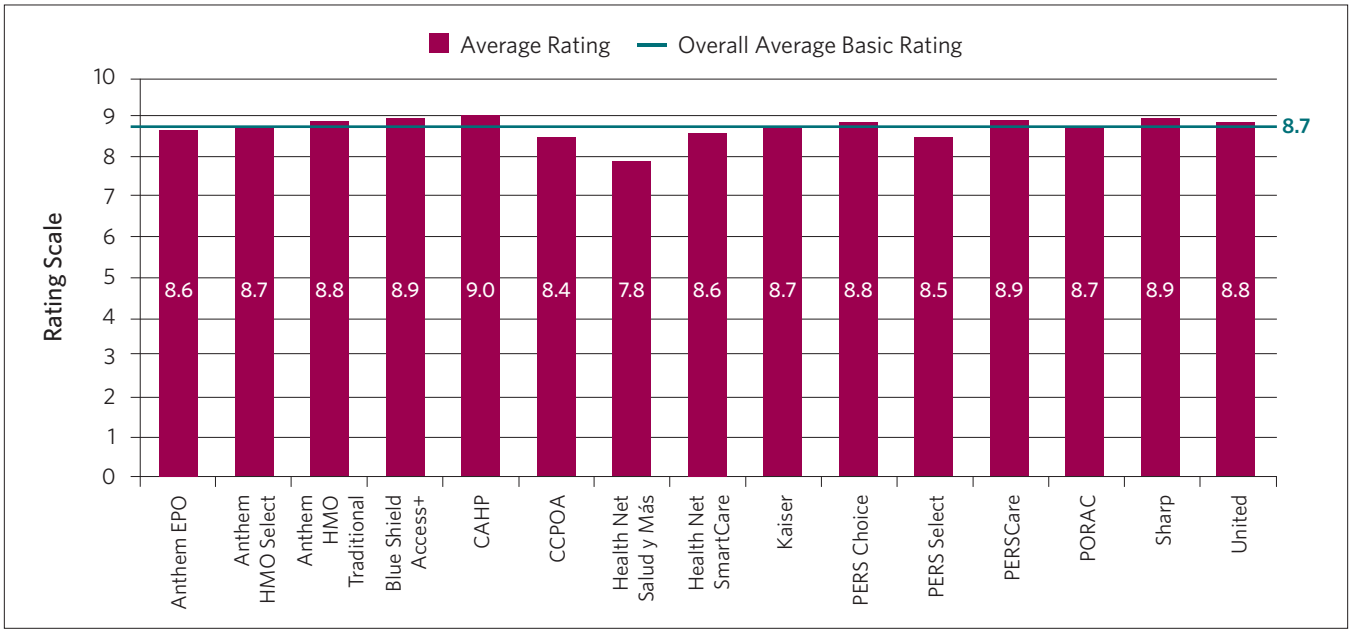


Medicare: Health Plan Satisfaction Ratings

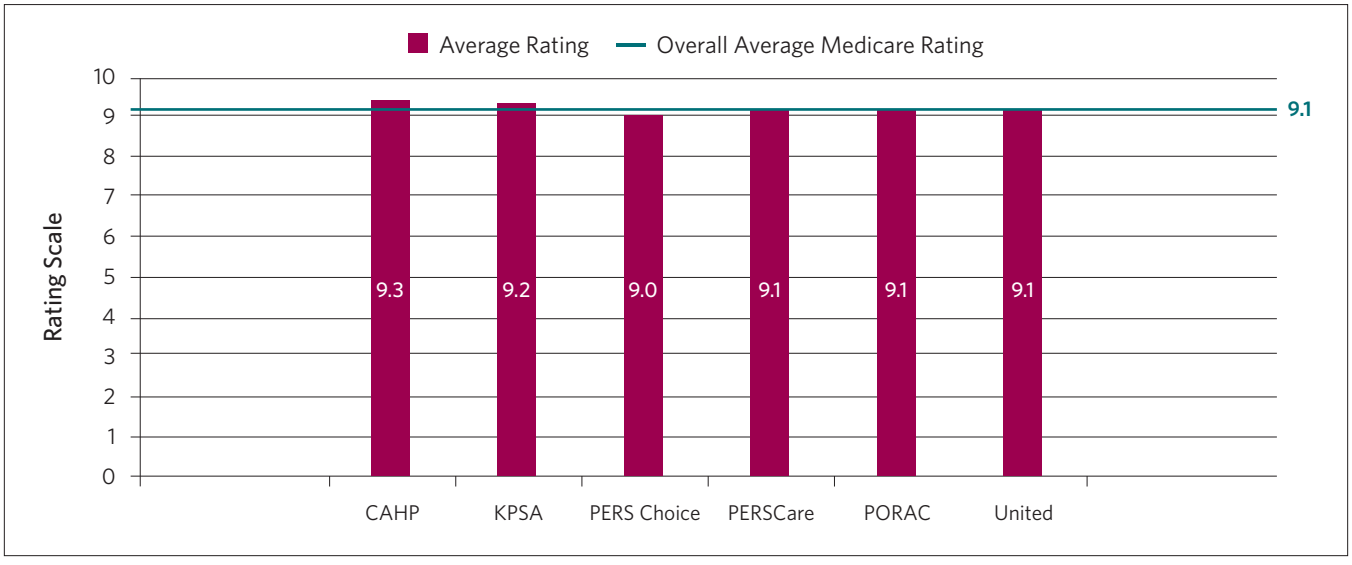


Members were asked: Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?

Basic: Personal Doctor Satisfaction Ratings



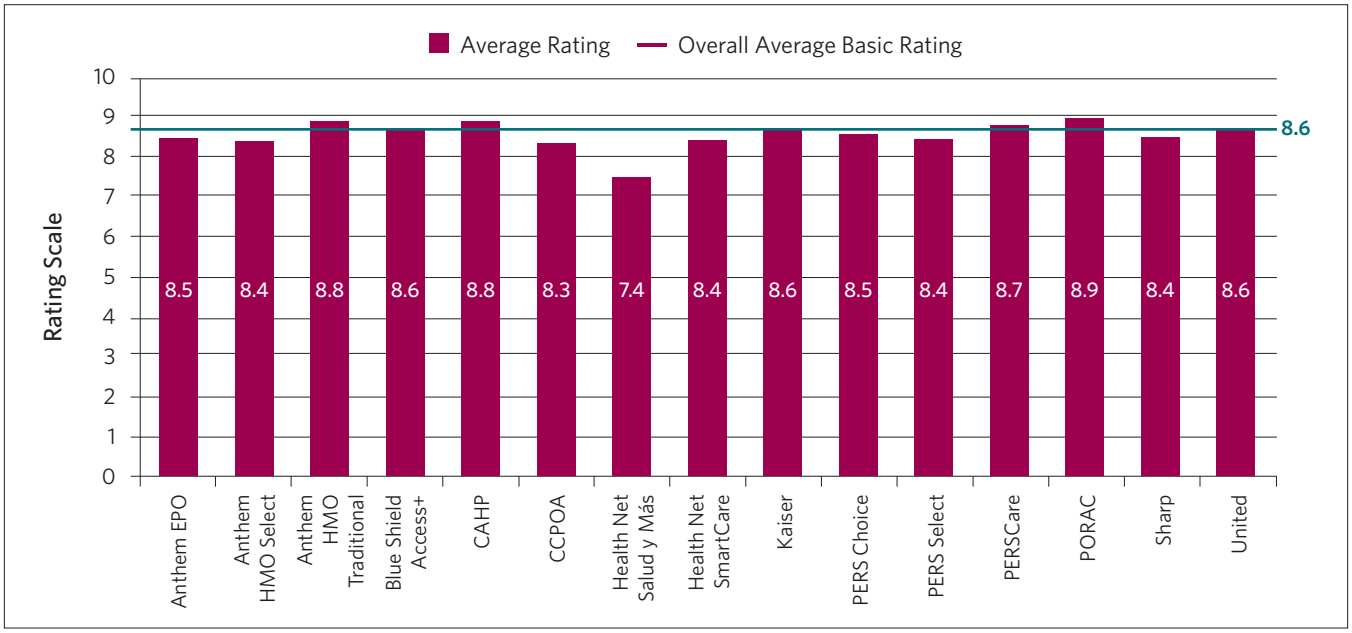
Medicare: Personal Doctor Satisfaction Ratings



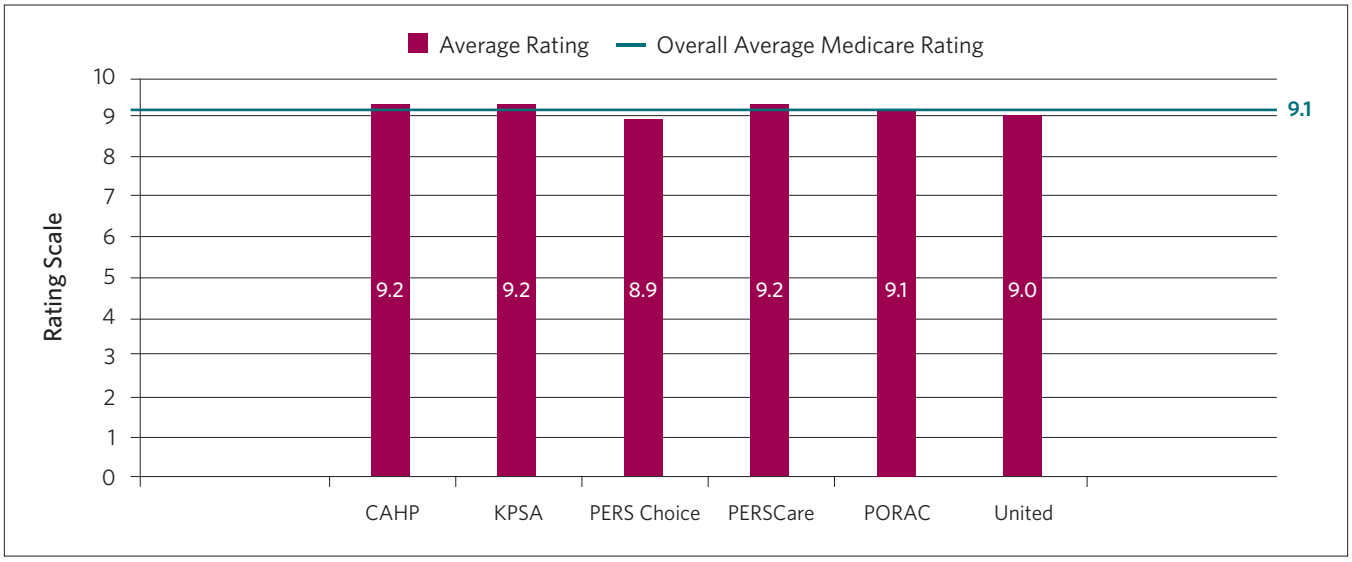
Appendix D – Member Satisfaction, cont.

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

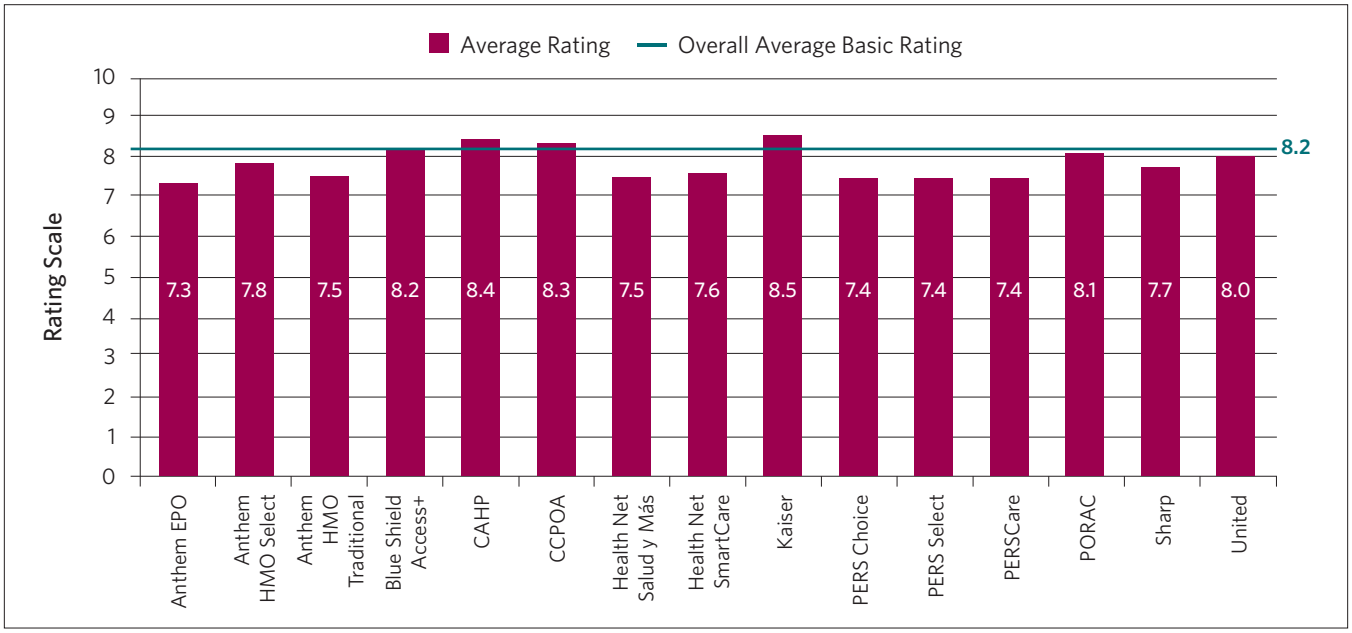


Medicare: Specialist Satisfaction Ratings

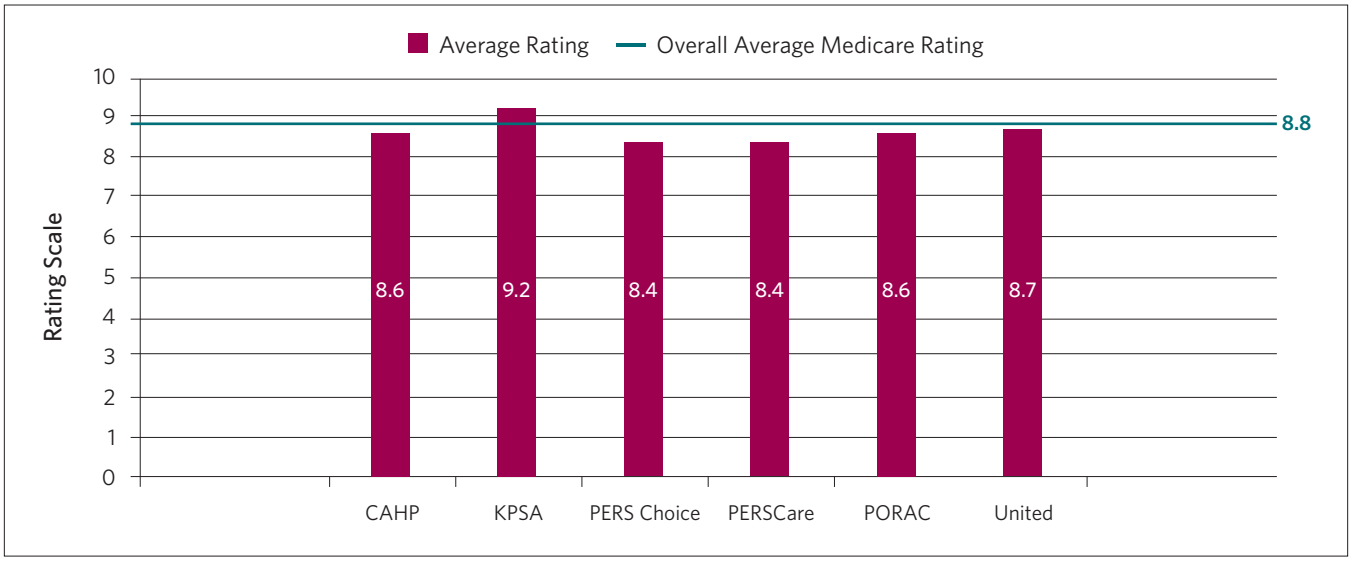


Members were asked: Using any number from 0 to 10, where 0 is the worst pharmacy services possible and 10 is the best pharmacy services possible, what number would you use to rate your overall satisfaction with your pharmacy services (i.e., your experience with obtaining prescriptions from a retail or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

Basic: Pharmacy Services Satisfaction Ratings



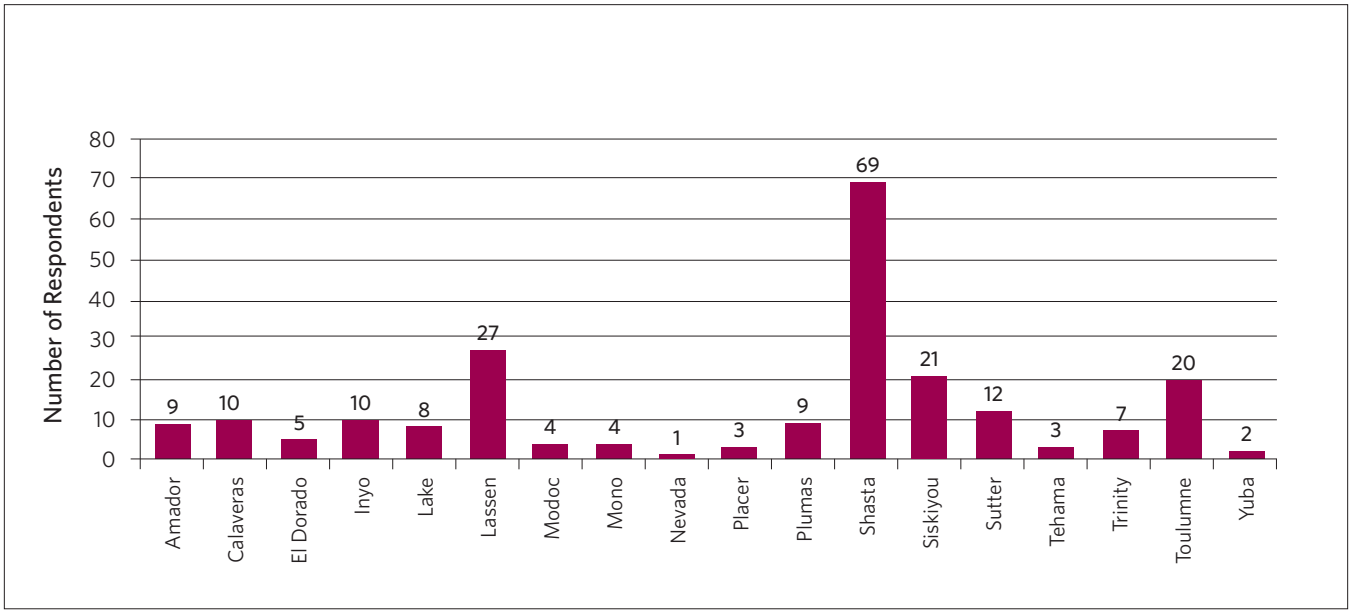
Medicare: Pharmacy Services Satisfaction Ratings



Appendix D – Member Satisfaction, cont.

Rural Area Member Demographics

The chart below shows 224 Basic plan respondents living in a rural area without access to an HMO (by county).



Emergency Room Care

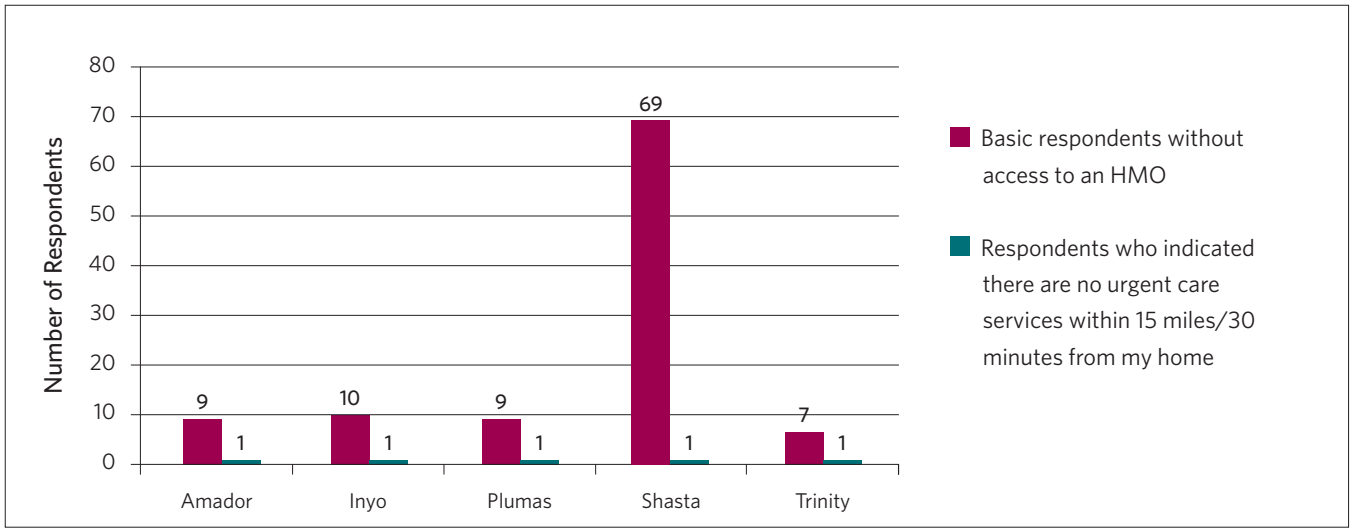
Members were asked:

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

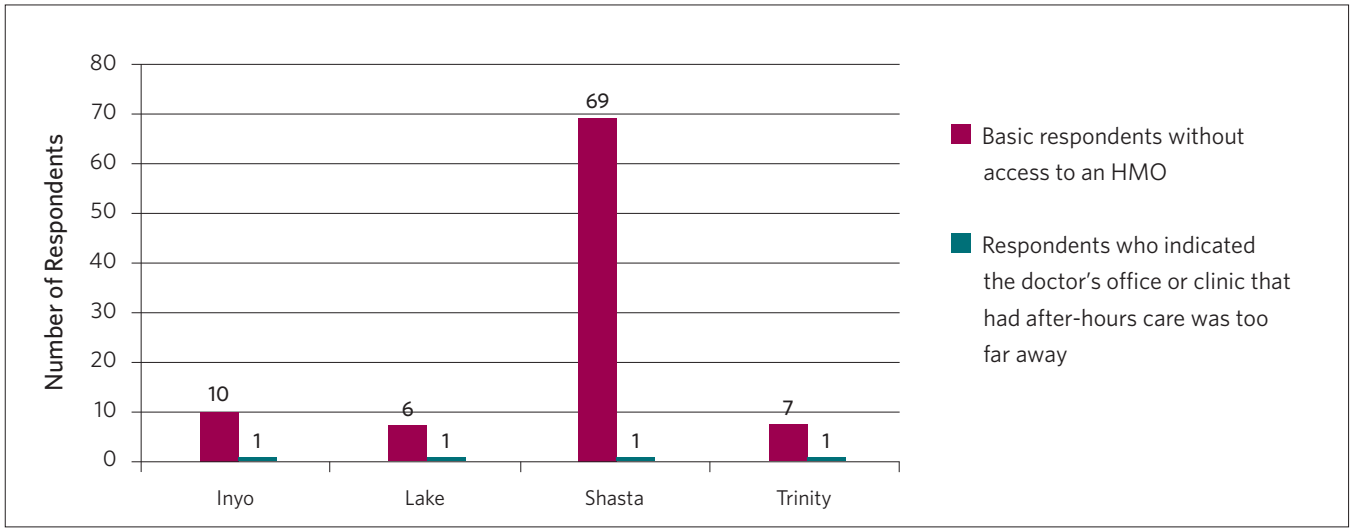
Members were asked:

Were any of the following a reason it was not easy to get the after-hours care 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.

- ● 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	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	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.

- ● 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, & PERSCare 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[1]

	2015	2016	2017
Basic HMO Plan			
Anthem HMO Select	22,401	28,707	29,278
Anthem HMO Traditional	10,825	15,824	13,576
Blue Shield Access+	166,860	150,339	163,915
Blue Shield NetValue[2]	147,275	85,910	—
Health Net Salud y Más	2,483	3,528	5,617
Health Net SmartCare	747	13,356	36,517
Kaiser	445,527	472,677	502,757
Kaiser Out-of-State	565	578	573
Sharp	7,733	9,555	10,313
UnitedHealthcare	19,238	51,842	73,258
Basic PPO Plan			
Anthem EPO Del Norte	—	88	107
Anthem EPO Monterey	1,418	2,592	3,760
PERS Choice	177,001	168,492	159,314
PERS Select	36,699	40,934	46,092
PERSCare	24,314	28,161	30,926
Basic ASN Plan			
CAHP	28,247	27,972	28,604
CCPOA North	9,341	9,918	10,705
CCPOA South	28,575	29,854	31,373
PORAC	25,884	25,191	24,889
Basic Total	**1,155,133**	**1,165,518**	**1,171,574**
Medicare HMO Plan			
Anthem HMO Select	44	—	—
Anthem HMO Traditional	167	—	—
Blue Shield Access+	31,430	—	—
Blue Shield NetValue	7,139	—	—
Health Net Salud y Más	33	—	—
Health Net SmartCare	17	—	—
Kaiser	81,991	86,665	90,805
Kaiser Out-of-State	1,710	1,812	1,878
Sharp	87	—	—
UnitedHealthcare	446	36,419	38,232

	2015	2016	2017
Medicare PPO Plan			
PERS Choice	60,425	64,959	67,258
PERS Select	1,275	1,601	1,792
PERSCare	51,587	56,441	58,361
Medicare ASN Plan			
CAHP	4,142	4,204	4,286
CCPOA North	327	379	447
CCPOA South	399	469	567
PORAC	1,801	1,981	2,160
Medicare Total	243,020	254,930	265,786
Grand Total	1,398,153	1,420,448	1,437,360
Program			
State	824,168	835,014	846,175
Contracting Agency	573,985	585,434	591,185
Total	1,398,153	1,420,448	1,437,360
Employment Status			
Active	967,650	979,210	986,223
Retired	430,503	441,238	451,137
Total	1,398,153	1,420,448	1,437,360
Subscriber and Dependent Tier			
Single	293,872	303,179	312,386
2-Party	378,685	386,163	392,805
Family	725,596	731,106	732,169
Total	1,398,153	1,420,448	1,437,360

[1] This table represents "points-in-time" data which is the best description of enrollment on a typical day.

[2] Effective January 1, 2017, CalPERS no longer offered the Blue Shield NetValue health plan. *CalPERS Pension and Health Benefits Committee Agenda Item 5, June 14, 2016.* https://www.calpers.ca.gov/docs/board-agendas/201606/pension/item-5-rev-w1.pdf

Appendix G – Historic Expenditures

Historic Expenditures

Estimated Expenditures (dollars in thousands)

	2015	2016	2017
Basic HMO Plan			
Anthem HMO Select	$138,374	$187,203	$198,485
Anthem HMO Traditional	83,444	124,164	116,810
Blue Shield Access+	1,084,123	1,038,475	1,282,944
Blue Shield NetValue	861,504	576,156	—
Health Net Salud y Más	12,237	17,390	23,380
Health Net SmartCare	4,898	84,865	223,271
Kaiser	2,713,433	3,007,829	3,180,572
Kaiser Out-of-State	5,660	5,808	5,919
Sharp	42,897	51,472	58,848
UnitedHealthcare	110,717	297,670	440,616
Basic PPO Plan			
Anthem EPO Del Norte	192	492	611
Anthem EPO Monterey	9,931	20,116	27,852
PERS Choice	1,096,068	1,164,269	1,159,173
PERS Select	214,666	261,112	291,357
PERSCare	187,624	231,797	261,089
Basic ASN Plan			
CAHP	138,874	138,922	140,966
CCPOA North	54,587	58,268	63,709
CCPOA South	134,804	141,945	150,087
PORAC	143,156	152,540	158,212
Basic Total	**$7,037,189**	**$7,560,493**	**$7,783,901**
Medicare HMO Plan			
Anthem HMO Select	$326	—	—
Anthem HMO Traditional	1,008	—	—
Blue Shield Access+	136,379	—	—
Blue Shield NetValue	32,823	—	—
Health Net Salud y Más	123	—	—
Health Net SmartCare	64	—	—
Kaiser	297,402	315,764	327,399
Kaiser Out-of-State	8,192	6,533	6,772
Sharp	417	—	—
UnitedHealthcare	1,677	144,187	148,711

	2015	2016	2017
Medicare PPO Plan			
PERS Choice	252,652	292,047	285,384
PERS Select	5,572	7,496	7,604
PERSCare	228,699	278,656	272,947
Medicare ASN Plan			
CAHP	17,633	17,904	18,109
CCPOA North	1,874	2,188	2,289
CCPOA South	2,302	2,708	2,903
PORAC	9,147	11,014	11,994
Medicare Total	$996,290	$1,078,497	$1,084,112
Grand Total	$8,033,479	$8,638,990	$8,868,013
Program			
State	$4,679,368	$4,999,974	$5,127,141
Contracting Agency	3,354,111	3,639,016	3,740,872
Total	$8,033,479	$8,638,990	$8,868,013
Employment Status			
Active	$5,735,181	$6,176,536	$6,375,273
Retired	2,298,298	2,462,454	2,492,740
Total	$8,033,479	$8,638,990	$8,868,013
Subscriber and Dependent Tier			
Single	$1,932,700	$2,105,208	$2,165,345
2-Party	2,456,350	2,636,508	2,708,354
Family	3,644,429	3,897,274	3,994,314
Total	$8,033,479	$8,638,990	$8,868,013

Appendix H – Premium Increases or Decreases from Prior Plan Year

2016 and 2017 State Basic Premiums (HMO, PPO, and ASN)

Basic		2016			2017			Percent Change (+/-)
		Single	2-Party	Family	Single	2-Party	Family	
HMO	Anthem HMO Select	$695.77	$1,391.54	$1,809.00	$740.23	$1,480.46	$1,924.60	6.39%
	Anthem HMO Traditional	752.48	1,504.96	1,956.45	872.91	1,745.82	2,269.57	16.00%
	Blue Shield Access+	767.45	1,534.90	1,995.37	830.44	1,660.88	2,159.14	8.21%
	Blue Shield NetValue	761.20	1,522.40	1,979.12	-	-	-	-
	Health Net Salud y Más	552.39	1,104.78	1,436.21	475.46	950.92	1,236.20	-13.93%
	Health Net SmartCare	651.23	1,302.46	1,693.20	692.89	1,385.78	1,801.51	6.40%
	Kaiser CA	661.76	1,323.52	1,720.58	662.92	1,325.84	1,723.59	0.18%
	Kaiser Out-of-State	930.29	1,860.58	2,418.75	940.67	1,881.34	2,445.74	1.12%
	Sharp	574.73	1,149.46	1,494.30	616.49	1,232.98	1,602.87	7.27%
	UnitedHealthcare	625.78	1,251.56	1,627.03	686.17	1,372.34	1,784.04	9.65%
PPO	Anthem EPO Del Norte	715.70	1,431.40	1,860.82	740.88	1,481.76	1,926.29	3.52%
	Anthem EPO Monterey	715.70	1,431.40	1,860.82	740.88	1,481.76	1,926.29	3.52%
	PERS Choice	715.70	1,431.40	1,860.82	740.88	1,481.76	1,926.29	3.52%
	PERS Select	649.76	1,299.52	1,689.38	673.25	1,346.50	1,750.45	3.62%
	PERSCare	801.58	1,603.16	2,084.11	826.37	1,652.74	2,148.56	3.09%
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	691.50	1,385.69	1,870.73	1.50%
	CCPOA South	561.88	1,126.30	1,521.82	570.26	1,143.15	1,544.60	1.50%
	PORAC	699.00	1,399.00	1,789.00	699.00	1,467.00	1,876.00	4.25%

2016 and 2017 State Medicare Premiums (HMO, PPO, and ASN)

Medicare		2016			2017			Percent Change (+/-)
		Single	2-Party	Family	Single	2-Party	Family	
HMO	Kaiser CA	$297.23	$594.46	$891.69	$300.48	$600.96	$901.44	1.09%
	Kaiser Out-of-State	297.23	594.46	891.69	300.48	600.96	901.44	1.09%
	UnitedHealthcare	320.98	641.96	962.94	324.21	648.42	972.63	1.01%
PPO	PERS Choice	366.38	732.76	1,099.14	353.63	707.26	1,060.89	-3.48%
	PERS Select	366.38	732.76	1,099.14	353.63	707.26	1,060.89	-3.48%
	PERSCare	408.04	816.08	1,224.12	389.76	779.52	1,169.28	-4.48%
ASN	CAHP	372.00	688.00	874.00	372.00	688.00	874.00	0.00%
	CCPOA	435.34	872.56	1,304.91	426.09	853.95	1,277.05	-2.13%
	PORAC	442.00	881.00	1,408.00	464.00	924.00	1,477.00	4.92%

Total Percent Change for Basic and Medicare Combined

Total PPO Change from 2016 to 2017	1.81%
Total HMO Change from 2016 to 2017	3.90%
Total ASN Change from 2016 to 2017	1.93%
Total Change	**3.24%**

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

2016 and 2017 Regional Contracting Agencies Premiums Basic (HMO, PPO, and ASN)

Basic		2016			2017			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 HMO Select	$721.79	$1,443.58	$1,876.65	$783.46	$1,566.92	$2,037.00	8.54%
HMO	Anthem HMO Traditional	855.42	1,710.84	2,224.09	990.05	1,980.10	2,574.13	15.74%
HMO	Blue Shield Access+	1,016.18	2,032.36	2,642.07	1,024.85	2,049.70	2,664.61	0.85%
HMO	Blue Shield NetValue	1,033.86	2,067.72	2,688.04	—	—	—	—
HMO	Health Net SmartCare	808.44	1,616.88	2,101.94	733.29	1,466.58	1,906.55	-9.30%
HMO	Kaiser CA	746.47	1,492.94	1,940.82	733.39	1,466.78	1,906.81	-1.75%
HMO	UnitedHealthcare	955.44	1,910.88	2,484.14	1,062.26	2,124.52	2,761.88	11.18%
PPO	PERS Choice	798.36	1,596.72	2,075.74	830.30	1,660.60	2,158.78	4.00%
PPO	PERS Select	730.07	1,460.14	1,898.18	736.27	1,472.54	1,914.30	0.85%
PPO	PERSCare	889.27	1,778.54	2,312.10	932.39	1,864.78	2,424.21	4.85%
ASN	PORAC	699.00	1,399.00	1,789.00	699.00	1,467.00	1,876.00	4.25%
Basic Premium Rates - Sacramento Area — El Dorado, Placer, Sacramento, and Yolo								
HMO	Anthem HMO Select	$902.07	$1,804.14	$2,345.38	$907.08	$1,814.16	$2,358.41	0.56%
HMO	Anthem HMO Traditional	1,112.54	2,225.08	2,892.60	1,286.41	2,572.82	3,344.67	15.63%
HMO	Blue Shield Access+	885.33	1,770.66	2,301.86	859.42	1,718.84	2,234.49	-2.93%
HMO	Blue Shield NetValue	900.73	1,801.46	2,341.90	—	—	—	—
HMO	Health Net SmartCare	747.55	1,495.10	1,943.63	672.66	1,345.32	1,748.92	-10.02%
HMO	Kaiser CA	695.11	1,390.22	1,807.29	690.56	1,381.12	1,795.46	-0.65%
HMO	UnitedHealthcare	686.36	1,372.72	1,784.54	756.78	1,513.56	1,967.63	10.26%
PPO	PERS Choice	727.58	1,455.16	1,891.71	723.47	1,446.94	1,881.02	-0.56%
PPO	PERS Select	665.35	1,330.70	1,729.91	641.47	1,282.94	1,667.82	-3.59%
PPO	PERSCare	810.40	1,620.80	2,107.04	812.40	1,624.80	2,112.24	0.25%
ASN	PORAC	699.00	1,399.00	1,789.00	699.00	1,467.00	1,876.00	4.25%

Basic		2016			2017			Percent Change (+/-)
		Single	2-Party	Family	Single	2-Party	Family	
Basic Premium Rates - Los Angeles Area — Los Angeles, San Bernardino, and Ventura								
HMO	Anthem HMO Select	$543.47	$1,086.94	$1,413.02	$592.78	$1,185.56	$1,541.23	9.07%
	Anthem HMO Traditional	610.64	1,221.28	1,587.66	713.69	1,427.38	1,855.59	16.88%
	Blue Shield Access+	566.53	1,133.06	1,472.98	675.98	1,351.96	1,757.55	19.32%
	Blue Shield NetValue	576.46	1,152.92	1,498.80	-	-	-	-
	Health Net Salud y Más	466.11	932.22	1,211.89	414.79	829.58	1,078.45	-11.01%
	Health Net SmartCare	585.39	1,170.78	1,522.01	526.73	1,053.46	1,369.50	-10.02%
	Kaiser CA	543.83	1,087.66	1,413.96	573.89	1,147.78	1,492.11	5.53%
	UnitedHealthcare	492.24	984.48	1,279.82	545.71	1,091.42	1,418.85	10.86%
PPO	PERS Choice	598.75	1,197.50	1,556.75	637.53	1,275.06	1,657.58	6.48%
	PERS Select	547.55	1,095.10	1,423.63	565.33	1,130.66	1,469.86	3.25%
	PERSCare	666.91	1,333.82	1,733.97	715.88	1,431.76	1,861.29	7.34%
ASN	PORAC	699.00	1,399.00	1,789.00	699.00	1,467.00	1,876.00	4.25%
Basic Premium Rates - Other Southern California — Fresno, Imperial, Inyo, Kern, Kings, Madera, Orange, Riverside, San Diego, San Luis Obispo, Santa Barbara, and Tulare								
HMO	Anthem HMO Select	$634.75	$1,269.50	$1,650.35	$659.03	$1,318.06	$1,713.48	3.83%
	Anthem HMO Traditional	710.79	1,421.58	1,848.05	799.15	1,598.30	2,077.79	12.43%
	Blue Shield Access+	654.87	1,309.74	1,702.66	778.45	1,556.90	2,023.97	18.87%
	Blue Shield NetValue	666.35	1,332.70	1,732.51	-	-	-	-
	Health Net Salud y Más	535.98	1,071.96	1,393.55	473.46	946.92	1,231.00	-11.66%
	Health Net SmartCare	596.98	1,193.96	1,552.15	537.20	1,074.40	1,396.72	-10.01%
	Kaiser CA	605.05	1,210.10	1,573.13	599.54	1,199.08	1,558.80	-0.91%
	Sharp	561.34	1,122.68	1,459.48	614.46	1,228.92	1,597.60	9.46%
	UnitedHealthcare	493.99	987.98	1,284.37	549.76	1,099.52	1,429.38	11.29%
PPO	PERS Choice	683.71	1,367.42	1,777.65	714.43	1,428.86	1,857.52	4.49%
	PERS Select	625.20	1,250.40	1,625.52	633.46	1,266.92	1,647.00	1.32%
	PERSCare	761.50	1,523.00	1,979.90	802.24	1,604.48	2,085.82	5.35%
ASN	PORAC	699.00	1,399.00	1,789.00	699.00	1,467.00	1,876.00	4.25%

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

2016 and 2017 Regional Contracting Agencies Premiums Basic (HMO, PPO, and ASN), cont.

Basic		2016			2017			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 HMO Select	$839.10	$1,678.20	$2,181.66	$892.13	$1,784.26	$2,319.54	6.32%
	Anthem HMO Traditional	964.91	1,929.82	2,508.77	1,169.87	2,339.74	3,041.66	21.24%
	Blue Shield Access+	879.96	1,759.92	2,287.90	954.51	1,909.02	2,481.73	8.47%
	Blue Shield NetValue	895.17	1,790.34	2,327.44	-	-	-	-
	Kaiser CA	755.27	1,510.54	1,963.70	733.99	1,467.98	1,908.37	-2.82%
	UnitedHealthcare	794.80	1,589.60	2,066.48	882.35	1,764.70	2,294.11	11.02%
	Anthem EPO Del Norte	795.57	1,591.14	2,068.48	820.38	1,640.76	2,132.99	3.12%
	Anthem EPO Monterey	795.57	1,591.14	2,068.48	820.38	1,640.76	2,132.99	3.12%
PPO	PERS Choice	795.57	1,591.14	2,068.48	820.38	1,640.76	2,132.99	3.12%
	PERS Select	727.47	1,454.94	1,891.42	727.45	1,454.90	1,891.37	0.00%
	PERSCare	886.15	1,772.30	2,303.99	921.24	1,842.48	2,395.22	3.96%
ASN	PORAC	699.00	1,399.00	1,789.00	699.00	1,467.00	1,876.00	4.25%
Basic Premium Rates – Out-of-State								
HMO	Kaiser Out-of-State	$930.29	$1,860.58	$2,418.75	$940.67	$1,881.34	$2,445.74	1.12%
PPO	PERS Choice	625.31	1,250.62	1,625.81	675.61	1,351.22	1,756.59	8.04%
	PERSCare	696.49	1,392.98	1,810.87	758.69	1,517.38	1,972.59	8.93%
ASN	PORAC	699.00	1,399.00	1,789.00	699.00	1,467.00	1,876.00	4.25%

2016 and 2017 Regional Contracting Agency Premiums Medicare (HMO, PPO, and ASN)

Medicare		2016			2017			Percent Change (+/-)
		Single	2-Party	Family	Single	2-Party	Family	
HMO	Kaiser CA	$297.23	$594.46	$891.69	$300.48	$600.96	$901.44	1.09%
	Kaiser Out-of-State	297.23	594.46	891.69	300.48	600.96	901.44	1.09%
	UnitedHealthcare	320.98	641.96	962.94	324.21	648.42	972.63	1.01%
PPO	PERS Choice	366.38	732.76	1,099.14	353.63	707.26	1,060.89	-3.48%
	PERS Select	366.38	732.76	1,099.14	353.63	707.26	1,060.89	-3.48%
	PERSCare	408.04	816.08	1,224.12	389.76	779.52	1,169.28	-4.48%
ASN	PORAC	442.00	881.00	1,408.00	464.00	924.00	1,477.00	4.92%

Appendix I – Basic HMO Plan HEDIS-Like Measures

Measure	Anthem HMO	BSC	KP North	KP South
Prevention and Screening				
Adult BMI Assessment*	31.7%	48.0%	94.0%	98.5%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)*	7.5%	8.1%	92.3%	99.2%
Childhood Immunization Status - Combination 3*	33.9%	54.8%	89.1%	86.6%
Childhood Immunization Status - Combination 10*	23.1%	34.2%	67.3%	67.3%
Immunizations for Adolescents Meningococcal*	62.9%	77.7%	90.3%	88.7%
Immunizations for Adolescents - Tdap/Td*	79.5%	85.4%	94.0%	93.5%
Immunizations for Adolescents - Combination 1*	57.0%	70.6%	89.3%	89.3%
Breast Cancer Screening - Total	79.6%	76.5%	87.8%	87.8%
Cervical Cancer Screening*	73.2%	67.9%	90.2%	90.2%
Colorectal Cancer Screening*	49.2%	60.4%	82.0%	82.0%
Chlamydia Screening in Women - Total	51.1%	50.6%	75.3%	71.8%
Respiratory Conditions				
Appropriate Treatment for Children With Pharyngitis	77.8%	73.3%	93.3%	94.1%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	41.6%	32.6%	43.9%	78.1%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	24.0%	32.6%	43.6%	73.6%
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	63.6%	74.4%	89.6%	87.0%
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	68.2%	84.8%	92.4%	95.9%
Cardiovascular Conditions				
Persistence of Beta-Blocker Treatment after a Heart Attack	76.2%	83.9%	93.7%	93.7%
Diabetes				
Comprehensive Diabetes Care - HbA1c Testing*	89.4%	87.4%	95.6%	95.6%
Comprehensive Diabetes Care - HbA1c Control (<8%)*	56.8%	54.6%	68.8%	68.8%
Comprehensive Diabetes Care - Eye Exams*	37.3%	44.4%	74.7%	74.7%
Comprehensive Diabetes Care - Medical Attention for Nephropathy*	91.4%	90.7%	94.6%	94.6%
Musculoskeletal Conditions				
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	80.5%	85.3%	91.8%	96.4%
Overuse/Appropriateness				
Appropriate Treatment for Children With Upper Respiratory Infection	94.5%	90.0%	98.1%	99.0%
Use of Imaging Studies for Low Back Pain	81.2%	84.2%	82.4%	82.4%

Measure	Anthem HMO	BSC	KP North	KP South
Behavioral Health				
Antidepressant Medication Management - Effective Acute Phase Treatment	63.8%	61.4%	77.0%	77.0%
Antidepressant Medication Management - Effective Continuation Phase Treatment	48.4%	48.3%	53.7%	53.7%
Follow Up Care for Children Prescribed ADHD Medication - Initiation Phase	42.9%	41.0%	57.5%	51.0%
Follow Up Care for Children Prescribed ADHD Medication - Continuation & Maintenance Phase	58.3%	58.6%	60.5%	54.9%
Follow Up After Hospitalization For Mental Illness - 7 days	45.2%	54.0%	74.8%	73.0%
Follow Up After Hospitalization For Mental Illness - 30 days	65.5%	75.0%	84.6%	83.0%
Medication Management				
Annual Monitoring for Patients on Persistent Medications - ACEIs or ARBs	82.5%	84.0%	88.5%	87.3%
Annual Monitoring for Patients on Persistent Medications - Diuretics	81.4%	84.0%	86.7%	85.5%
Annual Monitoring for Patients on Persistent Medications - Total	82.2%	84.0%	87.7%	86.6%
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Initiation - Total	30.7%	39.2%	49.4%	40.3%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Engagement - Total	8.6%	10.7%	23.3%	21.6%
Prenatal and Postpartum Care - Timeliness of Prenatal Care*	51.9%	52.0%	96.9%	95.6%
Prenatal and Postpartum Care - Postpartum Care*	39.8%	38.3%	89.3%	89.5%

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

Notes:

- The measures presented are from HEDIS® 2017 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 2017, 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
Prevention and Screening			
Adult BMI Assessment*	20.7%	15.4%	12.5%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)*	8.1%	7.3%	6.2%
Childhood Immunization Status - Combination 3*	45.3%	46.0%	43.2%
Childhood Immunization Status - Combination 10*	30.7%	29.3%	23.7%
Immunizations for Adolescents - Meningococcal*	63.0%	63.3%	49.4%
Immunizations for Adolescents - Tdap/Td*	79.0%	85.2%	84.0%
Immunizations for Adolescents - Combination 1*	59.5%	61.8%	46.7%
Breast Cancer Screening	73.8%	70.7%	65.9%
Cervical Cancer Screening*	72.8%	71.5%	71.4%
Colorectal Cancer Screening*	59.4%	62.5%	54.1%
Chlamydia Screening in Women - Total	48.3%	43.7%	41.3%
Respiratory Conditions			
Appropriate Treatment for Children With Pharyngitis	74.0%	75.3%	67.8%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	36.6%	33.5%	30.5%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	44.9%	36.4%	28.7%
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	57.1%	52.2%	55.6%
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	90.5%	80.5%	72.2%
Cardiovascular Conditions			
Persistence of Beta-Blocker Treatment after a Heart Attack	78.1%	87.5%	73.3%
Diabetes			
Comprehensive Diabetes Care - HbA1c Testing*	89.3%	87.2%	85.8%
Comprehensive Diabetes Care - HbA1c Control (<8%)*	36.6%	31.5%	34.7%
Comprehensive Diabetes Care - Eye Exams*	44.6%	38.8%	38.1%
Comprehensive Diabetes Care - Medical Attention for Nephropathy*	90.3%	86.6%	85.0%
Musculoskeletal Conditions			
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	81.1%	84.9%	85.6%
Overuse/Appropriateness			
Appropriate Treatment for Children With Upper Respiratory Infection	88.5%	90.0%	88.7%
Use of Imaging Studies for Low Back Pain	81.6%	81.8%	82.2%

Measure	PERSCare	PERS Choice	PERS Select
Behavioral Health			
Antidepressant Medication Management - Effective Acute Phase Treatment	67.7%	69.2%	69.7%
Antidepressant Medication Management - Effective Continuation Phase Treatment	54.4%	54.3%	51.0%
Follow Up Care for Children Prescribed ADHD Medication - Initiation Phase	46.4%	36.2%	42.9%
Follow Up Care for Children Prescribed ADHD Medication - Continuation & Maintenance Phase	50.0%	41.8%	50.0%
Follow Up After Hospitalization For Mental Illness - 7 days	58.5%	48.4%	47.8%
Follow Up After Hospitalization For Mental Illness - 30 days	76.8%	74.4%	73.1%
Medication Management			
Annual Monitoring for Patients on Persistent Medications - ACEIs or ARBs	86.0%	82.8%	76.6%
Annual Monitoring for Patients on Persistent Medications - Diuretics	85.8%	83.3%	75.3%
Annual Monitoring for Patients on Persistent Medications - Total	86.0%	83.0%	76.2%
Access/Availability of Care			
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Initiation - Total	31.7%	30.6%	32.1%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Engagement - Total	10.9%	10.9%	11.6%
Prenatal and Postpartum Care - Timeliness of Prenatal Care*	69.5%	67.0%	65.7%
Prenatal and Postpartum Care - Postpartum Care*	32.2%	37.9%	38.2%

* "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® 2017 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.

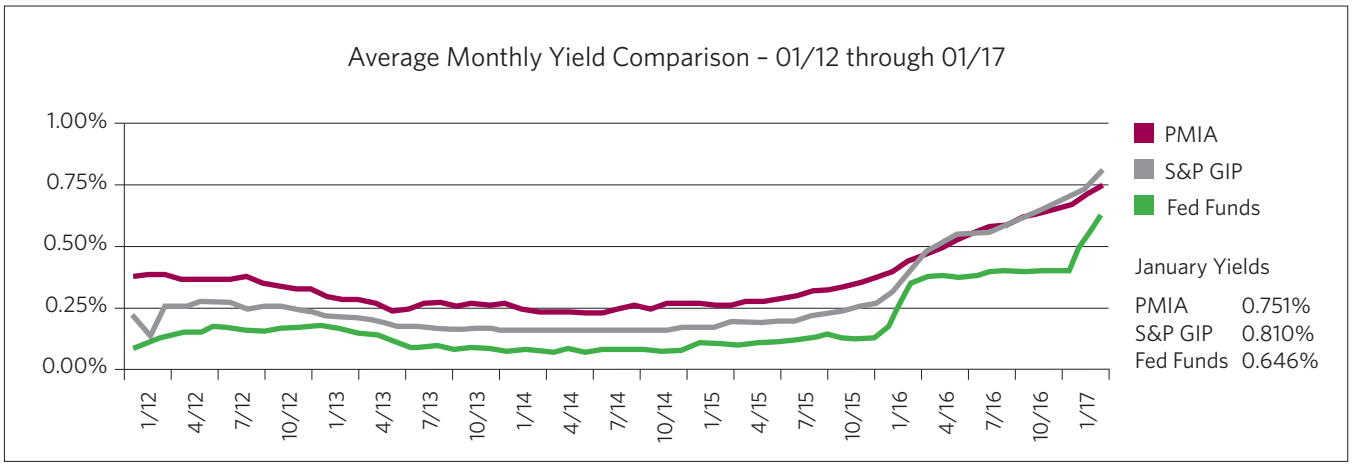
Appendix K – Surplus Money Investment Fund

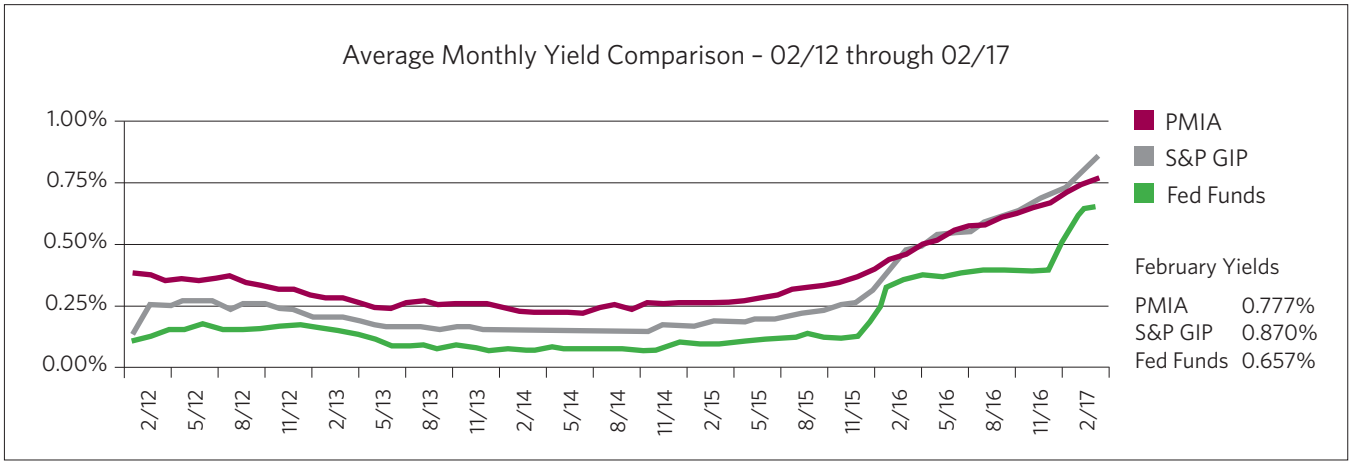
State Controller's Office
Division of Accounting and Reporting
Surplus Money Investment Fund
Apportionment Yield Rate

Period Ending	Rate	Period Ending	Rate
3/31/2007	5.172%	12/31/2012	0.316%
6/30/2007	5.235%	3/31/2013	0.275%
9/30/2007	5.236%	6/30/2013	0.246%
12/31/2007	4.955%	9/30/2013	0.249%
3/31/2008	4.174%	12/31/2013	0.248%
6/30/2008	3.108%	3/31/2014	0.222%
9/30/2008	2.769%	6/30/2014	0.228%
12/31/2008	2.533%	9/30/2014	0.234%
3/31/2009	1.903%	12/31/2014	0.249%
6/30/2009	1.512%	3/31/2015	0.254%
9/30/2009	0.889%	6/30/2015	0.283%
12/31/2009	0.594%	9/30/2015	0.316%
3/31/2010	0.551%	12/31/2015	0.364%
6/30/2010	0.559%	3/31/2016	0.460%
9/30/2010	0.503%	6/30/2016	0.543%
12/31/2010	0.456%	9/30/2016	0.599%
3/31/2011	0.508%	12/31/2016	0.672%
6/30/2011	0.480%	3/31/2017	0.769%
9/30/2011	0.377%	6/30/2017	0.922%
12/31/2011	0.378%	9/30/2017	1.069%
3/31/2012	0.374%	12/31/2017	1.128%*
6/30/2012	0.361%	3/31/2018	1.288%*
9/30/2012	0.349%	6/30/2018	1.529%*

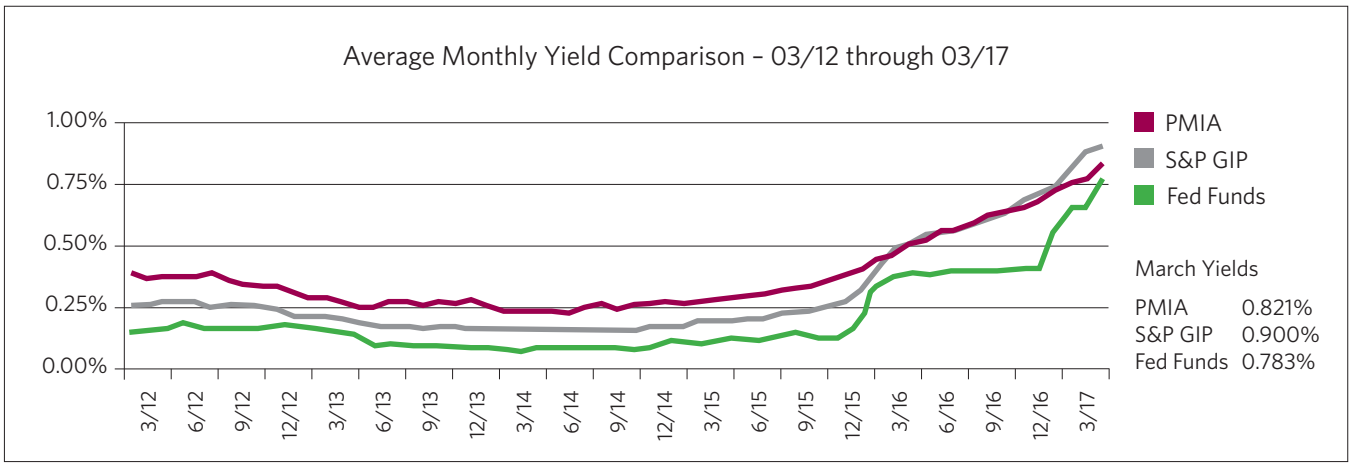
* Does not include interest earned on the Supplemental Pension Payment pursuant to Government Code 20825 (c)(1)

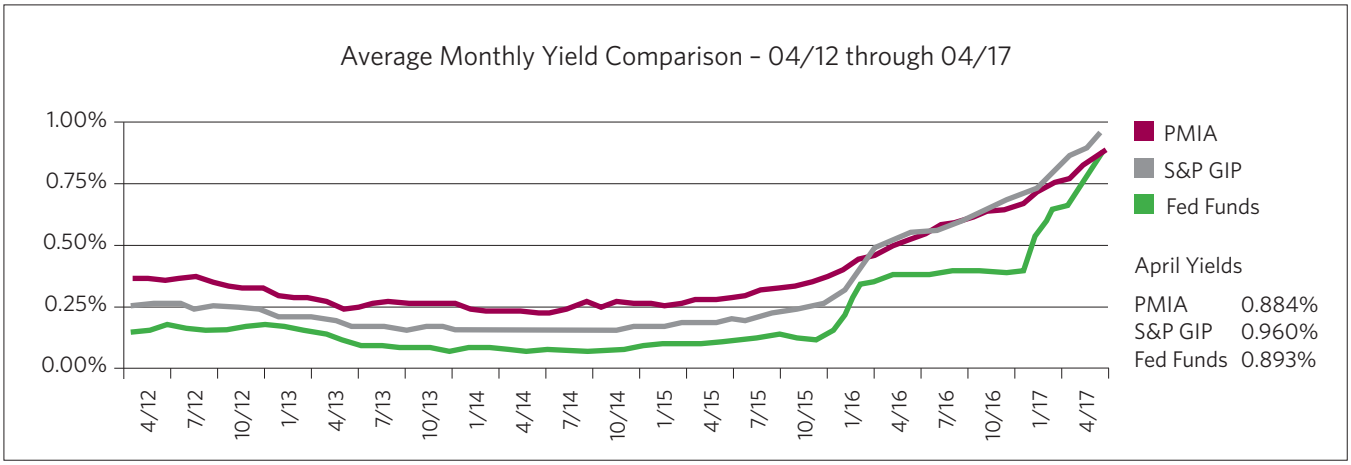
Appendix L – PMIA, S&P GIP, and Federal Funds Average Monthly Yield Comparison

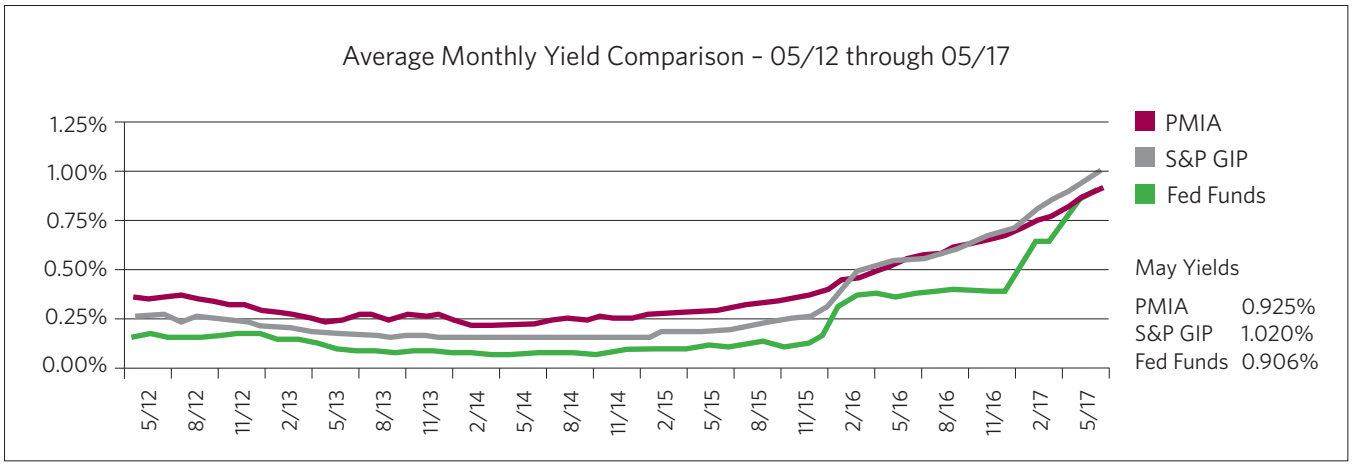


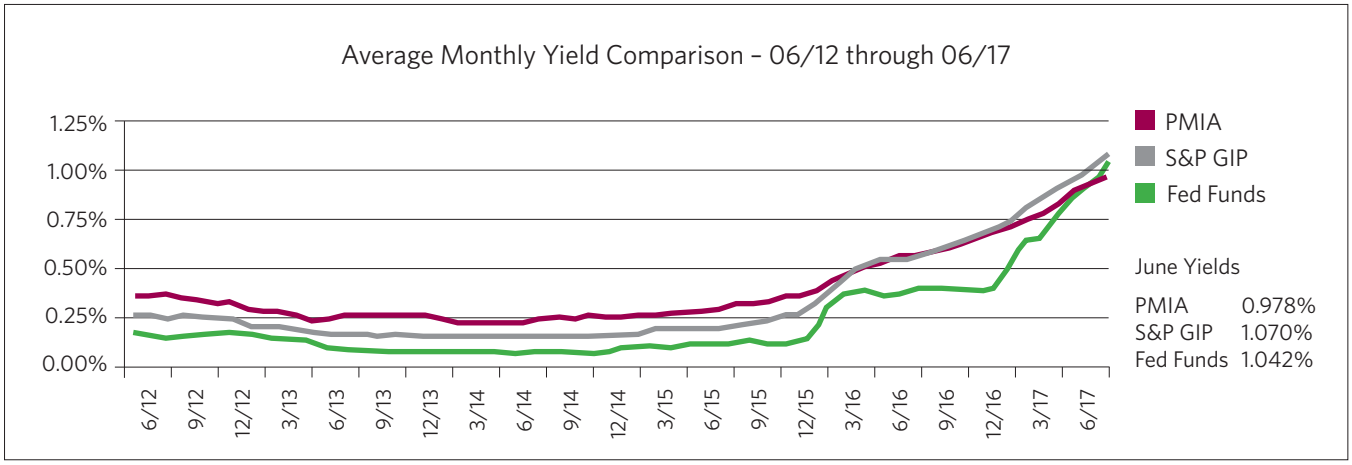


Appendix L – PMIA, S&P GIP, and Federal Funds Average Monthly Yield Comparison, cont.

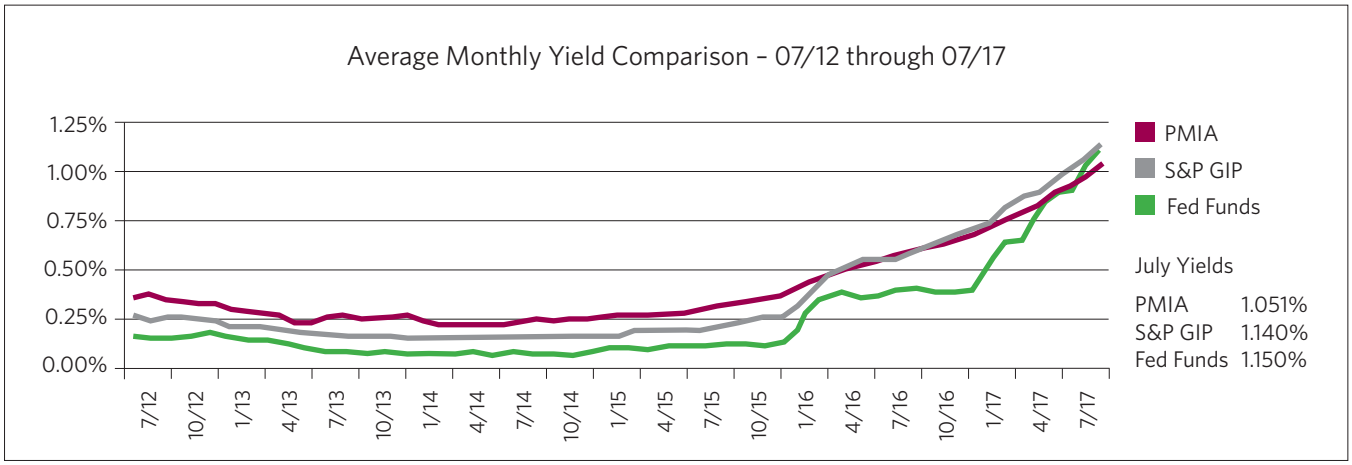


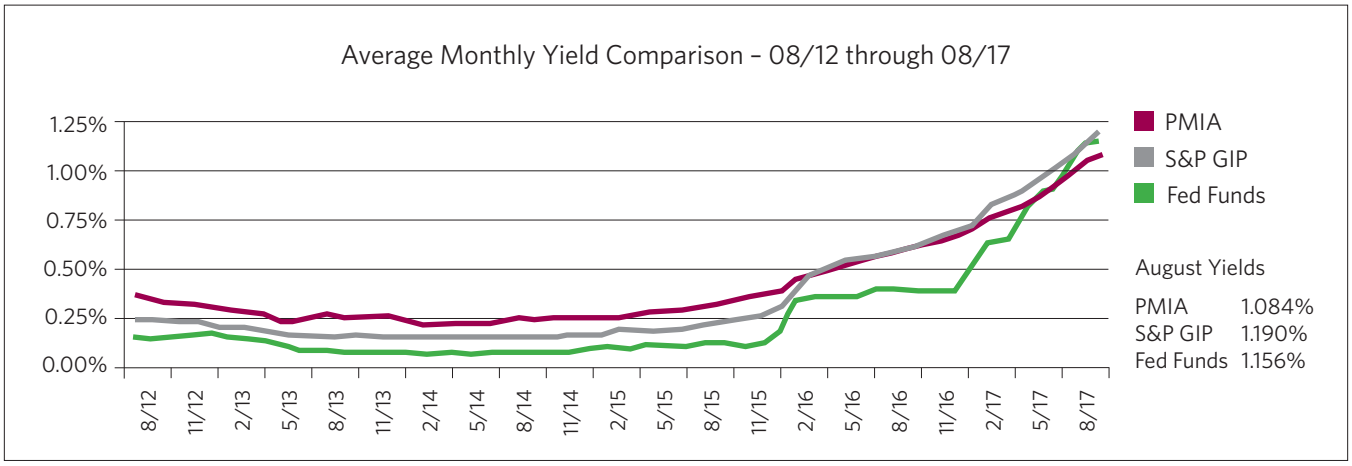


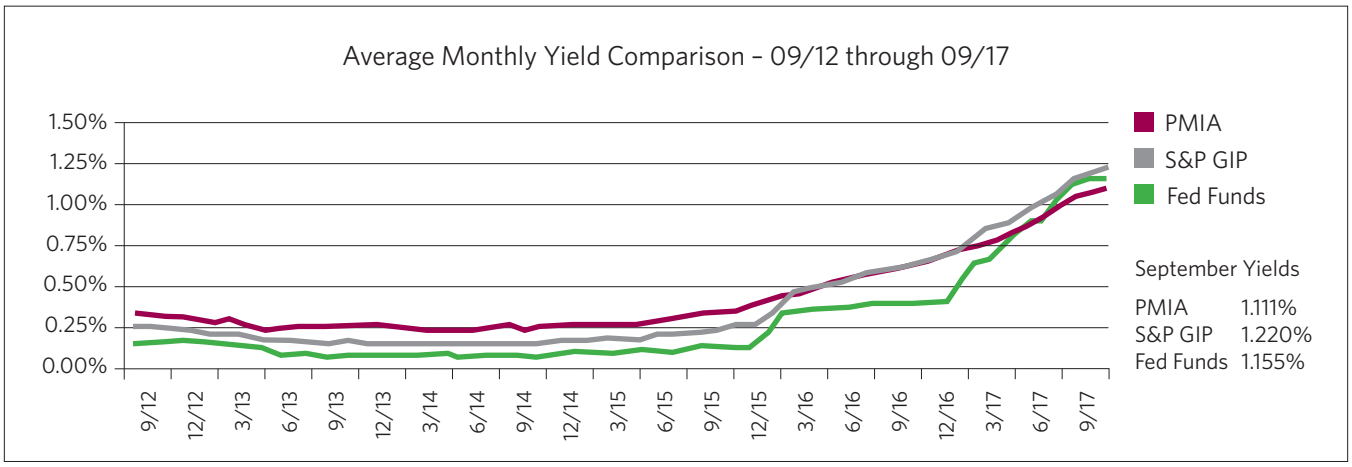

Average Monthly Yield Comparison – 05/12 through 05/17
1.25%
1.00%
0.75%
0.50%
0.25%
0.00%
5/12
8/12
11/12
2/13
5/13
8/13
11/13
2/14
5/14
8/14
11/14
2/15
5/15
8/15
11/15
2/16
5/16
8/16
11/16
2/17
5/17
PMIA
S&P GIP
Fed Funds
May Yields
PMIA 0.925%
S&P GIP 1.020%
Fed Funds 0.906%

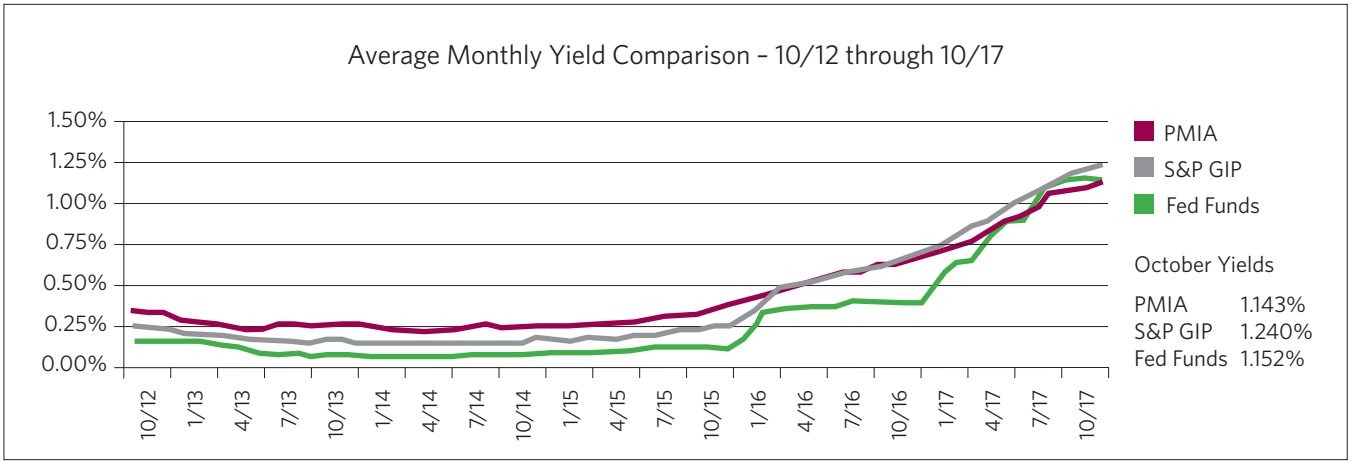

Average Monthly Yield Comparison – 06/12 through 06/17
1.25%
1.00%
0.75%
0.50%
0.25%
0.00%
6/12
9/12
12/12
3/13
6/13
9/13
12/13
3/14
6/14
9/14
12/14
3/15
6/15
9/15
12/15
3/16
6/16
9/16
12/16
3/17
6/17
PMIA
S&P GIP
Fed Funds
June Yields
PMIA 0.978%
S&P GIP 1.070%
Fed Funds 1.042%

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

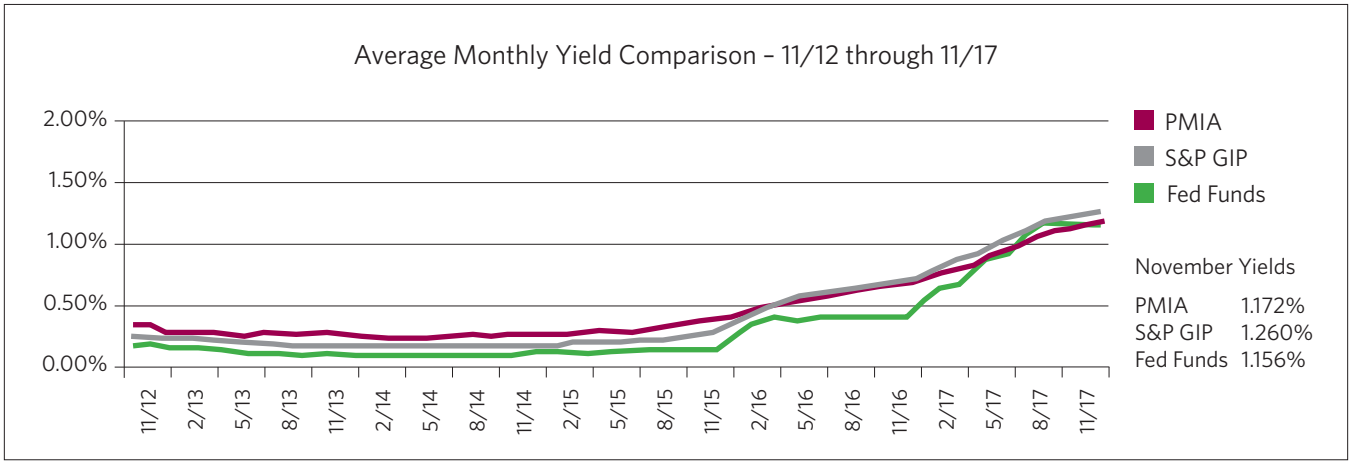


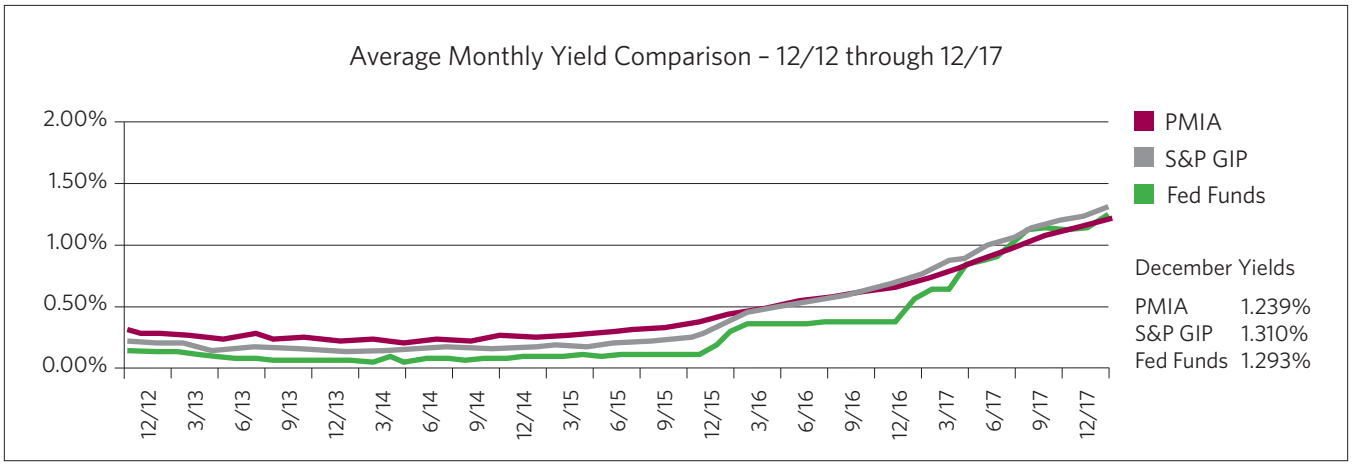



Average Monthly Yield Comparison – 09/12 through 09/17
1.50%
1.25%
1.00%
0.75%
0.50%
0.25%
0.00%
9/12
12/12
3/13
6/13
9/13
12/13
3/14
6/14
9/14
12/14
3/15
6/15
9/15
12/15
3/16
6/16
9/16
12/16
3/17
6/17
9/17
PMIA
S&P GIP
Fed Funds
September Yields
PMIA 1.111%
S&P GIP 1.220%
Fed Funds 1.155%


Average Monthly Yield Comparison – 10/12 through 10/17
1.50%
1.25%
1.00%
0.75%
0.50%
0.25%
0.00%
10/12
1/13
4/13
7/13
10/13
1/14
4/14
7/14
10/14
1/15
4/15
7/15
10/15
1/16
4/16
7/16
10/16
1/17
4/17
7/17
10/17
PMIA
S&P GIP
Fed Funds
October Yields
PMIA 1.143%
S&P GIP 1.240%
Fed Funds 1.152%

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





California Public Employees' Retirement System
400 Q Street
P.O. Box 942701
Sacramento, CA 94229-2701
www.calpers.ca.gov