Health Benefits Program | 2018 Annual Report

Published November 1, 2019

CalPERS

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Executive Summary

Members of the California Legislature and Director of Finance:

I am pleased to present the California Public Employees' Retirement System (CalPERS) Health Benefits Program Annual Report for the plan year January 1 through December 31, 2018. This report provides information about the CalPERS Health Benefits Program, pursuant to California Government Code Section 22866 (see Appendix A).

This year's annual report provides an overview of the health program including health plans, benefit designs, state and federal benefit requirements, historic enrollment and expenditure data, medical trends, and the results of our member satisfaction survey.

The report includes geographic coverage areas, premium changes year over year, and health plan quality measures. Financial information includes actuarial reserve levels, administrative expenditures, and historical investment performance for the program's two funding sources, the Public Employees' Contingency Reserve Fund (CRF) and the Public Employees' Health Care Fund (HCF).

CalPERS puts our 55+ years of experience as California's largest public health care purchaser to work for our 1.5 million members in achieving quality and affordability. In 2018, the overall premium increase of 2.33 percent was the lowest in 20 years.

In 2018, we continued important initiatives to address health care affordability. Our pharmacy benefit manager (PBM) contract saved $56 million and our reference pricing initiative saved our members and employers $8 million. Every dollar we save in costs mitigates future premium increases for our members and employers.

In 2019, we continue our efforts to contain costs while delivering high quality health care for our members.

Marcie Frost
Chief Executive Officer

Chief Health Director Message

The CalPERS Health Benefits Program is a nationally recognized leader in the health care industry. We put our expertise and influence to work to help us deliver quality, affordable health care for our members and employers.

In 2018, CalPERS spent an estimated $9.2 billion purchasing health benefits for our members. Of this amount, approximately $2.2 billion was spent on prescription drugs. We continue to work on health benefit strategies and engagement to mitigate the rising cost of prescription drugs for our members without sacrificing the quality of the CalPERS health care benefit.

Over the last two years, we evaluated and implemented a new value-based insurance design in our PERS Select Preferred Provider Organization (PPO) plan that encourages members to see a personal doctor and make healthy choices. In 2019, the overall monthly premium for PERS Select decreased 26 percent. Membership increased by 17,000.

Another important initiative was the evaluation of public agency and school health pricing regions. Local employers are 41 percent of our program, so it's vital we maintain a competitive edge with quality, comprehensive plans priced at market rates. Regional pricing helps to ensure local agency premiums are closely aligned to the cost of health care services in an area. Following a year-long evaluation during 2018 that included a cost of care analysis, assessment of market trends, and outreach with employers and stakeholders, the CalPERS Board of Administration approved three regions to replace the current five regions effective with 2020 health plan rates.

Foundational to the health program, the board also adopted its first set of health beliefs in 2018 to serve as a framework for strategic decision making and program management. The beliefs' themes of sustainability, quality and comprehensive care, affordability, competition, and quality administration help guide the effective management of the CalPERS Health Benefits Program.

We will continue to build on our success and advance our mission to provide superior service in the delivery of affordable, quality health care for those who serve California.

Don Moulds
Chief Health Director

About CalPERS

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 2018, we spent approximately $9.2 billion to purchase health benefits for 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.

Headquartered in Sacramento, CalPERS provides health benefit services to nearly 1.5 million covered lives for state, school, and public employers. CalPERS also operates eight Regional Offices located in Fresno, Glendale, Orange, Sacramento, San Diego, San Bernardino, San Jose, and Walnut Creek.

The 13-member board consisting of member-elected, appointed, and ex officio members, administers the California Public Employees' Medical and Hospital Care Act (PEMHCA) and is also subject to various state and federal laws, regulations, and guidance. The Pension and Health Benefits Committee (PHBC) is one of six committees that reports to the board. The PHBC oversees all matters related to the CalPERS Health Benefits Program including strategy, policy, structure, and actuarial studies as well as rate setting for pension, health, and CalPERS Long-Term Care Program administration.

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.

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 the result of a year-long collaborative process between our board and executive team that gives us a fresh look at the next five years. We also gathered valuable information and feedback from a variety of internal and external stakeholders. 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.

One of CalPERS' Strategic Plan goals is to transform health care purchasing and delivery to achieve health care affordability.

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 annually develops 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

The CalPERS 2017-22 Strategic Plan[1] has a stated goal to transform health care purchasing and delivery to achieve affordability along with the following objectives:

- 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

Table 1 shows the status of health-related Business Plan initiatives[2] and describes changes in strategic direction and major policy initiatives for the 2018 health plan year. It includes content from the CalPERS Strategic Plan, CalPERS Business Plan, and relevant CalPERS agenda items. These plans and agenda items are interrelated, complement each other, and focus on cost, quality, and accessibility.

CalPERS annually develops business plan objectives, strategic plan measures, and key performance indicators to monitor specific items that will achieve overarching goals.

[1] CalPERS 2017-22 Strategic Plan. https://www.calpers.ca.gov/docs/forms-publications/2017-22-strategic-plan.pdf
[2] CalPERS 2018-19 Business Plan. https://www.calpers.ca.gov/docs/forms-publications/2018-19-business-plan.pdf

Table 1: 2018 Health-Related Business Plan Initiatives

Initiative Title	Description	Status
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 (ACA) components.	Deferred[3]
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.	Completed[4]
Medical Pharmacy 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 (HMOs).	Ongoing
Pharmacy Benefits Management	Develop and implement strategies to align our PBM with our reference pricing model.	Ongoing
Medical 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.	Ongoing
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.	Ongoing
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.	Ongoing
Statewide Collaboration Through *Smart Care California*	Partner with Covered California and Department of Health Care Services through Smart Care California coalition to promote safe, affordable care in the areas of opioid use, caesarean sections, and spinal/back disorders.	Ongoing
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.	Ongoing
Research and Expand Evidence-Based Medicine	Apply outcome-based medical strategies to provide affordable and high-value care.	Ongoing

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

[4] *CalPERS Pension and Health Benefits Committee Agenda Item 6, March 20, 2018.* https://www.calpers.ca.gov/docs/board-agendas/201803/pension/item-6-a.pdf. The CalPERS health team recommended, and the Board approved, the proposed Value-Based Insurance Design for the PERS Select basic plan for the 2019 plan year.

Health Beliefs

In April 2018, the board adopted six health beliefs (see Table 2) to add to the existing pension and investment beliefs. They are a guide for making decisions that often require balancing multiple, interrelated decision factors. Together they establish a framework that provides context for CalPERS' actions, reflect CalPERS' values, and acknowledge CalPERS' responsibility to sustain its investment, pension, and health benefits programs for generations to come.

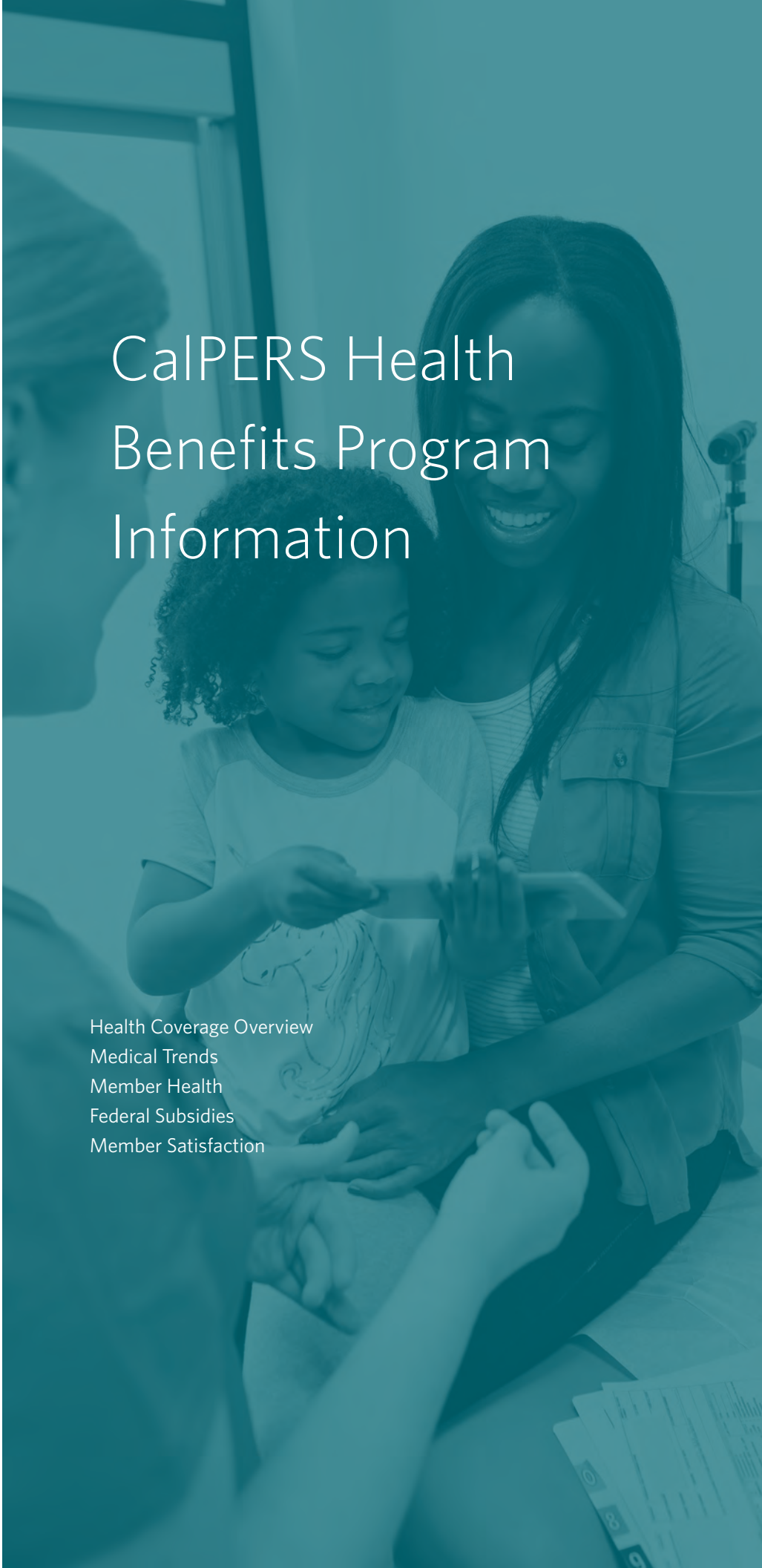
CalPERS' Core Values are engrained in the work we do every day. These values drive us to be transparent, accountable, and ethical to achieve our goals. As a leader, we shall engage in activities that influence the state and federal policy landscape, and align with other entities that share our values.

Table 2: CalPERS Health Beliefs

Theme	Belief
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.

CalPERS' Core Values drive us to be transparent, accountable, and ethical to achieve our goals.

CalPERS 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 2018 plan year, CalPERS' Basic health plan offerings included fully-insured and partially flex-funded HMO plans, self-insured 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
- Sharp
- UnitedHealthcare
- Western Health Advantage

CalPERS' Medicare health plan offerings include both Medicare Advantage plans and Medicare Supplemental plans. The following Medicare Advantage Plans are available to CalPERS members:

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

CalPERS also contracted with Anthem Blue Cross to administer the following Medicare Supplemental plans:

- PERS Select
- PERS Choice
- PERSCare

Three association plans are 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 association plans.

For the 2018 plan year, Western Health Advantage was selected as the newest HMO basic plan offered to CalPERS members. The one-year contract took effect January 1, 2018, and ended December 31, 2018. Anthem Medicare Preferred (PPO), a Medicare Advantage Plan, was added in areas where Anthem Traditional HMO is available.

OptumRx administered prescription drug benefits for Anthem Medicare Preferred members, as well as members in PERS Select, PERS Choice, and PERSCare PPO health plans. OptumRx also administered prescription drug benefits for members in Anthem Blue Cross, Health Net, Sharp, UnitedHealthcare, and Western Health Advantage Basic HMO health plans.

Look Ahead

New for 2020, Blue Shield will introduce Trio, a narrow-network HMO health plan for the following six counties: El Dorado, Los Angeles, Nevada, Placer, Sacramento, and Yolo.

The board awarded a 5-year PPO third-party administrator contract to Anthem Blue Cross, who will administer the PERS Choice, PERS Select, and PERSCare health plans beginning January 1, 2020 and ending December 31, 2024.

Benefit Requirements

State Law

CalPERS' Basic HMO health 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 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 EHB; however, CalPERS' HMO and PPO Basic health plans provide benefits in all the EHB categories, except for pediatric dental and vision care.[5]

Under the ACA, EHB 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 EHB for plans sold in the individual and small group market based on a state-specific EHB benchmark plan. The benchmark plan defines the EHB 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 EHB:

- Biofeedback
- Chiropractic services
- Hearing aid services

[5] 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 Design Changes

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

In June 2017, the board adopted the following benefit changes for the 2018 health plan year:

Value-Based Purchasing Design (VBPD) for use of Ambulatory Surgery Centers (ASCs)

The board elected to expand the VBPD program by 12 medical procedures for self-funded PPO Basic plans only.

Site of Care Management for Medical Pharmacy

The board elected to add a site of care program to steer members from non-clinically indicated higher cost sites of care (such as outpatient hospital) to lower cost sites of care (physician's office, ambulatory infusion center, and home infusion). This program is for the self-funded PPO Basic plans only.

Reduce Use of Emergency Room (ER) for Urgent Care

The board elected to add the Anthem Blue Cross Quick Care Options to the self-funded PPO Basic and Medicare plans. Quick Care is an educational product to help members find non-ER care where members will save time and have lower copays. The Quick Care Options mobile application enables members to quickly identify nearby in-network retail health clinics, walk-in doctors' offices, and urgent care centers that provide the care they need. The 24/7 NurseLine is also available to members to find alternate care locations.

Castlight

The board elected to continue to offer this tool to PPO Basic plan members in 2018. Originally offered as a pilot in 2014, this tool educates users about price variation across medical procedures with an intuitive, easy-to-use online application with expanded cost transparency based on CalPERS claims data.

Welvie

The board elected to continue the program in 2018 for PPO Basic plans due to high utilization by the PPO Basic plan members, and expanded it to PPO Medicare Supplement plan members. This online tool helps educate members on preference sensitive surgeries and places more power in their hands when it comes to minimizing unnecessary and inappropriate surgeries.

SilverSneakers

The board elected to add the SilverSneakers program to the self-funded PPO Medicare plans. SilverSneakers is a community fitness program specifically designed for older adults that provides members with regular exercise (strength training, aerobics, and flexibility) and social opportunities at more than 13,000 locations nationwide.

Look Ahead

In 2020, Anthem Blue Cross will introduce a new HMO Medicare Advantage plan in Monterey County. This plan will provide coverage options to members and families enrolled in a combination of Basic and Medicare.

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 insurance plan's AV indicates the average share of medical spending that is paid by the plan, as opposed to being paid out-of-pocket by the member. Plans with a higher AV typically have higher premiums than plans with a lower AV.

The ACA stipulates that AV be calculated based on the provision of EHB 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, EPO, and association health plans fall in the platinum tier, and its PPO plans are a combination of gold and platinum (see Tables 3a–c).

Table 3a: Metal Tiers for 2018 HMO Health Plans

HMO Plans	Actuarial Value	Metal Tier
Anthem Select HMO	98%	Platinum
Anthem Traditional HMO	98%	Platinum
Blue Shield Access+	98%	Platinum
Health Net Salud y Más	98%	Platinum
Health Net SmartCare	96%	Platinum
Kaiser	97%	Platinum
Sharp	98%	Platinum
UnitedHealthcare	97%	Platinum
Western Health Advantage	98%	Platinum

Table 3b: Metal Tiers for 2018 EPO and PPO Health Plans

EPO and PPO Plans	Actuarial Value	Metal Tier
Anthem Del Norte EPO	98%	Platinum
PERS Choice	89%	Gold
PERS Select	86%	Gold
PERSCare*	91%	Platinum

Table 3c: Metal Tiers for 2018 Association Health Plans

Association Plans	Actuarial Value	Metal Tier
CAHP	92%	Platinum
CCPOA*	97%	Platinum
PORAC*	92%	Platinum

* A change in methodology that more accurately calculates AV has caused some plans (PERSCare, CCPOA and PORAC) to change from Gold tiers in the previous report to Platinum tiers in this report.

Member Out-of-Pocket Costs

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

There was considerable variation in health care and prescription drug out-of-pocket costs in 2018 depending on whether the CalPERS member chose an HMO or PPO, or was enrolled in a Basic or Medicare health plan. A typical co-payment for a physician office visit for members enrolled in a Basic HMO plan was $15, $20 for members enrolled in a Basic PPO plan, $10 for members enrolled in a Medicare Advantage plan, and no charge for members enrolled in a Medicare Supplement plan. A typical deductible for members enrolled in a Basic PPO plan was $500 for individuals and $1,000 for a family. There were no deductibles for members enrolled in a Basic HMO plan or a Medicare plan.

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

CalPERS members paid on average $318 out-of-pocket for health care services and prescription drugs. For out-of-pocket costs, members paid on average $136 in Basic HMO plans; $290 in Medicare Advantage plans, $962 in Basic PPO plans, and $297 in Medicare Supplement plans. 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.

Medical Trends

The overall cost trend for CalPERS' HMO and PPO Basic health plans increased 3.6 percent in calendar year 2018. 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 allows a better understanding of the factors that impact healthcare premiums. The 2018 trend in service category costs varied, with the largest contributions from inpatient care, prescription drugs, and ambulatory surgery categories. Utilization rate increases occurred in all service categories for calendar year 2018 except inpatient, emergency room visits, and prescription drug days. See Appendix C for graphs displaying these medical trend changes.

The Medical Trends section includes methodology improvements. This section of the report will continuously change and improve to align with best practices to group and present the data.

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 2018, approximately 38 percent of members enrolled in a CalPERS health benefit plan have an existing chronic condition and 24 percent of CalPERS' California population have one or more of the seven common chronic conditions listed below:

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

The CalPERS population, on average, is older and has a higher prevalence of chronic conditions when compared to other insured populations. Hypertension, diabetes, and coronary artery disease are more prevalent in CalPERS Medicare members than Basic members.

As a result of an updated version of the medical episode grouper utilized in the CalPERS Health Care Decision Support System (HCDSS), the prevalence of many chronic conditions decreased from the prior year's report. To better align with industry standards of reporting chronic conditions, the updated medical episode grouper added and removed certain diagnosis codes across a number of categories. There was also different methodology used to determine what type of claim can initiate a chronic condition episode.

Table 4 provides a breakdown of chronic condition prevalence in Northern and Southern California counties, and statewide, based on information from the CalPERS HCDSS for 2018. Note that some members may have had more than one chronic condition, and these numbers do not account for any enrollment changes that may have occurred during 2018.

Table 4: 2018 Chronic Conditions Prevalence Among CalPERS Members*

	Northern California		Southern California		California	
	Percentages based on 761,088 members		Percentages based on 628,079 members		Percentages based on 1,389,167 members	
Chronic Condition	Population	Prevalence (%)	Population	Prevalence (%)	Population	Prevalence (%)
Hypertension	55,483	7.3	50,337	8.0	105,820	7.6
Diabetes	41,117	5.4	36,187	5.8	77,304	5.6
Depression	36,049	4.7	27,105	4.3	63,154	4.5
Asthma	26,446	3.5	16,714	2.7	43,160	3.1
Coronary artery disease	13,001	1.7	12,357	2.0	25,358	1.8
COPD	6,139	0.8	4,838	0.8	10,977	0.8
Congestive heart failure	2,432	0.3	2,098	0.3	4,530	0.3

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

Figure 1 displays the counties that encompass Nothern and Southern California as they relate to chronic conditions prevalence among CalPERS members.

Figure 1: 2018 Northern and Southern California Counties

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

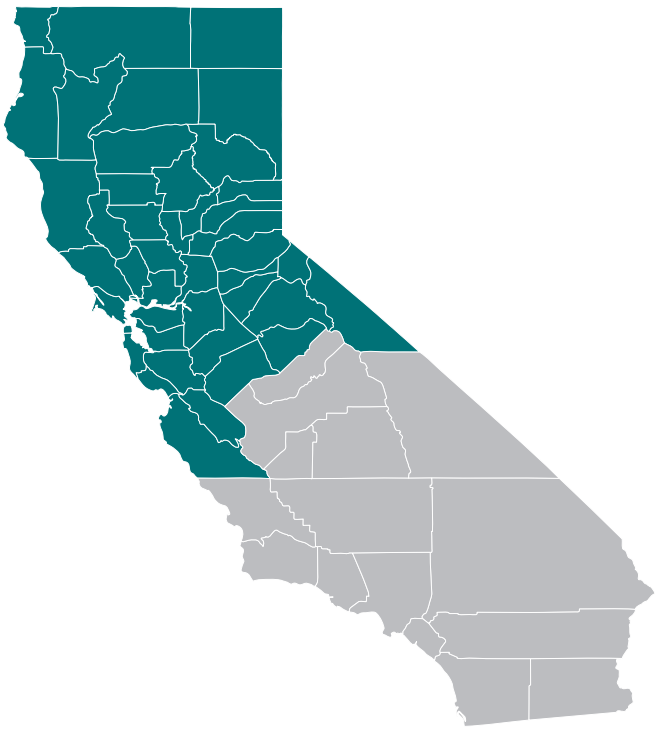


Table 5 provides a breakdown of chronic condition prevalence for Basic members in Northern and Southern California counties, and statewide, based on information from the CalPERS HCDSS for 2018. Note that some members may have had more than one chronic condition, and these numbers do not account for any enrollment changes that may have occurred during 2018.

Table 5: 2018 Chronic Conditions Prevalence Among CalPERS Basic Members*

	Northern California		Southern California		Total California	
	Percentages based on 620,762 members		Percentages based on 530,929 members		Percentages based on 1,151,691 members	
Chronic Condition	Population	Prevalence (%)	Population	Prevalence (%)	Population	Prevalence (%)
Hypertension	28,543	4.6	26,221	4.9	54,764	4.8
Diabetes	23,647	3.8	20,970	3.9	44,617	3.9
Depression	30,012	4.8	22,402	4.2	52,414	4.6
Asthma	22,256	3.6	13,585	2.6	35,841	3.1
Coronary artery disease	4,211	0.7	4,117	0.8	8,328	0.7
COPD	1,790	0.3	1,309	0.2	3,099	0.3
Congestive heart failure	631	0.1	515	0.1	1,146	0.1

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

Table 6 provides a breakdown of chronic condition prevalence for Medicare members in Northern and Southern California counties, and statewide, based on information from the CalPERS HCDSS for 2018. Note that some members may have had more than one chronic condition, and these numbers do not account for any enrollment changes that may have occurred during 2018.

Table 6: 2018 Chronic Conditions Prevalence Among CalPERS Medicare Members*

	Northern California		Southern California		Total California	
	Percentages based on 140,326 members		Percentages based on 97,150 members		Percentages based on 237,476 members	
Chronic Condition	Population	Prevalence (%)	Population	Prevalence (%)	Population	Prevalence (%)
Hypertension	26,940	19.2	24,116	24.8	51,056	21.5
Diabetes	17,470	12.4	15,217	15.7	32,687	13.8
Depression	6,037	4.3	4,703	4.8	10,740	4.5
Asthma	4,190	3.0	3,129	3.2	7,319	3.1
Coronary artery disease	8,790	6.3	8,240	8.5	17,030	7.2
COPD	4,349	3.1	3,529	3.6	7,878	3.3
Congestive heart failure	1,801	1.3	1,583	1.6	3,384	1.4

* 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 similar risk profiles, and the CalPERS 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 up to the past 18 months 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 CalPERS 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 and sets regional rates for contracting agencies. The board established regions in 2005 for contracting agency Basic premiums. The implementation of regional pricing helped mitigate the loss of contracting agencies from the health program and stabilize membership. Regional pricing helps ensure local agency premiums are more closely aligned to the cost of health care services in an area and allows CalPERS to remain competitive with market rates to attract and retain local employers to the health program. In 2018, CalPERS assessed regions to determine if changes would benefit our employers and members. The assessment included a comprehensive analysis of health care costs throughout the state, employer and stakeholder input, and the development of various regional scenarios. In December 2018, the board adopted a new three-region model effective with the 2020 health plan year. CalPERS plans to reevaluate the region model every five years.

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 PBM 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, catastrophic reinsurance, coverage gap discounts, low income cost-sharing subsidies, and low income premium subsidies. In 2018, CalPERS collected nearly $23 million in federal subsidies, which makes up less than one percent of total health premiums collected.

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 the 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. The Low Income Cost-share Subsidies (LICS) are payments to plan administrators to offset the statutory reduction in cost sharing for qualified low-income members. The Low Income Premium Subsidies (LIPS) are payments to plan administrators to lower the costs of premiums for members that meet low-income guidelines. The 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

Each year, CalPERS conducts a survey to evaluate members' experience 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.

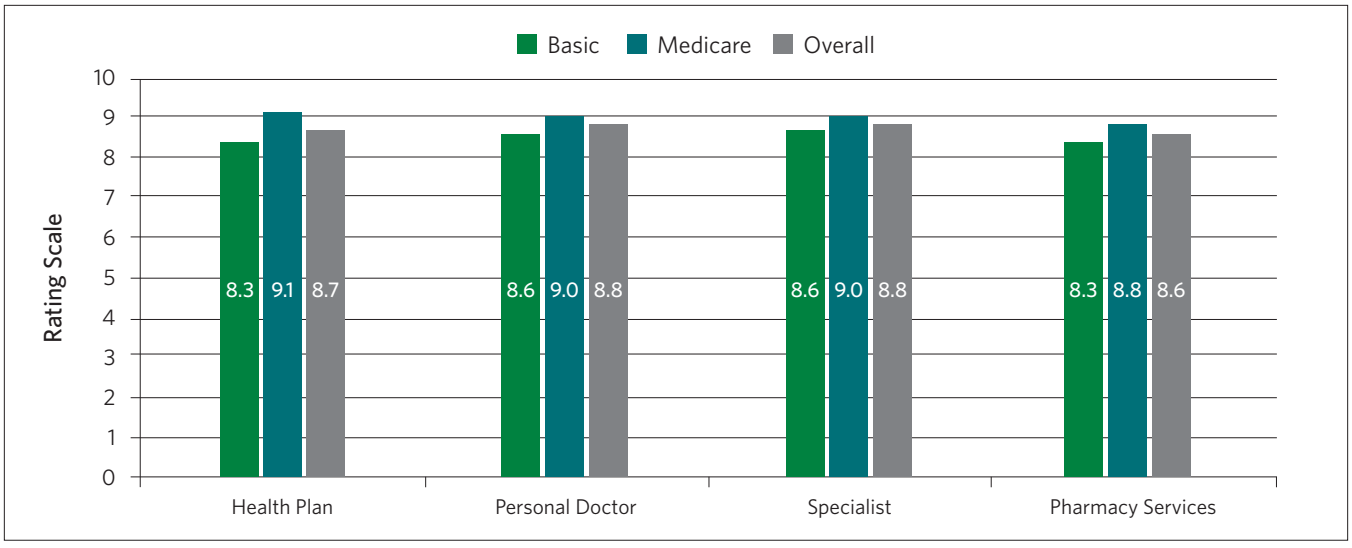
The 2019 CalPERS Health Plan Member Survey, evaluating plan year 2018 experiences, ran from January 8 through March 5, 2019. Health plans with an enrollment of at least 2,000 eligible members had 1,100 people randomly selected from each plan. In total, 24,200 members from 15 Basic and seven Medicare health plans received a survey and 8,400 members responded. As in previous years, the response rate for Medicare plans was higher than Basic plans – 61 percent compared with 24 percent.

During the survey, members were asked to rate their healthcare 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 the following using the 10-point scale (see Figure 2):

- Health Plan
- Personal Doctor
- Specialist
- Pharmacy Services

Figure 2: Member Satisfaction Ratings Survey Responses



Rural Healthcare Accessibility

The annual survey asked Basic plan members to report their level of accessibility. According to survey data, 213 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 a Medicare Advantage plan in all 58 counties in California. Appendix D includes graphical data on specific responses.

Emergency Room Care

Out of the 213 respondents living in a rural area, 64 utilized the emergency room to get care for themselves.

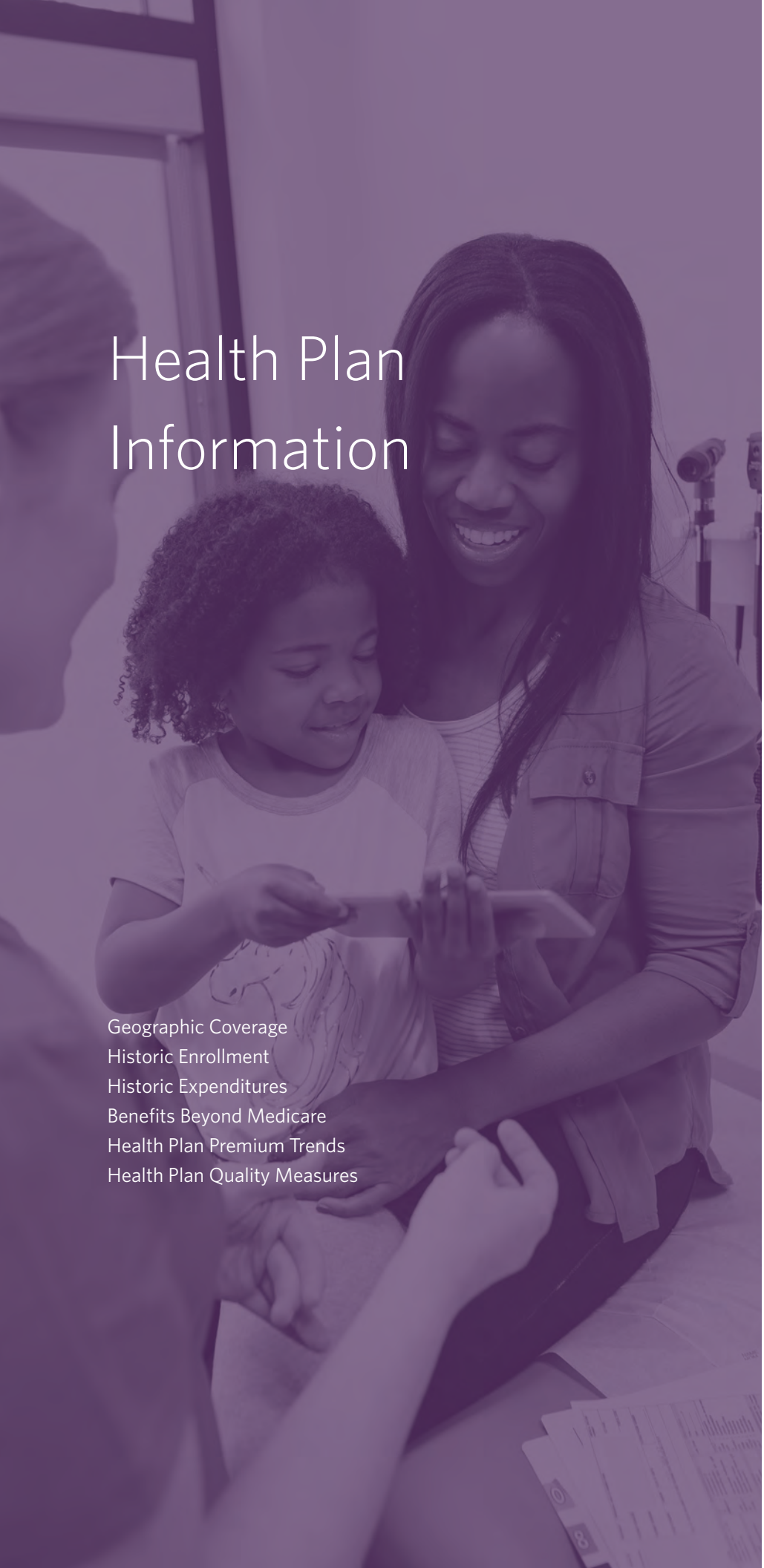
Of those 64 respondents, nine responded that they went to the emergency room because there were no urgent care services within 15 miles/30 minutes of their homes. These individuals resided in Calaveras, Inyo, Lassen, Mono, and Tehama counties.

After Hours Care

Out of the 213 respondents living in a rural area, 29 responded that it was not easy to get after hours care.

Of these 29 respondents, three felt that the reason it was not easy to get the after hours care needed was because the doctor's office or clinic was too far away. These individuals resided in Inyo, Shasta, and Siskiyou counties.

CalPERS members continue to report high satisfaction with their health plans. On a scale of 1-10, Basic members rate their health plans 8.3. 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, members can log in to their my|CalPERS account to explore their health plan options. my|CalPERS allows members to access customized health information as well as tools and resources to help them with their open enrollment decisions. Members can use the Find a Medical Plan tool to discover health plans and monthly premium rates based on their eligibility ZIP code. Members can also view a matrix indicating the availability of health plans by county and by state within the Health Benefit Summary. 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

For 2019 Open Enrollment, the Find a Medical Plan tool was renamed to Search Health Plans. The tool allows CalPERS members to compare available health plans and search if their primary care doctor accepts those plans.

my|CalPERS allows members to access customized health information as well as tools and resources to help make health enrollment decisions.

Historic Enrollment

CalPERS has seen its health plan enrollment grow over the past 10 years. Between 2009 and 2018, CalPERS' total enrollment has increased by over 13 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 CalPERS Health Benefits Program and attract new public agency and school employers. In 2018, we were successful in retaining over 99 percent of our contracting public agency and school employers. We also added nearly 10,000 total covered lives to the program through successful contracts with nine new agencies as well as one existing agency adding three new employee groups.

Basic and Medicare

Table 7 displays ten years (2009-2018) of CalPERS' total estimated enrollment counts by Basic and Medicare as of January 1 (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.

In 2018, we were successful in retaining over 99 percent of our contracting public agency and school employers.

Other Enrollment Information

In addition to the Basic and Medicare enrollment information included in this section, the Historic Enrollment tables (see Appendix F) provide enrollment data for plan years 2015-2018. The CalPERS total enrollment count includes state, public agency, and school members, excluding individuals on Consolidated Omnibus Budget Reconciliation Act (COBRA). Appendix F also displays 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).

Table 7: Estimated Basic and Medicare Enrollment
(Enrollment in Thousands)

	Basic	Medicare	Total*
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
2018	1,180	277	1,457

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

Historic Expenditures

CalPERS Health Benefits Program total estimated expenditure in 2018 was approximately $9.2 billion.

Basic and Medicare

Table 8 displays 10 years (2009-2018) 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., 2018 expenditures were calculated based on 2018 premiums and January 2018 enrollment counts).

Average annual increase for the program's total estimated expenditures was approximately 5.3 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.

Table 8: Estimated Basic and Medicare Expenditures
(Dollars in Millions)

	Basic	Medicare	Total*	Year Over Year
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%
2018	8,012	1,142	9,154	3.1%

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

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 plan years 2015-2018. 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).

In 2018, the CalPERS Health Benefits Program spent an estimated $9.2 billion on health benefits for active employees, retirees, and their dependents.

Benefits Beyond Medicare

In 2018, CalPERS offered PERS Select, PERS Choice, and PERSCare PPO Medicare Supplemental plans. Most benefits in these plans were Medicare-approved services with Medicare payment supplemented by the plan. However, the plans provided coverage for some benefits not covered by Medicare (e.g., acupuncture). Furthermore, the plans also provided coverage for medically necessary services and supplies when benefits under Medicare were exhausted or when charges for certain 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, Kaiser Permanente Senior Advantage, and Anthem Medicare Preferred (PPO) 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 Medicare members.

Aggregated Cost of Benefits Beyond Medicare

Table 9 shows the aggregated cost of claims paid for benefits beyond Medicare for PERS Select, PERS Choice, and PERSCare Medicare members in calendar year 2018.

Table 9: 2018 Benefits Beyond Medicare
(Dollars in Thousands)

Benefit	Aggregated Cost
Acupuncture or acupressure services	$2,294
Blood replacement	6
Christian Science nurse or practitioner	0
Hearing aid	5,671
Hospital services and supplies (inpatient and outpatient)	58,642
Immunizations	78
Lancets	68
Mental health services and supplies (inpatient and outpatient)	2,482
Physical or occupational therapy	1,982
Skilled nursing services	1,806
Smoking cessation programs	2
Speech therapy	12
Vision care	142
Total	$73,187

CalPERS' Medicare plans include acupuncture and hearing aid services as additional benefits beyond those covered under the original Medicare program.

Health Plan Premium Trends

CalPERS health plan premiums are set annually. The rates are established through analysis of approximately 18 months of the recent claims data, changes to benefit design, and estimates for future health care costs, in accordance with generally accepted actuarial standards of practice. The process to establish the 2018 health plan premiums started in 2017, using data from 2016 and 2017.

The CalPERS 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.

The Health Care Decision Support System contains more than a decade of anonymized claims data for all CalPERS Health Benefits Program enrollees.

Trend Factors

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

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

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

The estimated future health care costs used to set CalPERS' rates are based on the data available during the rate development process. Actual costs are affected by numerous factors occurring in the time 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 absolute certainty. This results in 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 2018, premiums increased an overall 2.33 percent for all Basic and Medicare plans combined. Basic HMO plans increased by an average of 3.71 percent, Basic PPO plans decreased by an average of 2.50 percent, and Medicare plans increased by an average of one percent. For the HMO and PPO plans, there was an increase in medical costs and a decrease in pharmacy 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 agencies and school (contracting agencies) regions across California. Appendix H shows tables reflecting premium increases or decreases between plan years 2017 and 2018 for state and contracting agency HMO, PPO, and association plans. CalPERS is not responsible for the benefit administration of association plans and does not negotiate association premiums.

Look Ahead

After a comprehensive analysis, the board approved a new three-region model for public agency and school employers. The region change goes into effect January 1, 2020.

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 CalPERS 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.

Table 10 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 premium amount paid to each carrier from January through December 2018. The premium information was extracted from my|CalPERS as of June 8, 2019.

Table 10: Health Premium Management Report for Calendar Year 2018
(Dollars in Thousands)

Health Plan Carriers	Health Premiums Amount
Anthem Blue Cross	$2,570,564
Associations (CAHP, CCPOA, and PORAC)*	573,433
Blue Shield of California	1,165,717
Health Net of California	161,232
Kaiser*	3,932,167
Sharp	66,304
UnitedHealthcare	651,556
Western Health Advantage	41,193
Total	**$9,162,166**

* Kaiser and association plan 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

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.[6] The current set of HEDIS® measures addresses "preventive services, chronic disease management, behavioral health care, appropriateness/overuse of services, and value."[7]

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.[8] 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[9] data specific to CalPERS members on an annual basis. Data analysis and reporting during the reporting year[10] is based on data collected from health plans during the measurement year.[11]

This report includes HEDIS® and HEDIS-like data for reporting year 2019 based on data collected during measurement year 2018. 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.

HEDIS® measures are used by more than 90 percent of health plans in the U.S. to compare their plan performance and, more importantly, to make improvements in their quality of care and service.

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

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

[8] http://healthinsuranceratings.ncqa.org/2018/Default.aspx

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

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

[11] The calendar year preceding the reporting year, during which the events measured actually occurred.

Furthermore, the scores in Appendices I and J are not strictly comparable. For some of the measures (marked with an asterisk), a PPO's score may be lower than an HMO's score solely because of how the data is 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.

Medicare Star Ratings

Medicare uses a Star Rating System to measure how well Medicare Advantage and Medicare Prescription Drug (Part D) plans perform.[12] 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.

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

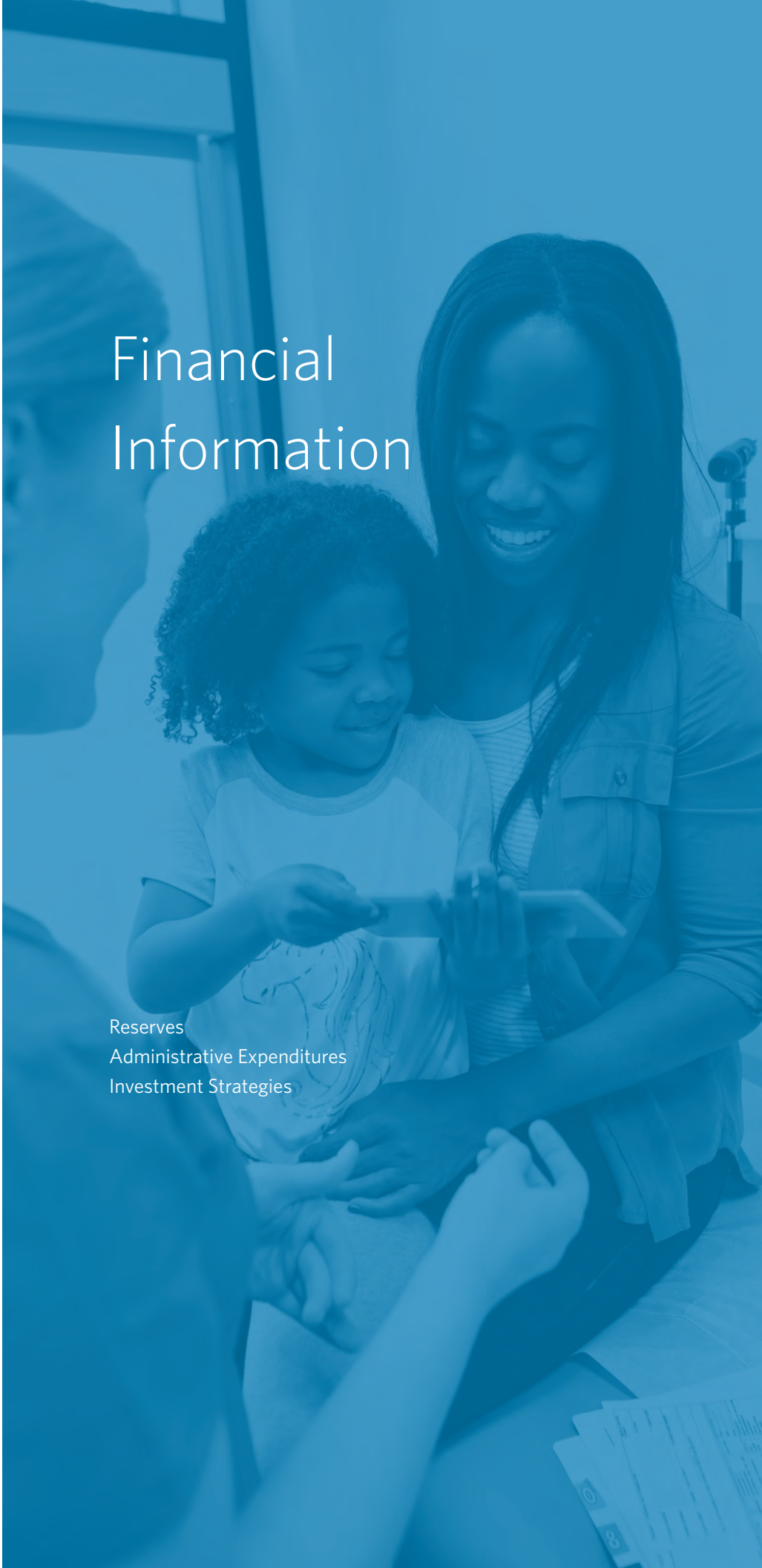
Other Quality Measurements

Other quality measurements (see Table 11) contained in the board's health plan carrier contracts include the following:

Table 11: 2018 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.
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.
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.
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 Utilization Review Accredidation Commission (URAC)).

Financial Information



Reserves
Administrative Expenditures
Investment Strategies

Reserves

Reserve Levels/Adequacy

As of December 31, 2018, the actuarial reserve level for the self-funded PPO plans was $506.8 million, and the total assets level was $659.8 million. These amounts adequately account for worst-case scenarios, e.g., Risk-Based Capital (RBC) reserves meant to pay for medical and pharmacy claims in the case of a sudden drop in enrollment, natural disaster, or an unexpected health pandemic.

For the self-funded pharmacy portion of CalPERS' HMO plans, total assets were $21.0 million as of December 31, 2018.

Expected Change in Reserve Levels

CalPERS forecasts the actuarial reserve at the end of every calendar year. In addition, we assess a worst-case scenario whereby the reserve is simultaneously designed to cover the Incurred But Not Reported (IBNR) claims from a sudden drop in enrollment, natural disaster, unforeseen pressures on premiums such as a pandemic, and a change in interest rates which would affect the value of the reserve fund.

Based on an evaluation of the above, current reserves are sufficient to cover unforeseen events.

Policies to Reduce Surplus Reserves/ Rebuild Inadequate Reserves

CalPERS implemented a new HCF reserve policy in September 2018. The main purposes of the policy are to review the appropriate PPO reserve level and the methodology for handling surpluses or deficits based on predetermined thresholds:

- If the plan assets at the end of the year are within plus or minus 10% of the actuarial reserve, no action will be taken;
- If the plan assets exceed 110% of the actuarial reserve amount, a premium reduction will be considered to lower the reserve level back to 100%;
- Conversely, if the plan assets fall below 90% of the actuarial reserve amount, an additional surcharge may be considered for future premiums.

CalPERS did not lower any plans' 2018 premiums with surplus reserves. The 2018 premiums were determined before the new reserve policy was implemented.

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 collected for a plan, CalPERS then determines if there is existing money in the plan's account which can be used to fill the gap.

CalPERS board approved a new Health Care Fund reserve policy in September 2018.

Administrative Expenditures

In fiscal year 2018-19, CalPERS expended $72.8 million to support the Health Benefits Program. These administrative expenditures included both personal services costs (salaries, wages, and benefits), and operating expenses and equipment.

Of the total 2,875 authorized CalPERS positions, 445.2 directly and indirectly supported the Health Benefits Program in fiscal year 2018-19 (see Table 12). Direct support positions include those in the Health Policy and Benefits Branch, the Actuarial Office, the Legal Office, and Customer Services and Support. In contrast, enterprise support positions are those that indirectly supported the program, including but not limited to, positions in the Financial Office and the Operations and Technology Branch. Personal services expenditures totaled $51.5 million in 2018-19 (see Table 13).

Table 12: Staff Levels

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

Table 13: Personal Services
(Dollars in Thousands)

Salary and Wages	$34,101
Staff Benefits	17,383
Total Personal Services	**$51,484**

Operating expenses and equipment costs included internal and external professional consulting services, as well as various general operating expenses such as communication, travel, printing, and data processing. Further, statewide administrative costs, known as pro-rata, were assessed to the program. Operating expenses and equipment expenses in fiscal year 2018-19 totaled $21.3 million (see Table 14).

Table 14: Operating Expenses & Equipment
(Dollars in Thousands)

Consultant and Professional Services – Internal	$322
Consultant and Professional Services – External	7,247
General Operating Expenses	8,934
Statewide Administrative Cost (Pro-Rata)	4,811
Total Operating Expenses & Equipment	**$21,314**

Funding to support CalPERS' Health Benefits Program comes from the Public Employees' CRF and the Public Employees' HCF (see table 15).

Table 15: Funding Sources
(Dollars in Thousands)

Public Employees' CRF	$29,837
Public Employees' HCF	42,961
Total Funding	**$72,798**

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) (see Table 16). 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 will 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.

Table 16: Historical Investment Performance of the Surplus Money Investment Fund*
(Net of Fees)

Fiscal Year End	Allocation	Invested Assets	Annual Return
14/15	Surplus Money Investment Fund (SMIF)	$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%
18/19		644,041,241	2.27%

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

Expected Investment Returns

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

Public Employees' Health Care Fund

The Public Employees' HCF is invested at the State Treasurer's Office in the SMIF and with State Street Global Advisors (SSGA) (see Table 17). 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.

Expected Investment Returns

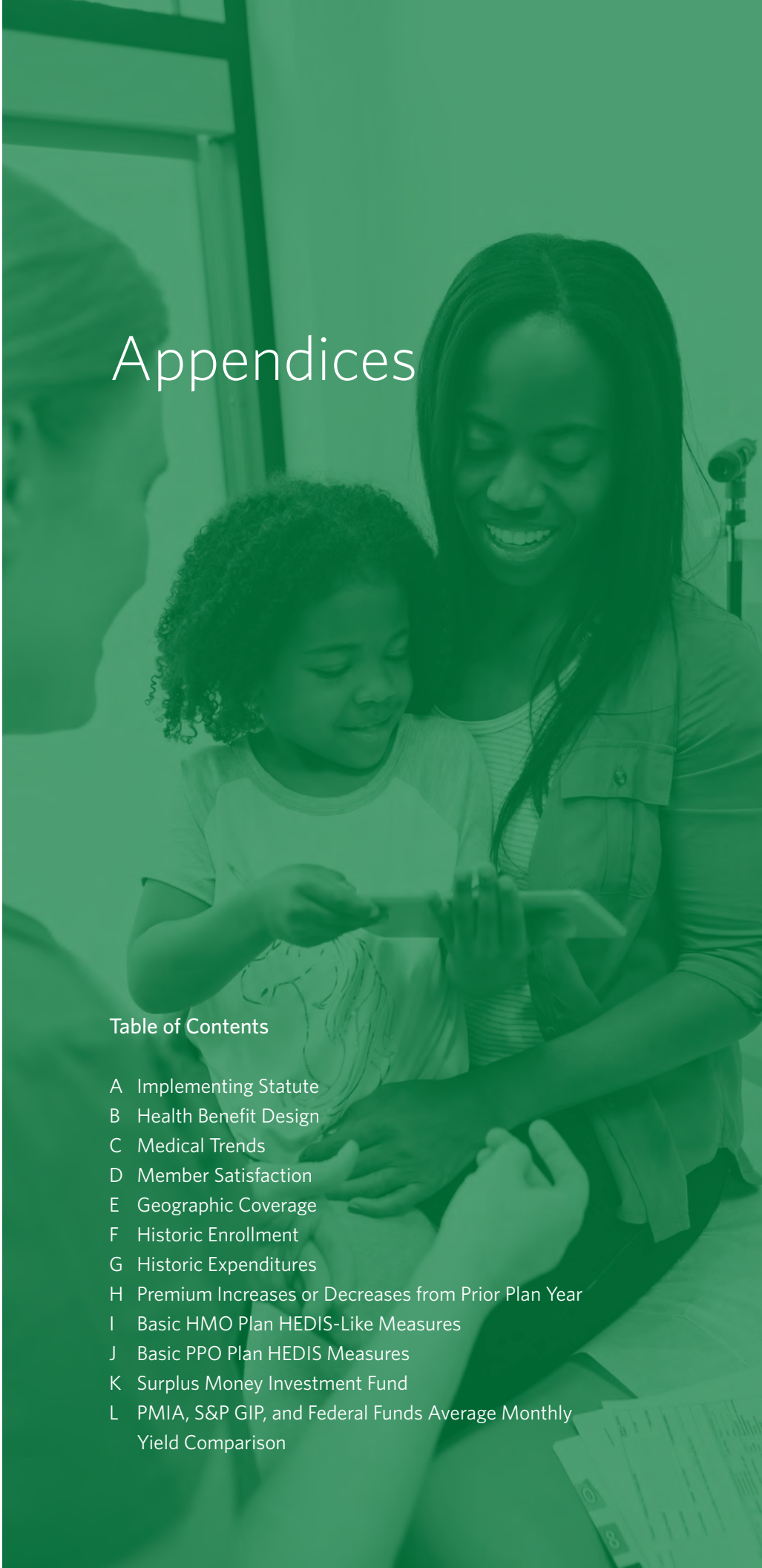
The SSGA U.S. Aggregate Bond Index Fund is passively managed to follow the Bloomberg Barclays U.S. Aggregate Bond Index. While the 10-year historical annualized investment return for the index as of June 30, 2019, is 3.90%, past performance is not a guarantee of future results.

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.

Table 17: Historical Investment Performance of State Street Global Advisors U.S. Aggregate Bond Index Fund, and the Surplus Money Investment Fund*
(Net of Fees)

Fiscal Year End	Allocation	Invested Assets	Annual Return
14/15	State Street Global Advisors (SSGA) U.S. Aggregate Bond Index Fund	$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%)
18/19		478,180,431	7.87%
14/15	Surplus Money Investment Fund (SMIF)	$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%
18/19		371,458,597	2.27%

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



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.

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(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+ HMO & Access+ EPO	Health Net Salud y Más & SmartCare	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	CCPOA (Association Plan)	Western Health Advantage HMO
Calendar Year Deductible								
Individual	N/A	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	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)	$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)	$3,000 (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	N/A
Inpatient	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	$100/ admission	No Charge
Outpatient Facility/ Surgery Service	No Charge	No Charge	No Charge	$15	No Charge	No Charge	$50	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
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	$6,000	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+ HMO & Access+ EPO	Health Net Salud y Más & SmartCare	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	CCPOA (Association Plan)	Western Health Advantage HMO
Emergency Services								
Emergency Room Deductible	N/A	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	$50
Non-Emergency (co-pay waived if admitted as an inpatient or for observation as an outpatient)	$50	$50	$50	$50	$50	$50	$75	$50
Physician Services (including Mental Health and Substance Abuse)								
Office Visits (co-pay for each service provided)	$15	$15	$15	$15	$15	$15	$15	$15
Inpatient Visits	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Outpatient Visits	$15	$15	$15	$15	$15	$15	$15	$15
Urgent Care Visits	$15	$15	$15	$15	$15	$15	$15	$15
Preventive Services	No Charge	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	No Charge
Diagnostic X-Ray/Lab								
	No Charge	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+ HMO & Access+ EPO	Health Net Salud y Más & SmartCare	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	CCPOA (Association Plan)	Western Health Advantage HMO
Prescription Drugs								
Deductible	N/A	N/A	N/A	N/A	N/A	N/A	Tier 2,3, and 4: $50 (not to exceed $150/ family)	N/A
Retail Pharmacy (not to exceed 30-day supply)	Generic: $5 Brand Formulary: $20 Non-Formulary: $50	Generic: $5 Brand Formulary: $20 Non-Formulary: $50	Generic: $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	Tier 1: $10 Tier 2: $25 Tier 3 and 4: $50	Generic: $5 Brand Formulary: $20 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	Tier 1: $10 Tier 2: $25 Tier 3 and 4: $50	Generic: $10 Brand Formulary: $40 Non-Formulary: $100
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	Tier 1: $20 Tier 2: $50 Tier 3 $100	Generic: $10 Brand Formulary: $40 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	$1,000
Durable Medical Equipment								
	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge

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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: $6 Single Source: $25 Multi Source: $35		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: $12 Single Source: $50 Multi Source: $70		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: $12 Single Source: $50 Multi Source: $70		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% (pre-certification required for equipment)	20%	40% (pre-certification required for equipment)	10%	40% (pre-certification required for equipment $1,000 or more)	10%	40%	20%	20%

CalPERS Health Plan Benefit Comparison—Basic Plans, cont.

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

Benefits	EPO & HMO Basic Plans							
	Anthem Blue Cross EPO Select HMO Traditional HMO	Blue Shield Access+ HMO & Access+ EPO	Health Net Salud y Más & SmartCare	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	CCPOA (Association Plan)	Western Health Advantage HMO
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	50% of Covered 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	No Charge
Outpatient (office and home visits)	$15	$15	$15	$15	$15	$15	No Charge	$15
Diabetes Services								
Glucose monitors	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Self-management training	$15	$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	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)
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)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)

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%	50%
Occupational/Physical/Speech Therapy										
Inpatient (hospital or skilled nursing facility)	No Charge		No Charge		No Charge		10%	40%	$20; Speech therapy: 10%	10%
Outpatient (office and home visits)	20% (pre-certification required for more than 24 visits)	40%; Occupational therapy: 20%	20% (pre-certification required for more than 24 visits)	40%; Occupational therapy: 20%	10% (pre-certification required for more than 24 visits)	40%; Occupational therapy: 10%	10% (pre-certification required for more than 24 visits)	40%	$20	10%
Diabetes Services										
Glucose monitors	Coverage Varies		Coverage Varies		Coverage Varies		Coverage Varies		Coverage Varies	
Self-management training	$20	60% non-PPO	$20	60% non-PPO	$20	60% non-PPO	$15	60% non-PPO	$20	60% non-PPO
Acupuncture										
	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40%	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40%	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40%	10% (acupuncture/chiropractic; combined 20 visits per calendar year)	40%	$20 (10% for all other services)	10%
Chiropractic										
	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40%	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40%	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	40%	10% (acupuncture/chiropractic; combined 20 visits per calendar year)	40%	$20/up to 20 visits	10%

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	Anthem Medicare Preferred (PPO)	UnitedHealthcare Group Medicare Advantage (PPO)	CCPOA Medicare Supplement (Association Plan)
Calendar Year Deductible				
Individual	N/A	N/A	N/A	N/A
Family	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/co-insurance)	$1,500 (co-pay)	$1,500 (co-pay)
Family	$3,000 (co-pay)	N/A	N/A	$4,500 (3 or more)
Hospital (including Mental Health and Substance Abuse)				
Inpatient	No Charge	No Charge	No Charge	$100/admission
Outpatient Facility/ Surgery Services	$10	No Charge	No Charge	No Charge
Skilled Nursing Facility				
Medicare (up to 100 days/ benefit period)	No Charge	No Charge	No Charge	No Charge
Home Health Services				
Medicare	No Charge	No Charge	No Charge	$15/visit (up to 100 visits per calendar year)
Hospice				
Medicare	No Charge	No Charge	No Charge	No Charge
Emergency Services				
Medicare (waived if admitted or kept for observation)	$50	$50	$50	No Charge
Ambulance Services				
Medicare	No Charge	No Charge	No Charge	No Charge
Surgery/Anesthesia				
	No Charge inpatient; $10 outpatient	No Charge	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	Anthem Medicare Preferred (PPO)	UnitedHealthcare Group Medicare Advantage (PPO)	CCPOA Medicare Supplement (Association Plan)
Physician Services (including Mental Health and Substance Abuse)				
Office Visits	$10	$10	$10	$10
Inpatient Visits	No Charge	No Charge	No Charge	No Charge
Outpatient Visits	$10	$10	$10	$10
Urgent Care Visits	$10	$25	$25	$10
Preventive Services	No Charge	No Charge	No Charge	No Charge
Diagnostic X-Ray/Lab				
	No Charge	No Charge	No Charge	No Charge
Durable Medical Equipment				
Medicare	No Charge	10% (co-insurance)	No Charge	No Charge
Prescription Drugs				
Deductible	N/A	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: $50	Tier 1: $5 Tier 2: $20 Tier 3: $35 Tier 4 and 5: $50
Retail Pharmacy Long-Term Prescription Medications filled after 2nd fill (i.e. 90-day supply)	N/A	Generic: $10 Preferred: $40 Non-Preferred: $100 (for non-Medicare Part D covered drugs)	Generic: $10 Preferred: $40 Non-Preferred $100	Tier 1: $10 Tier 2: $40 Tier 3: $70 Tier 4 and 5: $150
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 $100	Tier 1: $10 Tier 2: $40 Tier 3: $70 Tier 4 and 5: $150
Mail order maximum co-payment per person per calendar year	N/A	$1,000	$1,000	N/A
Occupational/Physical/Speech Therapy				
Inpatient (hospital or skilled nursing facility)	No Charge	No Charge	No Charge	No Charge
Outpatient (office and home visits)	$10	$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: $6 Single Source: $25 Multi Source: $35	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 30 day supply)		Generic: $10 Preferred: $40 Non-Preferred: $100 (not to exceed 34 day supply)		Generic: $6 Single Source: $25 Multi Source: $35	N/A
Mail Order Pharmacy Program (not to exceed 90-day supply)	Generic: $10 Preferred: $40 Non-Preferred: $100 (for non-Medicare Part D covered drugs)		Generic: $10 Preferred: $40 Non-Preferred: $100 (for non-Medicare Part D covered drugs)		Generic: $10 Preferred: $40 Non-Preferred: $100 (for non-Medicare Part D covered drugs)		Generic: $12 Single Source: $50 Multi Source: $70	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	Anthem Medicare Preferred (PPO)	UnitedHealthcare Group Medicare Advantage (PPO)	CCPOA Medicare Supplement (Association Plan)
Diabetes Services				
Glucose monitors, test strips	No Charge	10% (co-insurance)	No Charge	No Charge
Self-management training	No Charge	No Charge	No Charge	$10
Hearing Services				
Routine Hearing Exam	$10	No Charge	No Charge	No Charge
Physician Services	$10	$10	$10	$15
Hearing Aids	$1,000 max/36 months	$1,000 max/36 months	$1,000 max/36 months	$500 max/member
Vision Care				
Vision Exam	$10	$10	$10	$10
Eyeglasses (following cataract surgery)	No Charge	No Charge	No Charge	No Charge
Contact Lenses (following cataract surgery)	No Charge	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)	$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 (up to 20 visits per calendar year)

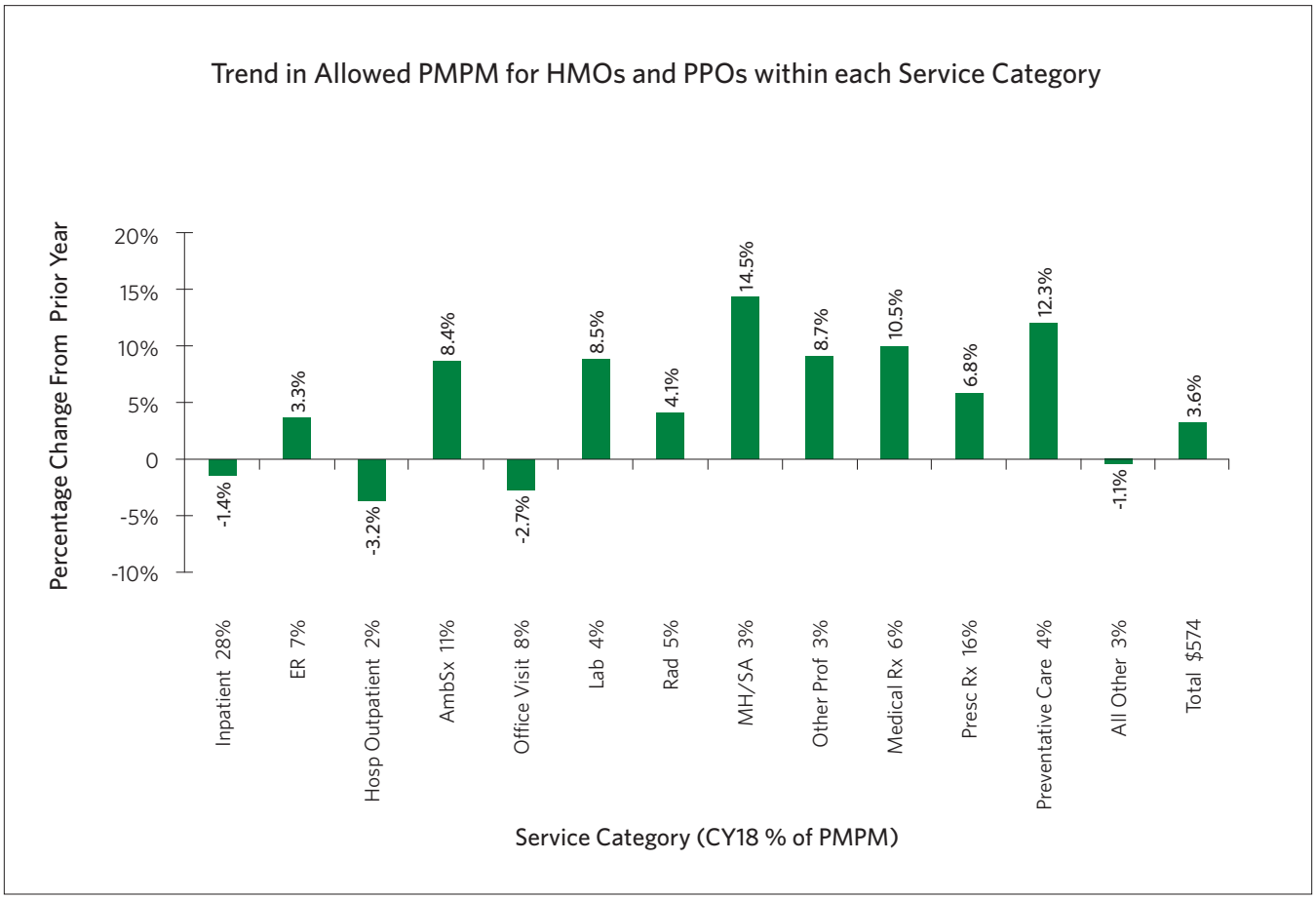
Benefits	Medicare Plans							
	PERS Select		PERS Choice		PERSCare		CAHP Medicare Supplement (Association Plan)	PORAC (Association Plan)
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO		
Diabetes Services								
Glucose monitors, test strips	No Charge		No Charge		No Charge		No Charge	No Charge
Self-management 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)		10% ($1,000 max/ 36 months)	20% ($900 max/ 36 months)
Vision Care								
Vision Exam	One exam per calendar year		One exam per calendar year		One exam per calendar year		N/A	20%
Eyeglasses	One set of frames during a 24-month period; $30 maximum allowance		One set of frames during a 24-month period; $30 maximum allowance		One set of frames during a 24-month period; $30 maximum allowance		No Charge	20%
Contact Lenses	$100 maximum allowance		$100 maximum allowance		$100 maximum allowance		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[13] cost[14] is examined across 13 service categories, revealing the key drivers of medical trend changes for the last year.

The chart below shows the three major drivers that account for 55 percent of the total allowed PMPM are inpatient (28 percent), prescription drugs (Presc Rx) (16 percent), and ambulatory surgery (AmbSx) (11 percent). For individual categories, the largest increase was in Mental Health/Substance Abuse (MH/SA) at 14.5 percent.



Data as of Jun 24, 2019

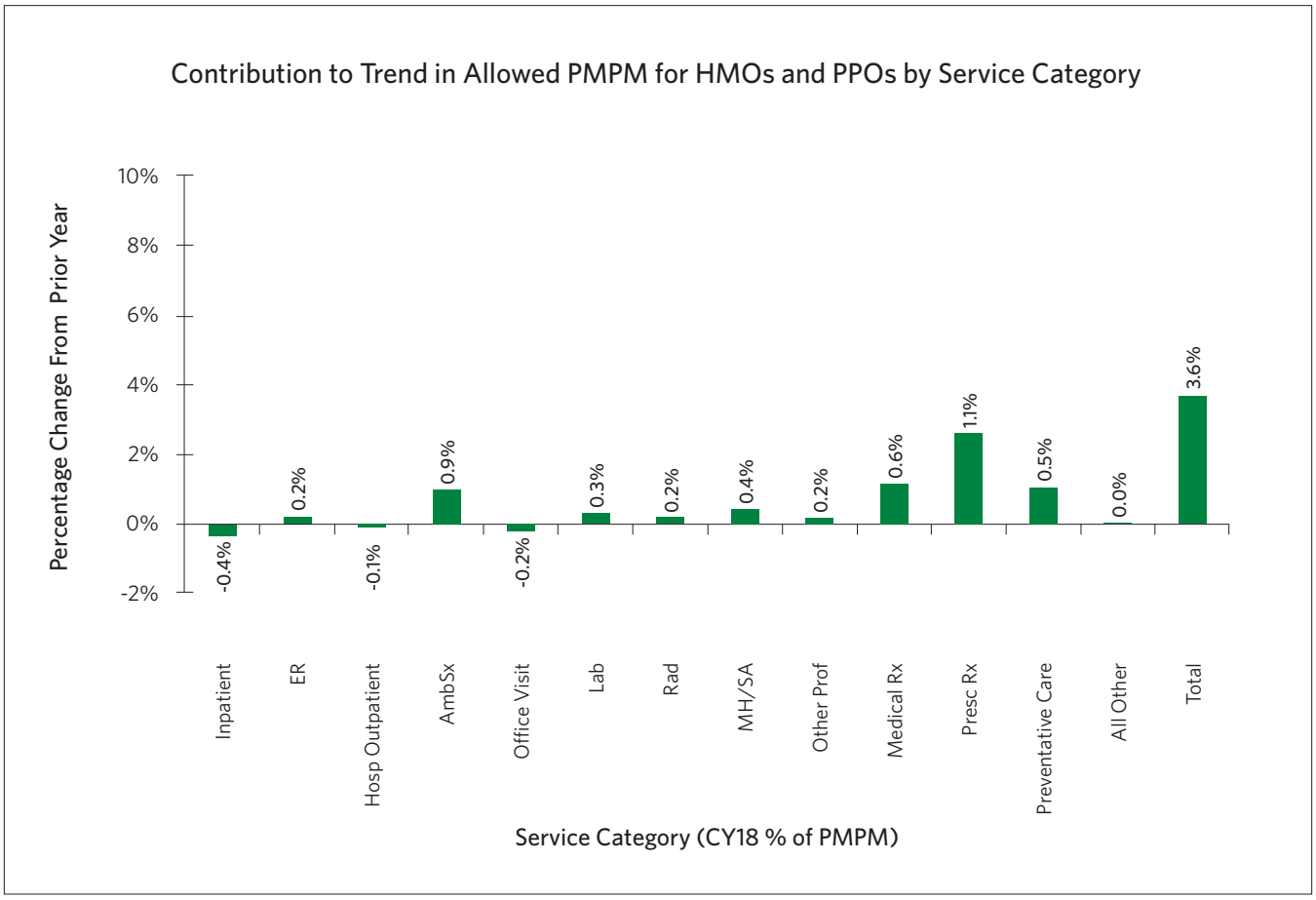
[13] Allowed cost divided by sum of member months in period, adjusted for population size.

[14] 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 2018, the total allowed PMPM increased 3.6 percent across all service categories.

The chart below shows the major drivers that contributed to trend in allowed PMPM for calendar year 2018. Inpatient accounted for -0.4 percent, prescription drug (Presc Rx) was 1.1 percent, and ambulatory surgery (AmbSx) was 0.9 percent.



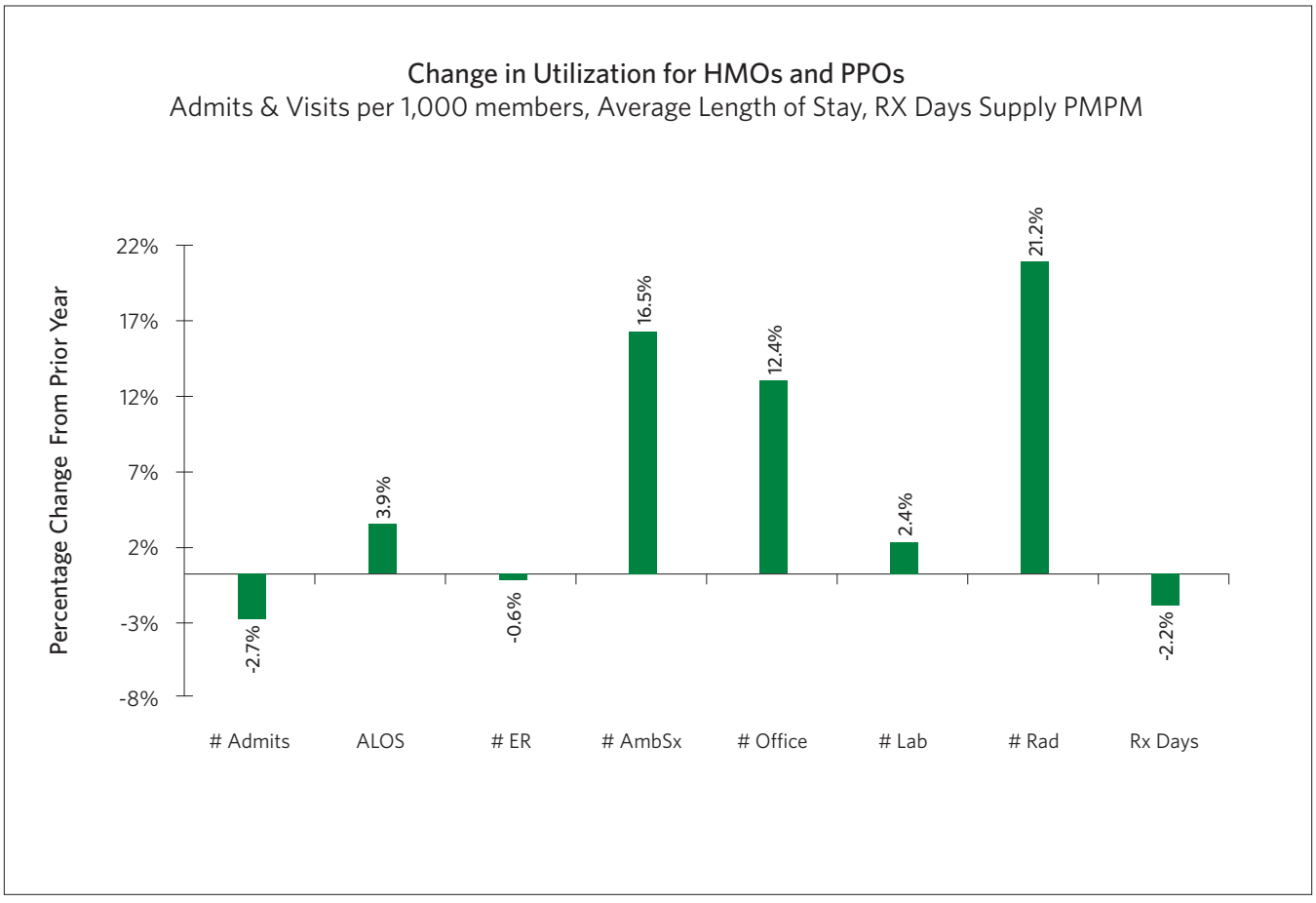
Data as of Jun 24, 2019

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 radiology services (# Rad) by 21.2 percent, number of ambulatory surgeries (# AmbSx) by 16.5 percent, number of office visits (# Office) by 12.4 percent, average length of stay (ALOS) by 3.9 percent, and number of laboratory services (# Lab) by 2.4 percent.
- Decreases in utilization occurred in number of admits (# Admits) by 2.7 percent, prescription drug days (Rx Days) by 2.2 percent, and number of emergency room visits (# ER) by 0.6 percent.

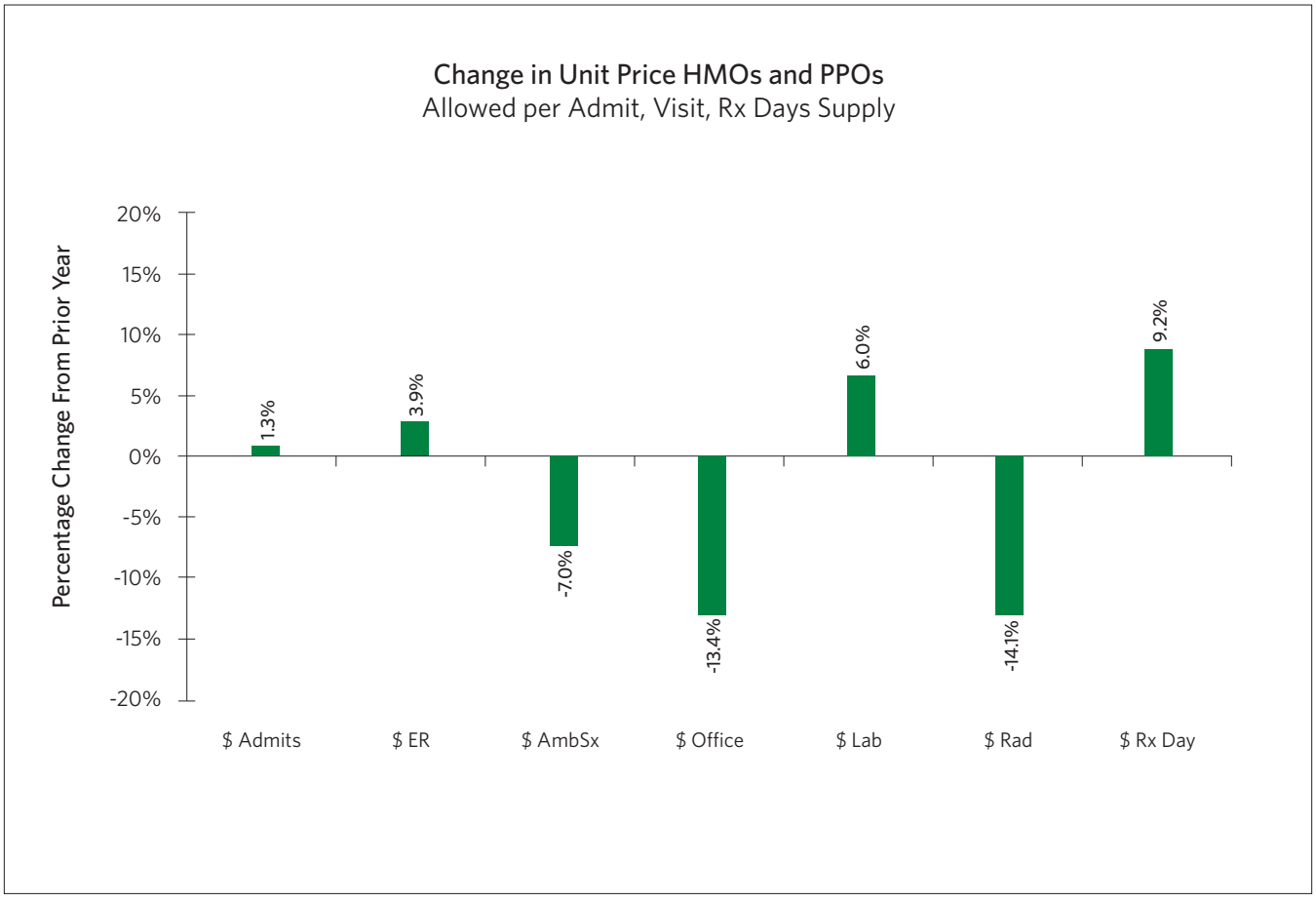


Data as of Jun 24, 2019

Change in Unit Price by Key Service Categories

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

- Unit price increased for prescription drug days ($ RxDay) by 9.2 percent, laboratory services ($ Lab) by 6.0 percent, emergency room visits ($ ER) by 3.9 percent and admissions ($ Admits) by 1.3 percent.
- Unit price decreased for radiology services ($ Rad) by 14.1 percent, office visits ($ Office) by 13.4 percent, and ambulatory surgeries ($ AmbSx) by 7.0 percent.

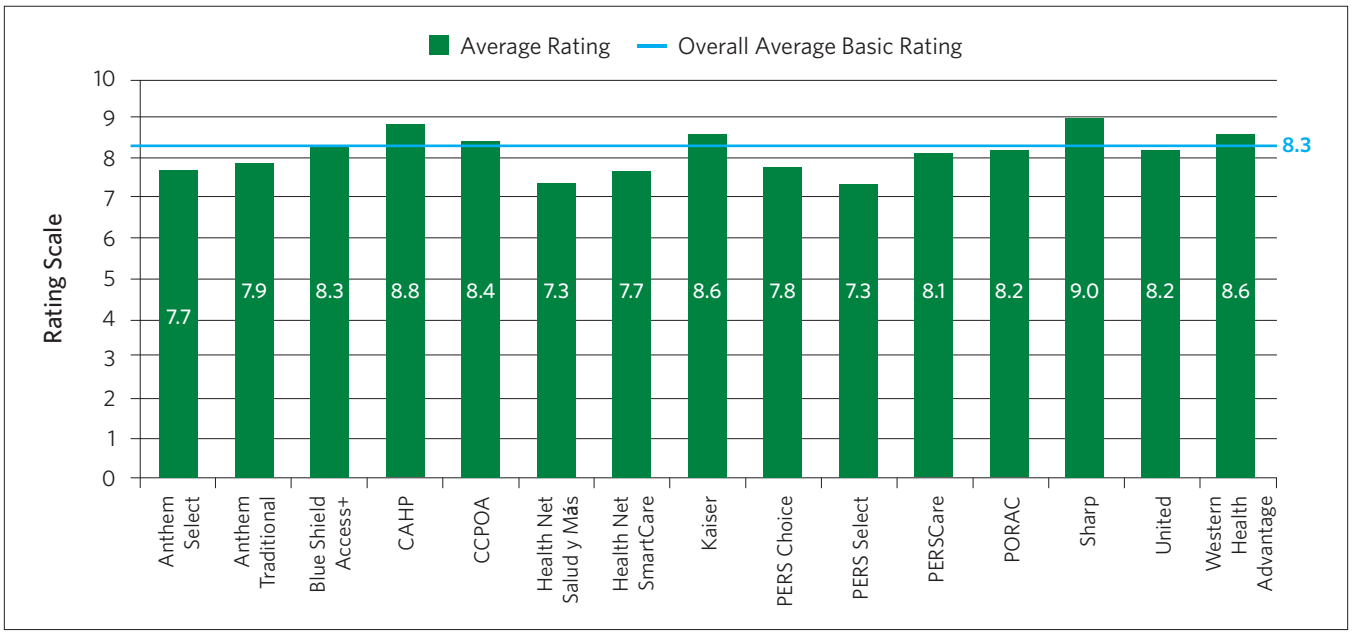


Data as of Jun 24, 2019

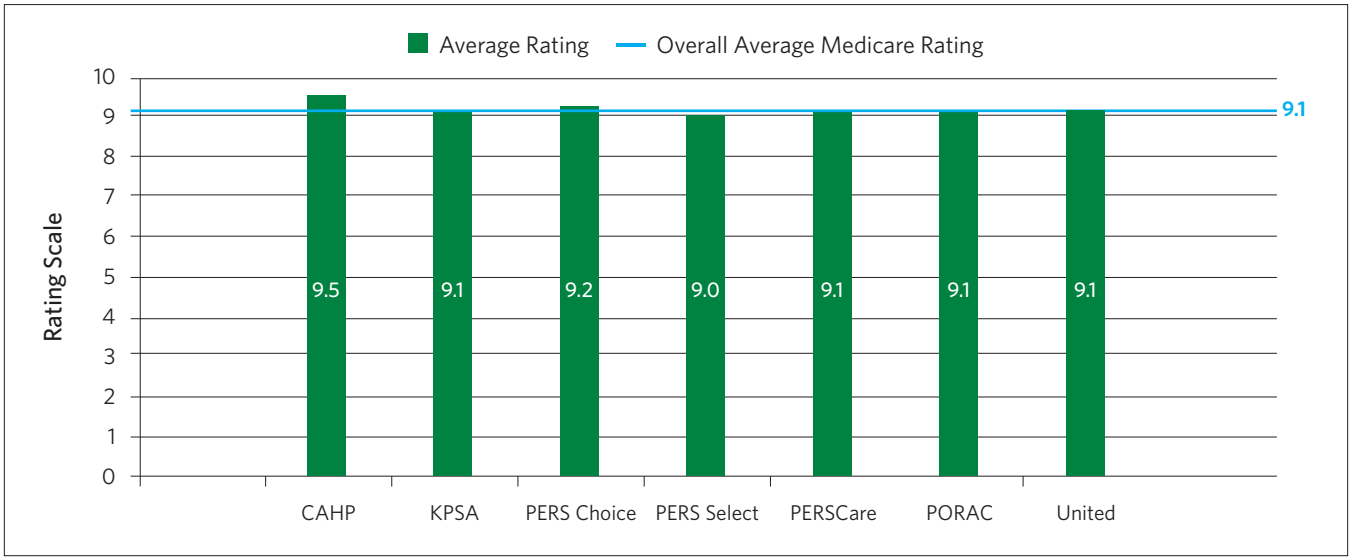
Appendix D – Member Satisfaction

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

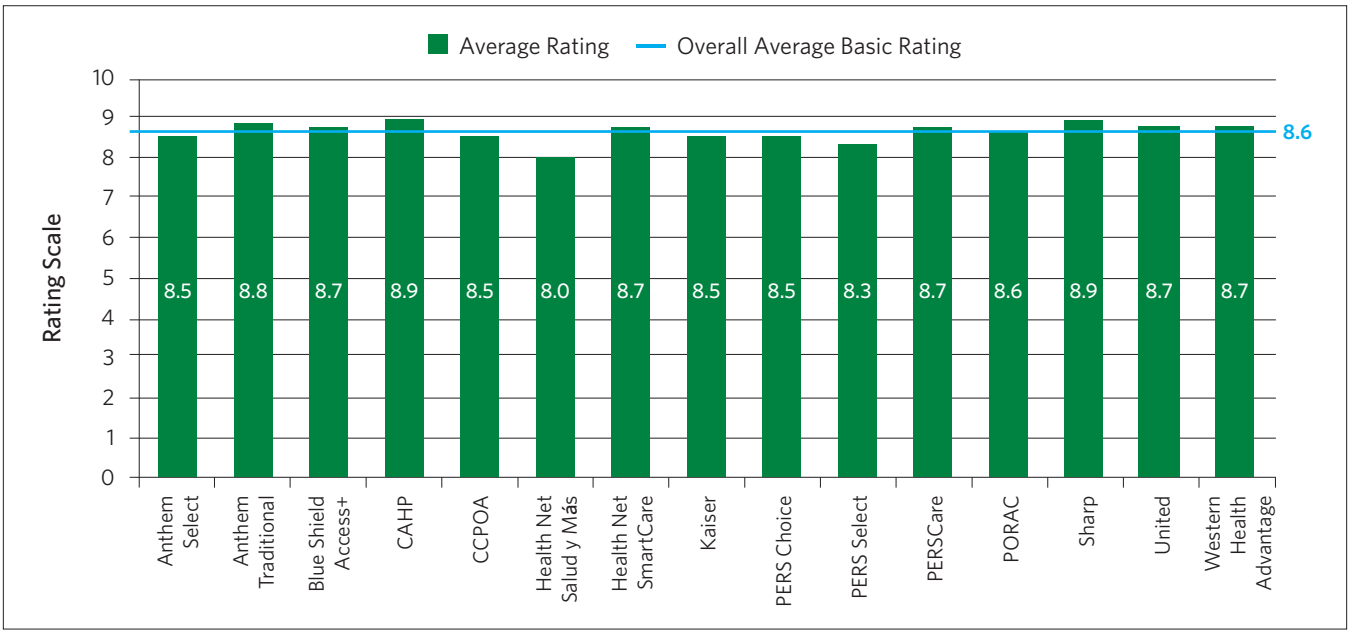


Medicare: Health Plan Satisfaction Ratings

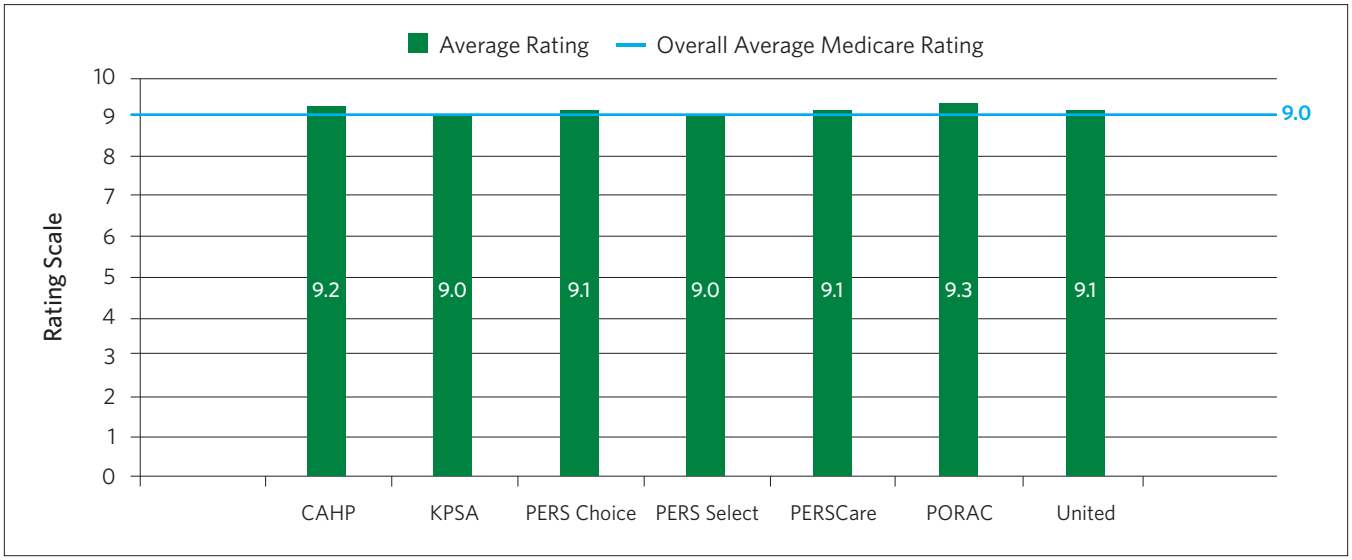


Members were asked: Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?

Basic: Personal Doctor Satisfaction Ratings



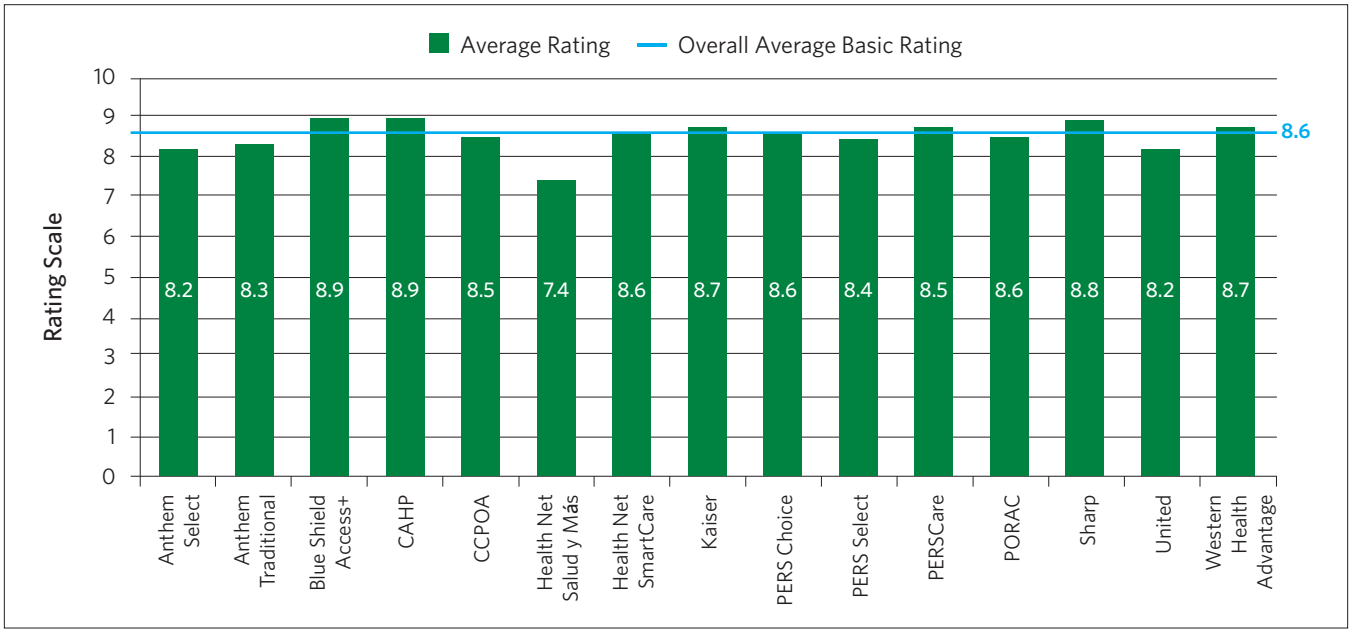
Medicare: Personal Doctor Satisfaction Ratings



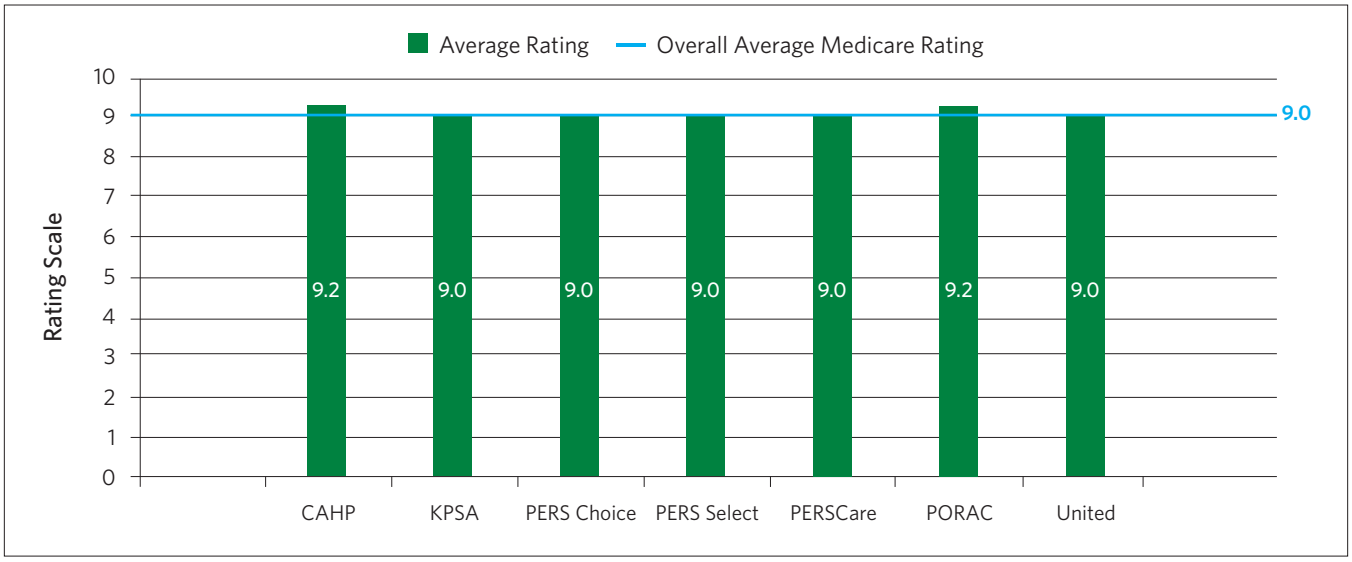
Appendix D – Member Satisfaction, cont.

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

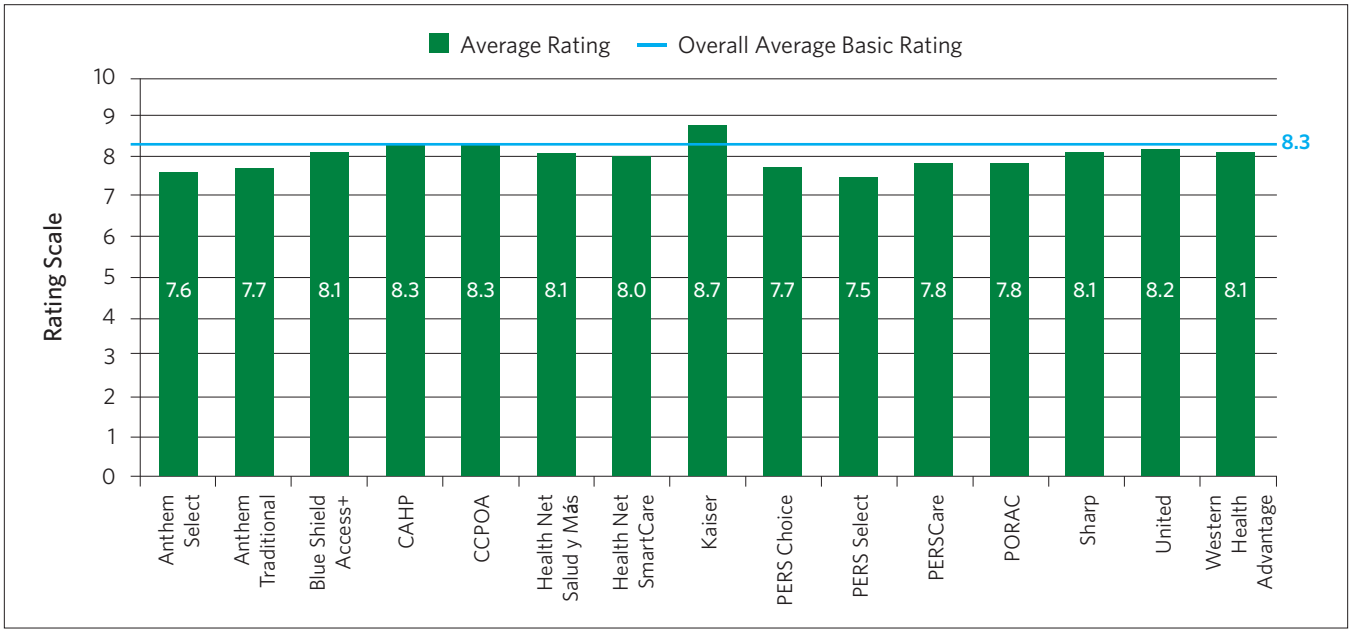


Medicare: Specialist Satisfaction Ratings

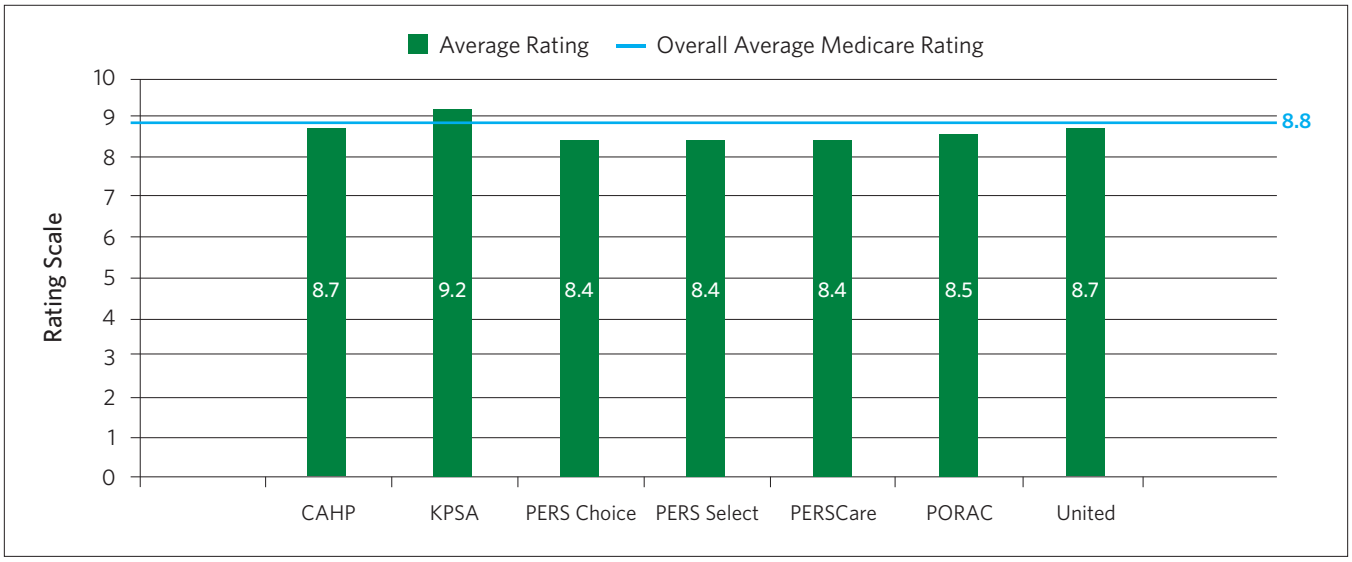


Members were asked: Using any number from 0 to 10, where 0 is the worst pharmacy services possible and 10 is the best pharmacy services possible, what number would you use to rate your overall satisfaction with your pharmacy services (i.e., your experience with obtaining prescriptions from a retail or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

Basic: Pharmacy Services Satisfaction Ratings



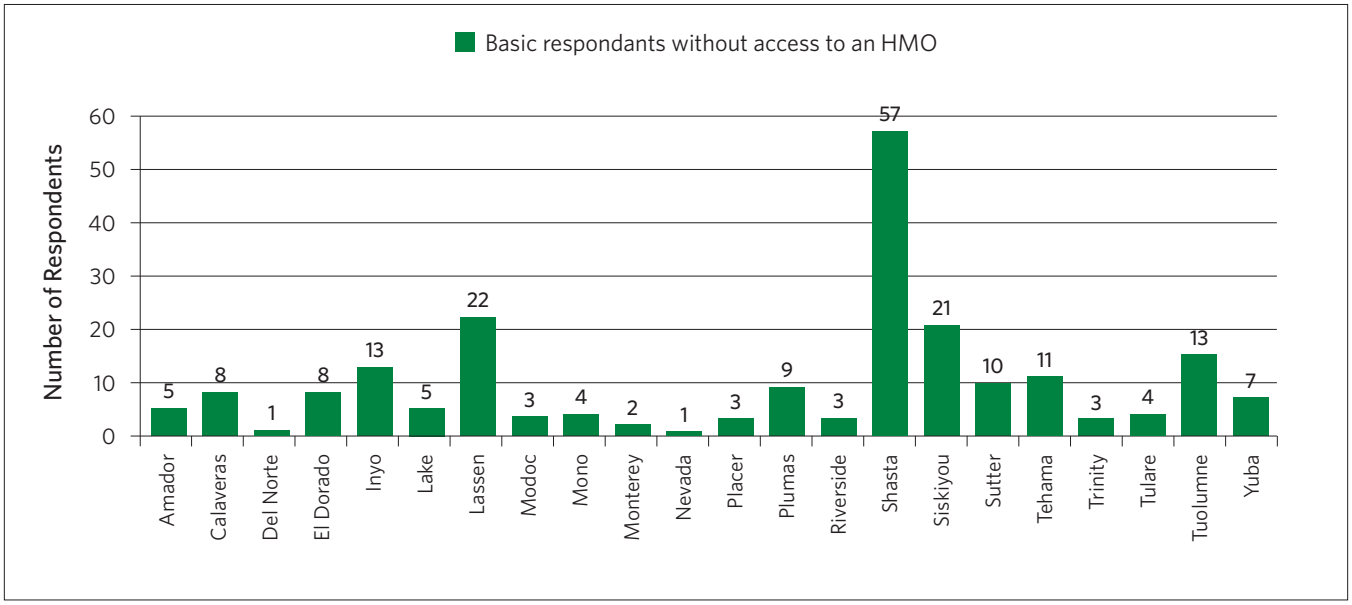
Medicare: Pharmacy Services Satisfaction Ratings



Appendix D – Member Satisfaction, cont.

Rural Area Member Demographics

The chart below shows 213 Basic plan respondents living in a rural area without access to an HMO (by county).



Emergency Room Care

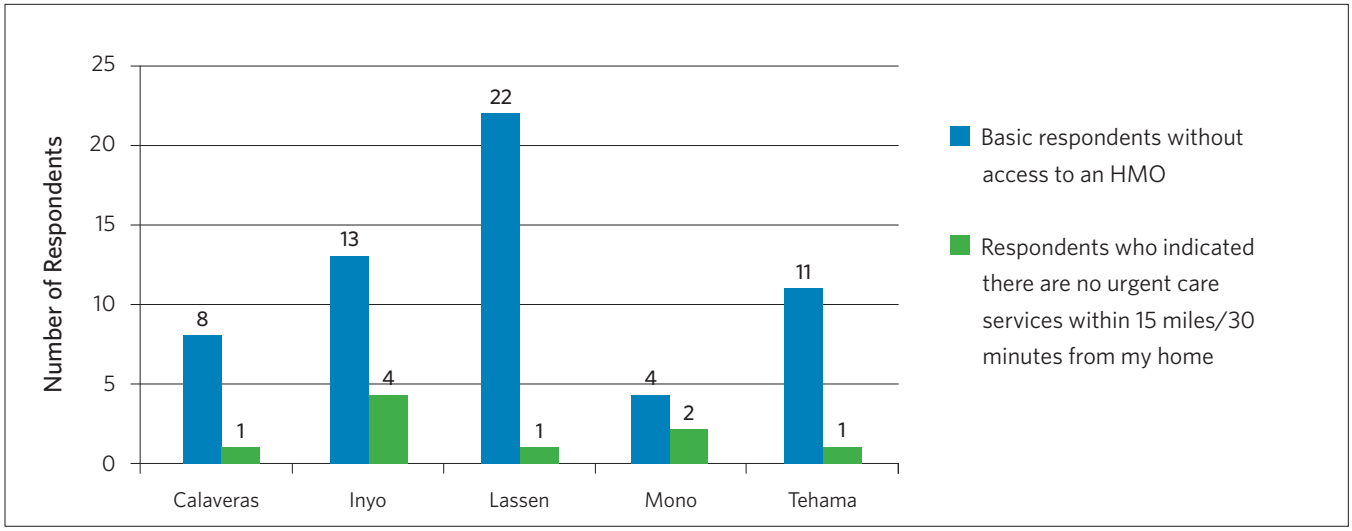
Members were asked:

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

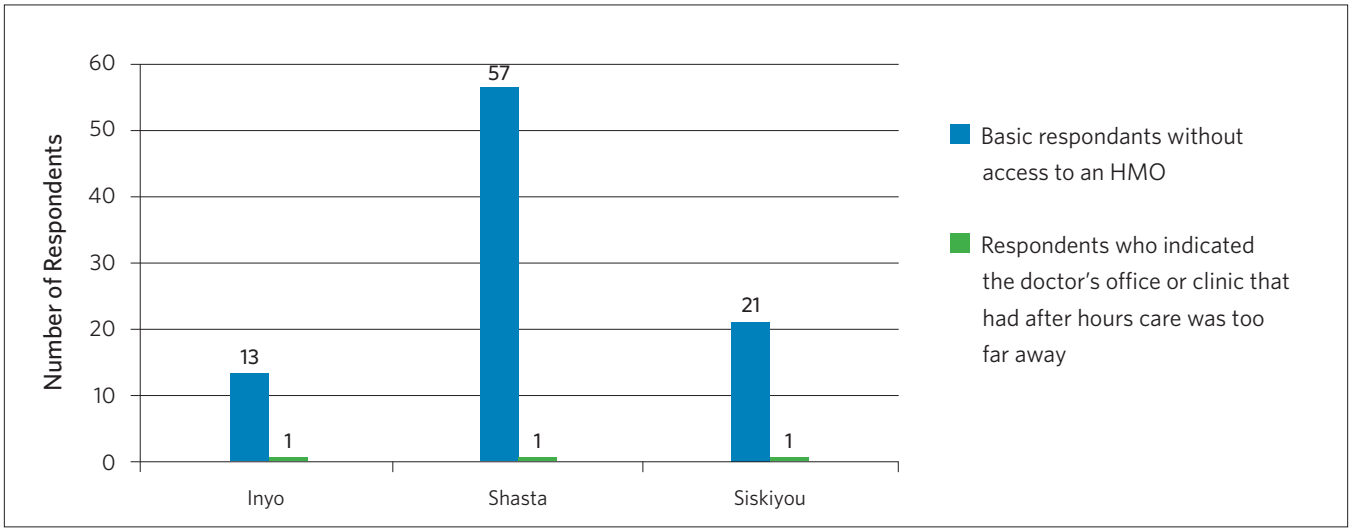
Members were asked:

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+ HMO	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	Western Health Advantage HMO
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+ HMO	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	Western Health Advantage HMO
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										●	▲	●			

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	Anthem Medicare Preferred PPO	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	●	●			●	●	●
Merced	●	●	●		●	●	●
Modoc		●			●	●	●
Mono		●			●	●	●

County	Anthem Medicare Preferred PPO	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
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[15]

	2015	2016	2017	2018
Basic HMO Plan				
Anthem Select HMO	22,401	28,707	29,278	24,059
Anthem Traditional HMO	10,825	15,824	13,576	13,079
Blue Shield Access+	166,860	150,339	163,915	168,998
Blue Shield NetValue	147,275	85,910	—	—
Health Net Salud y Más	2,483	3,528	5,617	8,413
Health Net SmartCare	747	13,356	36,517	19,107
Kaiser	445,527	472,677	502,757	517,206
Kaiser Out-of-State	565	578	573	664
Sharp	7,733	9,555	10,313	11,316
UnitedHealthcare	19,238	51,842	73,258	76,612
Western Health Advantage	—	—	—	5,955
Basic PPO Plan				
Anthem Del Norte EPO	—	88	107	139
Anthem Monterey EPO	1,418	2,592	3,760	—
PERS Choice	177,001	168,492	159,314	151,784
PERS Select	36,699	40,934	46,092	50,168
PERSCare	24,314	28,161	30,926	38,622
Basic Association Plan				
CAHP	28,247	27,972	28,604	28,743
CCPOA North	9,341	9,918	10,705	9,449
CCPOA South	28,575	29,854	31,373	31,582
PORAC	25,884	25,191	24,889	23,718
Basic Total	**1,155,133**	**1,165,518**	**1,171,574**	**1,179,614**
Medicare HMO Plan				
Anthem Select HMO	44	—	—	—
Anthem Traditional HMO	167	—	—	459
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	95,063
Kaiser Out-of-State	1,710	1,812	1,878	2,014
Sharp	87	—	—	—
UnitedHealthcare	446	36,419	38,232	39,631

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

	2015	2016	2017	2018
Medicare PPO Plan				
PERS Choice	60,425	64,959	67,258	69,545
PERS Select	1,275	1,601	1,792	1,939
PERSCare	51,587	56,441	58,361	60,796
Medicare Association Plan				
CAHP	4,142	4,204	4,286	4,343
CCPOA North	327	379	447	511
CCPOA South	399	469	567	626
PORAC	1,801	1,981	2,160	2,265
Medicare Total	**243,020**	**254,930**	**265,786**	**277,192**
Grand Total	**1,398,153**	**1,420,448**	**1,437,360**	**1,456,806**
Program				
State	824,168	835,014	846,175	857,733
Contracting Agency	573,985	585,434	591,185	599,073
Total	**1,398,153**	**1,420,448**	**1,437,360**	**1,456,806**
Employment Status				
Active	967,650	979,210	986,223	994,481
Retired	430,503	441,238	451,137	462,325
Total	**1,398,153**	**1,420,448**	**1,437,360**	**1,456,806**
Subscriber and Dependent Tier				
Single	293,872	303,179	312,386	318,586
2-Party	378,685	386,163	392,805	400,827
Family	725,596	731,106	732,169	737,393
Total	**1,398,153**	**1,420,448**	**1,437,360**	**1,456,806**

Appendix G – Historic Expenditures

Historic Expenditures

Estimated Expenditures (dollars in thousands)*

	2015	2016	2017	2018
Basic HMO Plan				
Anthem Select HMO	$138,374	$187,203	$198,485	$179,429
Anthem Traditional HMO	83,444	124,164	116,810	108,476
Blue Shield Access+	1,084,123	1,038,475	1,282,944	1,183,603
Blue Shield NetValue	861,504	576,156	—	—
Health Net Salud y Más	12,237	17,390	23,380	34,176
Health Net SmartCare	4,898	84,865	223,271	131,035
Kaiser	2,713,433	3,007,829	3,180,572	3,536,700
Kaiser Out-of-State	5,660	5,808	5,919	6,964
Sharp	42,897	51,472	58,848	65,318
UnitedHealthcare	110,717	297,670	440,616	489,667
Western Health Advantage	—	—	—	39,250
Basic PPO Plan				
Anthem Del Norte EPO	192	492	611	814
Anthem Monterey EPO	9,931	20,116	27,852	—
PERS Choice	1,096,068	1,164,269	1,159,173	1,077,571
PERS Select	214,666	261,112	291,357	311,141
PERSCare	187,624	231,797	261,089	301,576
Basic Association Plan				
CAHP	138,874	138,922	140,966	148,809
CCPOA North	54,587	58,268	63,709	61,699
CCPOA South	134,804	141,945	150,087	165,021
PORAC	143,156	152,540	158,212	158,807
Basic Total	**$7,037,189**	**$7,560,493**	**$7,783,901**	**$8,000,056**
Medicare HMO Plan				
Anthem Select HMO	$326	—	—	—
Anthem Traditional HMO	1,008	—	—	2,040
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	360,840
Kaiser Out-of-State	8,192	6,533	6,772	7,645
Sharp	417	—	—	—
UnitedHealthcare	1,677	144,187	148,711	157,284

	2015	2016	2017	2018
Medicare PPO Plan				
PERS Choice	252,652	292,047	285,384	288,701
PERS Select	5,572	7,496	7,604	8,050
PERSCare	228,699	278,656	272,947	278,880
Medicare Association Plan				
CAHP	17,633	17,904	18,109	19,236
CCPOA North	1,874	2,188	2,289	2,760
CCPOA South	2,302	2,708	2,903	3,381
PORAC	9,147	11,014	11,994	13,201
Medicare Total	**$996,290**	**$1,078,497**	**$1,084,112**	**$1,142,018**
Grand Total	**$8,033,479**	**$8,638,990**	**$8,868,013**	**$9,142,074**
Program				
State	$4,679,368	$4,999,974	$5,127,141	$5,292,417
Contracting Agency	3,354,111	3,639,016	3,740,872	3,849,657
Total	**$8,033,479**	**$8,638,990**	**$8,868,013**	**$9,142,074**
Employment Status				
Active	$5,735,181	$6,176,536	$6,375,273	$6,581,150
Retired	2,298,298	2,462,454	2,492,740	2,560,924
Total	**$8,033,479**	**$8,638,990**	**$8,868,013**	**$9,142,074**
Subscriber and Dependent Tier				
Single	$1,932,700	$2,105,208	$2,165,345	$2,231,747
2-Party	2,456,350	2,636,508	2,708,354	2,789,267
Family	3,644,429	3,897,274	3,994,314	4,121,060
Total	**$8,033,479**	**$8,638,990**	**$8,868,013**	**$9,142,074**

* The tables above exclude COBRA expenditures.

Appendix H – Premium Increases or Decreases from Prior Plan Year

2017 and 2018 State Basic Premiums (HMO, PPO, and Association)

Basic		2017			2018			Percent Change (+/-)
		Single	2-Party	Family	Single	2-Party	Family	
HMO	Anthem Select HMO	$740.23	$1,480.46	$1,924.60	$796.73	$1,593.46	$2,071.50	7.63%
	Anthem Traditional HMO	872.91	1,745.82	2,269.57	841.34	1,682.68	2,187.48	-3.62%
	Blue Shield Access+	830.44	1,660.88	2,159.14	752.32	1,504.64	1,956.03	-9.41%
	Health Net Salud y Más	475.46	950.92	1,236.20	471.51	943.02	1,225.93	-0.83%
	Health Net SmartCare	692.89	1,385.78	1,801.51	790.73	1,581.46	2,055.90	14.12%
	Kaiser	662.92	1,325.84	1,723.59	717.38	1,434.76	1,865.19	8.22%
	Kaiser Out-of-State	940.67	1,881.34	2,445.74	957.05	1,914.10	2,488.33	1.74%
	Sharp	616.49	1,232.98	1,602.87	624.70	1,249.40	1,624.22	1.33%
	UnitedHealthcare	686.17	1,372.34	1,784.04	704.59	1,409.18	1,831.93	2.68%
	Western Health Advantage	—	—	—	720.44	1,440.88	1,873.14	—
PPO	Anthem Del Norte EPO	740.88	1,481.76	1,926.29	724.16	1,448.32	1,882.82	-2.26%
	Anthem Monterey EPO	740.88	1,481.76	1,926.29	—	—	—	—
	PERS Choice	740.88	1,481.76	1,926.29	724.16	1,448.32	1,882.82	-2.26%
	PERS Select	673.25	1,346.50	1,750.45	661.29	1,322.58	1,719.35	-1.78%
	PERSCare	826.37	1,652.74	2,148.56	776.19	1,552.38	2,018.09	-6.07%
Association	CAHP	620.79	1,205.17	1,576.26	651.83	1,265.43	1,655.07	5.00%
	CCPOA North	691.50	1,385.69	1,870.73	752.64	1,508.47	2,036.58	8.86%
	CCPOA South	570.26	1,143.15	1,544.60	620.63	1,244.40	1,681.49	8.86%
	PORAC	699.00	1,467.00	1,876.00	734.00	1,540.00	1,970.00	5.00%

2017 and 2018 State Medicare Premiums (HMO, PPO, and Association)

Medicare		2017			2018			Percent Change (+/-)
		Single	2-Party	Family	Single	2-Party	Family	
HMO	Anthem Traditional HMO	—	—	—	$370.34	$740.68	$1,111.02	—
	Kaiser	$300.48	$600.96	$901.44	316.34	632.68	949.02	5.28%
	Kaiser Out-of-State	300.48	600.96	901.44	316.34	632.68	949.02	5.28%
	UnitedHealthcare	324.21	648.42	972.63	330.76	661.52	992.28	2.02%
PPO	PERS Choice	353.63	707.26	1,060.89	345.97	691.94	1,037.91	-2.17%
	PERS Select	353.63	707.26	1,060.89	345.97	691.94	1,037.91	-2.17%
	PERSCare	389.76	779.52	1,169.28	382.30	764.60	1,146.90	-1.91%
Association	CAHP	372.00	688.00	874.00	391.00	722.00	918.00	4.99%
	CCPOA	426.09	853.95	1,277.05	449.40	900.84	1,347.25	5.48%
	PORAC	464.00	924.00	1,477.00	487.00	970.00	1,551.00	4.97%

Total Percent Change for Basic and Medicare Combined

Total PPO Change from 2017 to 2018	-2.39%
Total HMO Change from 2017 to 2018	3.75%
Total Association Change from 2017 to 2018	6.51%
Total Change	**2.33%**

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

2017 and 2018 Regional Contracting Agencies Premiums Basic (HMO, PPO, and Association)

Basic		2017			2018			Percent Change (+/-)
		Single	2-Party	Family	Single	2-Party	Family	
Basic Premium Rates - Bay Area — Alameda, Amador, Contra Costa, Marin, Napa, Nevada, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Sutter, and Yuba								
HMO	Anthem Select HMO	$783.46	$1,566.92	$2,037.00	$856.41	$1,712.82	$2,226.67	9.31%
	Anthem Traditional HMO	990.05	1,980.10	2,574.13	925.47	1,850.94	2,406.22	-6.52%
	Blue Shield Access+	1,024.85	2,049.70	2,664.61	889.02	1,778.04	2,311.45	-13.25%
	Health Net SmartCare	733.29	1,466.58	1,906.55	863.48	1,726.96	2,245.05	17.75%
	Kaiser	733.39	1,466.78	1,906.81	779.86	1,559.72	2,027.64	6.34%
	UnitedHealthcare	1,062.26	2,124.52	2,761.88	1,371.84	2,743.68	3,566.78	29.14%
	Western Health Advantage	—	—	—	792.56	1,585.12	2,060.66	—
PPO	PERS Choice	830.30	1,660.60	2,158.78	800.27	1,600.54	2,080.70	-3.62%
	PERS Select	736.27	1,472.54	1,914.30	717.50	1,435.00	1,565.50	-2.55%
	PERSCare	932.39	1,864.78	2,424.21	882.45	1,764.90	2,294.37	-5.36%
Association	PORAC	699.00	1,467.00	1,876.00	734.00	1,540.00	1,970.00	5.00%

Basic		2017			2018			Percent Change (+/-)
		Single	2-Party	Family	Single	2-Party	Family	
Basic Premium Rates - Sacramento Area — El Dorado, Placer, Sacramento, and Yolo								
HMO	Anthem Select HMO	$907.08	$1,814.16	$2,358.41	$942.29	$1,884.58	$2,449.95	3.88%
	Anthem Traditional HMO	1,286.41	2,572.82	3,344.67	1,054.62	2,109.24	2,742.01	-18.02%
	Blue Shield Access+	859.42	1,718.84	2,234.49	806.71	1,613.42	2,097.45	-6.13%
	Health Net SmartCare	672.66	1,345.32	1,748.92	980.82	1,961.64	2,550.13	45.81%
	Kaiser	690.56	1,381.12	1,795.46	703.96	1,407.92	1,830.30	1.94%
	UnitedHealthcare	756.78	1,513.56	1,967.63	831.42	1,662.84	2,161.69	9.86%
	Western Health Advantage	—	—	—	744.79	1,489.58	1,936.45	—
PPO	PERS Choice	723.47	1,446.94	1,881.02	735.38	1,470.76	1,911.99	1.65%
	PERS Select	641.47	1,282.94	1,667.82	684.90	1,369.80	1,780.74	6.77%
	PERSCare	812.40	1,624.80	2,112.24	797.61	1,595.22	2,073.79	-1.82%
Association	PORAC	699.00	1,467.00	1,876.00	734.00	1,540.00	1,970.00	5.00%

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

2017 and 2018 Regional Contracting Agencies Premiums Basic (HMO, PPO, and Association), cont.

Basic		2017			2018			Percent Change (+/-)
		Single	2-Party	Family	Single	2-Party	Family	
Basic Premium Rates - Los Angeles Area — Los Angeles, San Bernardino, and Ventura								
HMO	Anthem Select HMO	$592.78	$1,185.56	$1,541.23	$660.17	$1,320.34	$1,716.44	11.37%
	Anthem Traditional HMO	713.69	1,427.38	1,855.59	784.72	1,569.44	2,040.27	9.95%
	Blue Shield Access+	675.98	1,351.96	1,757.55	613.29	1,226.58	1,594.55	- 9.27%
	Health Net Salud y Más	414.79	829.58	1,078.45	404.32	808.64	1,051.23	-2.52%
	Health Net SmartCare	526.73	1,053.46	1,369.50	577.15	1,154.30	1,500.59	9.57%
	Kaiser	573.89	1,147.78	1,492.11	642.70	1,285.40	1,671.02	11.99%
	UnitedHealthcare	545.71	1,091.42	1,418.85	602.78	1,205.56	1,567.23	10.46%
PPO	PERS Choice	637.53	1,275.06	1,657.58	620.39	1,240.78	1,613.01	-2.69%
	PERS Select	565.33	1,130.66	1,469.86	573.21	1,146.42	1,409.35	1.39%
	PERSCare	715.88	1,431.76	1,861.29	673.73	1,347.46	1,751.70	-5.89%
Association	PORAC	699.00	1,467.00	1,876.00	734.00	1,540.00	1,970.00	5.00%

Basic		2017			2018			Percent Change (+/-)
		Single	2-Party	Family	Single	2-Party	Family	
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 Select HMO	$659.03	$1,318.06	$1,713.48	$659.69	$1,319.38	$1,715.19	0.10%
	Anthem Traditional HMO	799.15	1,598.30	2,077.79	735.08	1,470.16	1,911.21	-8.02%
	Blue Shield Access+	778.45	1,556.90	2,023.97	695.97	1,391.94	1,809.52	-10.60%
	Health Net Salud y Más	473.46	946.92	1,231.00	461.56	923.12	1,200.06	-2.51%
	Health Net SmartCare	537.20	1,074.40	1,396.72	607.68	1,215.36	1,579.97	13.12%
	Kaiser	599.54	1,199.08	1,558.80	666.80	1,333.60	1,733.68	11.22%
	Sharp	614.46	1,228.92	1,597.60	618.14	1,236.28	1,607.16	0.60%
	UnitedHealthcare	549.76	1,099.52	1,429.38	616.66	1,233.32	1,603.32	12.17%
PPO	PERS Choice	714.43	1,428.86	1,857.52	698.96	1,397.92	1,817.30	-2.17%
	PERS Select	633.46	1,266.92	1,647.00	654.74	1,309.48	1,702.32	3.36%
	PERSCare	802.24	1,604.48	2,085.82	733.50	1,467.00	1,907.10	-8.57%
Association	PORAC	699.00	1,467.00	1,876.00	734.00	1,540.00	1,970.00	5.00%

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

2017 and 2018 Regional Contracting Agencies Premiums Basic (HMO, PPO, and Association), cont.

Basic		2017			2018			Percent Change (+/-)
		Single	2-Party	Family	Single	2-Party	Family	
Basic Premium Rates - Other Northern California — Alpine, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Plumas, San Benito, Shasta, Sierra, Siskiyou, Stanislaus, Tehama, Trinity, and Tuolumne								
HMO	Anthem Select HMO	$892.13	$1,784.26	$2,319.54	$910.90	$1,821.80	$2,368.34	2.10%
	Anthem Traditional HMO	1,169.87	2,339.74	3,041.66	954.75	1,909.50	2,482.35	-18.39%
	Blue Shield Access+	954.51	1,909.02	2,481.73	894.43	1,788.86	2,325.52	-6.29%
	Kaiser	733.99	1,467.98	1,908.37	795.43	1,590.86	2,068.12	8.37%
	UnitedHealthcare	882.35	1,764.70	2,294.11	1,205.55	2,411.10	3,134.43	36.63%
	Western Health Advantage	—	—	—	744.79	1,489.58	1,936.45	—
PPO	Anthem Del Norte EPO	820.38	1,640.76	2,132.99	813.96	1,627.92	2,116.30	-0.78%
	Anthem Monterey EPO	820.38	1,640.76	2,132.99	—	—	—	—
	PERS Choice	820.38	1,640.76	2,132.99	813.96	1,627.92	2,116.30	-0.78%
	PERS Select	727.45	1,454.90	1,891.37	691.78	1,383.56	1,798.63	-4.90%
	PERSCare	921.24	1,842.48	2,395.22	866.93	1,733.86	2,254.02	-5.90%
Association	PORAC	699.00	1,467.00	1,876.00	734.00	1,540.00	1,970.00	5.00%
Basic Premium Rates – Out-of-State								
HMO	Kaiser Out-of-State	$940.67	$1,881.34	$2,445.74	$957.05	$1,914.10	$2,488.33	1.74%
PPO	PERS Choice	675.61	1,351.22	1,756.59	661.45	1,322.90	1,719.77	-2.10%
	PERSCare	758.69	1,517.38	1,972.59	718.98	1,437.96	1,869.35	-5.23%
Association	PORAC	699.00	1,467.00	1,876.00	734.00	1,540.00	1,970.00	5.00%

2017 and 2018 Regional Contracting Agency Premiums Medicare (HMO, PPO, and Association)

Medicare		2017			2018			Percent Change (+/-)
		Single	2-Party	Family	Single	2-Party	Family	
HMO	Anthem Traditional HMO	—	—	—	$370.34	$740.68	$1,111.02	—
	Kaiser	$300.48	$600.96	$901.44	316.34	632.68	949.02	5.28%
	Kaiser Out-of-State	300.48	600.96	901.44	316.34	632.68	949.02	5.28%
	UnitedHealthcare	324.21	648.42	972.63	330.76	661.52	992.28	2.02%
PPO	PERS Choice	353.63	707.26	1,060.89	345.97	691.94	1,037.91	-2.17%
	PERS Select	353.63	707.26	1,060.89	345.97	691.94	1,037.91	-2.17%
	PERSCare	389.76	779.52	1,169.28	382.30	764.60	1,146.90	-1.91%
Association	PORAC	464.00	924.00	1,477.00	487.00	970.00	1,551.00	4.97%

Appendix I – Basic HMO Plan HEDIS-Like Measures

Measure	Anthem HMO	BSC	KP North**	KP South**
Prevention and Screening				
Adult BMI Assessment*	42.2%	85.6%	95.3%	98.4%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents — BMI percentile (Total)*	9.2%	64.5%	99.1%	99.1%
Childhood Immunization Status — Combination 3*	43.7%	75.2%	88.8%	85.2%
Childhood Immunization Status — Combination 10*	30.8%	48.9%	69.5%	69.5%
Immunizations for Adolescents — Meningococcal*	73.9%	81.8%	90.4%	88.2%
Immunizations for Adolescents — Tdap/Td*	89.7%	94.4%	94.2%	93.6%
Immunizations for Adolescents — Combination 1*	70.4%	80.1%	89.5%	89.5%
Breast Cancer Screening — Total	79.6%	77.1%	87.4%	87.4%
Cervical Cancer Screening*	75.4%	77.3%	90.3%	90.3%
Colorectal Cancer Screening*	56.8%	71.7%	82.1%	82.1%
Chlamydia Screening in Women — Total	51.4%	51.7%	70.4%	72.5%
Respiratory Conditions				
Appropriate Treatment for Children with Pharyngitis	79.7%	75.0%	93.3%	94.5%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	44.2%	29.6%	50.1%	81.0%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	37.5%	32.7%	46.8%	76.3%
Pharmacotherapy Management of COPD Exacerbation — Systemic Corticosteroid	65.0%	70.8%	90.6%	87.6%
Pharmacotherapy Management of COPD Exacerbation — Bronchodilator	85.0%	78.1%	92.7%	96.3%
Cardiovascular Conditions				
Persistence of Beta-Blocker Treatment after a Heart Attack	79.2%	85.2%	93.5%	93.5%
Diabetes				
Comprehensive Diabetes Care — HbA1c Testing*	87.4%	91.7%	94.8%	94.8%
Comprehensive Diabetes Care — HbA1c Control (<8%)*	43.8%	65.5%	68.4%	68.4%
Comprehensive Diabetes Care — Eye Exams*	41.6%	52.7%	76.6%	76.6%
Comprehensive Diabetes Care — Medical Attention for Nephropathy*	90.3%	94.7%	92.7%	92.7%
Musculoskeletal Conditions				
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	80.4%	83.6%	91.1%	96.3%
Overuse/Appropriateness				
Use of Imaging Studies for Low Back Pain	85.0%	79.4%	86.3%	86.3%

Measure	Anthem HMO	BSC	KP North**	KP South**
Behavioral Health				
Antidepressant Medication Management — Effective Acute Phase Treatment	65.1%	63.9%	77.4%	77.4%
Antidepressant Medication Management — Effective Continuation Phase Treatment	50.3%	50.1%	53.9%	53.9%
Follow Up Care for Children Prescribed ADHD Medication — Initiation Phase	41.8%	47.4%	52.8%	56.9%
Follow Up Care for Children Prescribed ADHD Medication — Continuation & Maintenance Phase	53.3%	54.3%	55.0%	61.0%
Follow Up after Hospitalization for Mental Illness — 7-days	40.2%	46.9%	71.6%	74.7%
Follow Up after Hospitalization for Mental Illness — 30-days	60.9%	67.0%	84.3%	83.7%
Medication Management				
Annual Monitoring for Patients on Persistent Medications — ACEIs or ARBs	84.1%	85.1%	88.5%	86.1%
Annual Monitoring for Patients on Persistent Medications — Diuretics	83.5%	85.1%	86.6%	84.4%
Annual Monitoring for Patients on Persistent Medications — Total	83.9%	85.1%	87.8%	85.5%
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment — Initiation — Total	38.8%	30.6%	50.2%	40.0%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment — Engagement — Total	12.4%	7.6%	23.6%	22.5%
Prenatal and Postpartum Care — Timeliness of Prenatal Care*	59.7%	56.3%	97.7%	94.4%
Prenatal and Postpartum Care — Postpartum Care*	39.1%	45.6%	89.5%	90.0%

* "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.

**Kaiser percentages that are equal in value represent the combined average for Kaiser North and South.

Notes:

- The measures presented are from HEDIS® 2018 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 2018, 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 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*	31.1%	27.0%	25.4%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents — BMI percentile (Total)*	8.3%	9.2%	8.5%
Childhood Immunization Status — Combination 3*	45.5%	43.8%	46.4%
Childhood Immunization Status — Combination 10*	32.0%	29.5%	25.3%
Immunizations for Adolescents — Meningococcal*	64.1%	65.8%	59.6%
Immunizations for Adolescents — Tdap/Td*	84.1%	86.0%	85.6%
Immunizations for Adolescents — Combination 1*	61.0%	63.8%	57.4%
Breast Cancer Screening	74.7%	71.6%	66.4%
Cervical Cancer Screening*	73.5%	71.9%	72.2%
Colorectal Cancer Screening*	60.9%	63.4%	54.9%
Chlamydia Screening in Women — Total	48.0%	45.6%	42.6%
Respiratory Conditions			
Appropriate Treatment for Children with Pharyngitis	75.6%	76.4%	69.2%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	43.3%	35.5%	30.8%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	38.2%	32.1%	30.9%
Pharmacotherapy Management of COPD Exacerbation — Systemic Corticosteroid	73.3%	59.5%	58.3%
Pharmacotherapy Management of COPD Exacerbation — Bronchodilator	93.3%	78.6%	75.0%
Cardiovascular Conditions			
Persistence of Beta-Blocker Treatment after a Heart Attack	69.2%	89.0%	70.8%
Diabetes			
Comprehensive Diabetes Care — HbA1c Testing*	88.7%	87.6%	86.8%
Comprehensive Diabetes Care — HbA1c Control (<8%)*	36.0%	32.6%	34.0%
Comprehensive Diabetes Care — Eye Exams*	44.6%	40.2%	38.8%
Comprehensive Diabetes Care — Medical Attention for Nephropathy*	89.5%	87.3%	83.7%
Musculoskeletal Conditions			
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	82.6%	81.9%	78.3%
Overuse/Appropriateness			
Use of Imaging Studies for Low Back Pain	81.1%	83.7%	83.2%

Measure	PERSCare	PERS Choice	PERS Select
Behavioral Health			
Antidepressant Medication Management — Effective Acute Phase Treatment	75.4%	69.3%	68.6%
Antidepressant Medication Management — Effective Continuation Phase Treatment	60.5%	56.1%	52.6%
Follow Up Care for Children Prescribed ADHD Medication — Initiation Phase	32.3%	36.0%	31.8%
Follow Up Care for Children Prescribed ADHD Medication — Continuation & Maintenance Phase	33.3%	37.5%	46.7%
Follow Up after Hospitalization for Mental Illness — 7-days	44.8%	39.2%	35.8%
Follow Up after Hospitalization for Mental Illness — 30-days	64.8%	63.9%	54.7%
Medication Management			
Annual Monitoring for Patients on Persistent Medications — ACEIs or ARBs	85.2%	83.1%	76.2%
Annual Monitoring for Patients on Persistent Medications — Diuretics	85.4%	83.2%	76.0%
Annual Monitoring for Patients on Persistent Medications — Total	85.3%	83.1%	76.1%
Access/Availability of Care			
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment — Initiation — Total	31.8%	31.9%	33.2%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment — Engagement — Total	11.4%	11.8%	13.1%
Prenatal and Postpartum Care — Timeliness of Prenatal Care*	64.6%	68.4%	65.2%
Prenatal and Postpartum Care — Postpartum Care*	41.1%	39.4%	37.9%

* "Hybrid measure" for which additional information is gathered from patients' medical records, however, only administrative data is currently being reported.

Notes:

- Unlike the HMO "HEDIS-like" measures, the PPO measures are audited and therefore satisfy HEDIS requirements.
- The measures presented are from HEDIS® 2018 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 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.

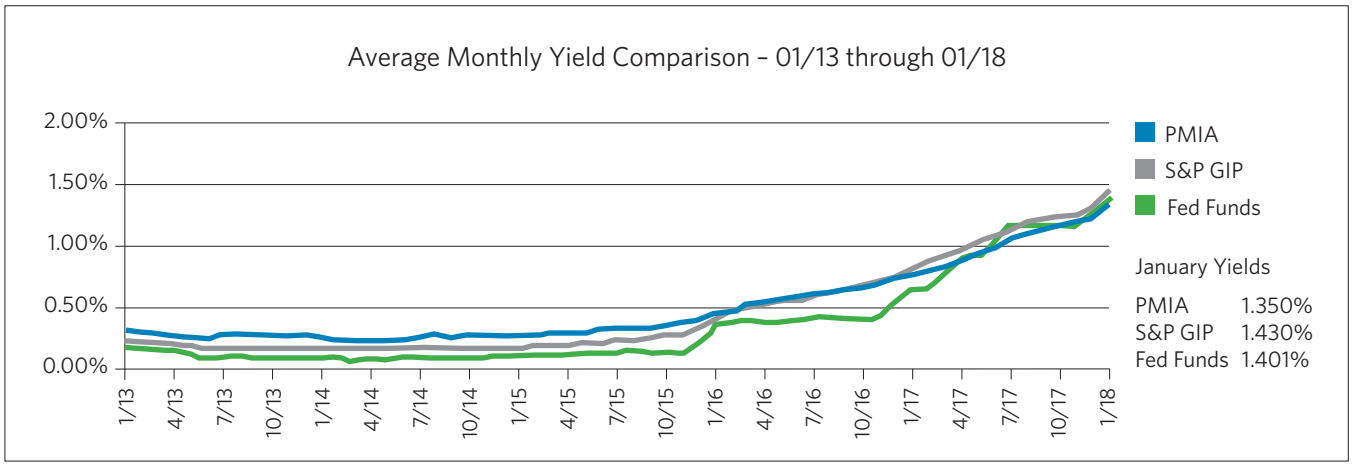
Appendix K – Surplus Money Investment Fund

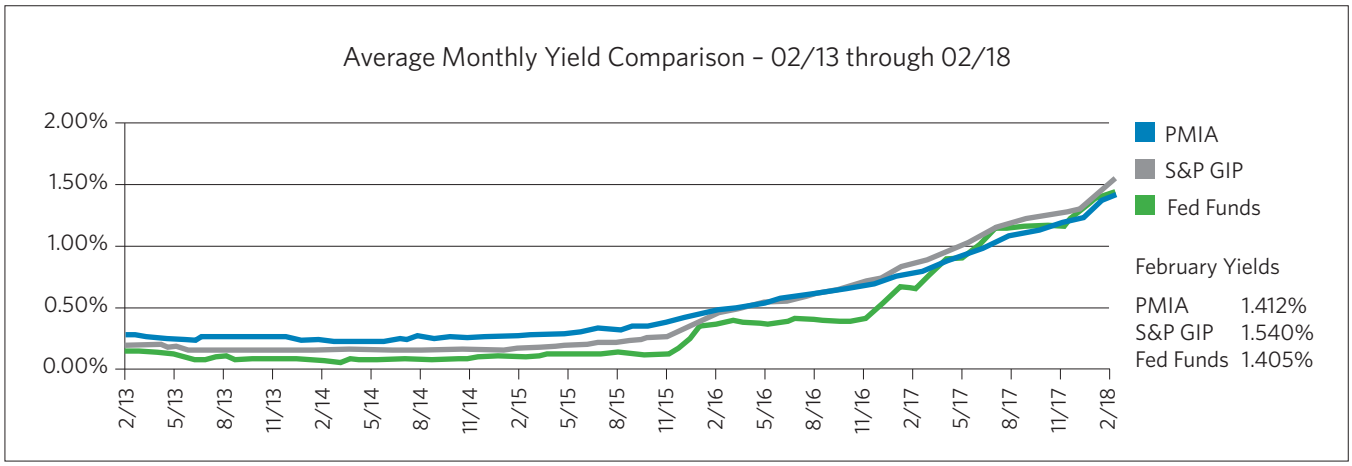
State Controller's Office
Division of Accounting and Reporting
Surplus Money Investment Fund
Apportionment Yield Rate

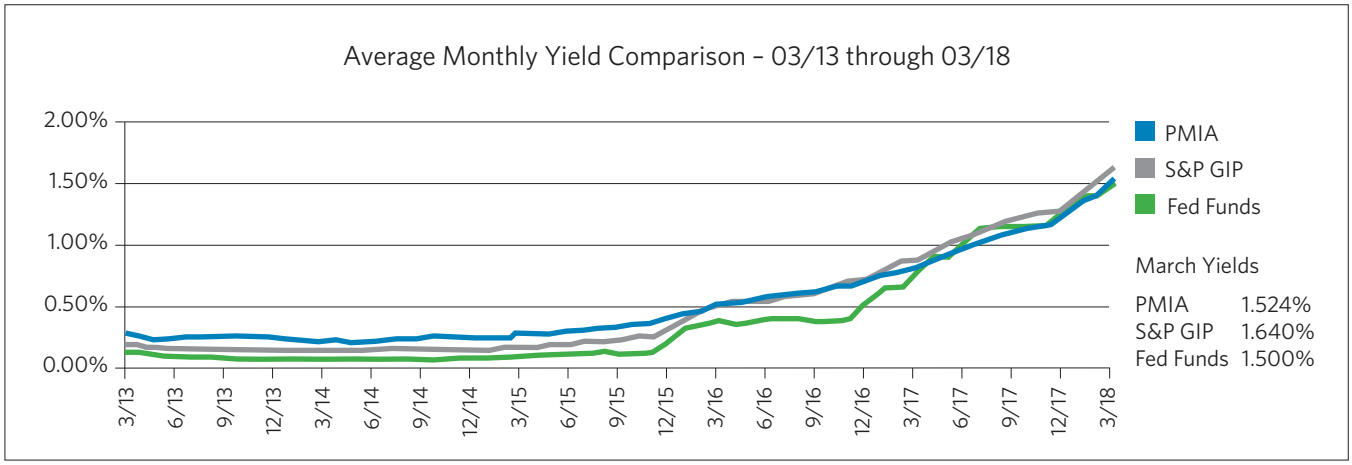
Period Ending	Rate	Period Ending	Rate
3/31/2008	4.174%	12/31/2013	0.248%
6/30/2008	3.108%	3/31/2014	0.222%
9/30/2008	2.769%	6/30/2014	0.228%
12/31/2008	2.533%	9/30/2014	0.234%
3/31/2009	1.903%	12/31/2014	0.249%
6/30/2009	1.512%	3/31/2015	0.254%
9/30/2009	0.889%	6/30/2015	0.283%
12/31/2009	0.594%	9/30/2015	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%*
12/31/2012	0.316%	9/30/2018	1.731%*
3/31/2013	0.275%	12/31/2018	1.921%*
6/30/2013	0.246%	3/31/2019	2.088%*
9/30/2013	0.249%	6/30/2019	2.148%*

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

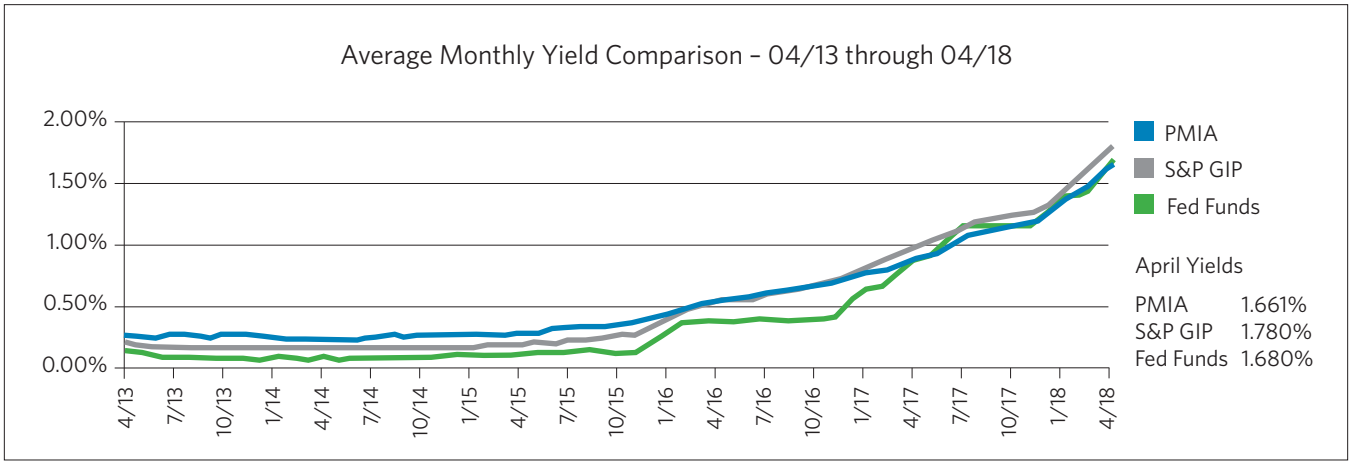
Appendix L – PMIA, S&P GIP, and Federal Funds Average Monthly Yield Comparison

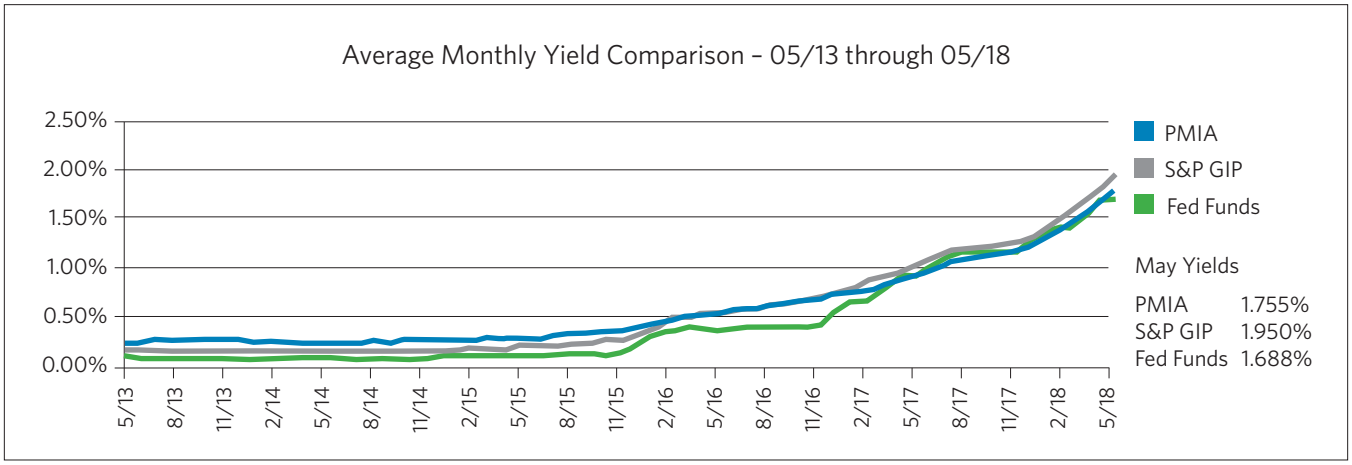


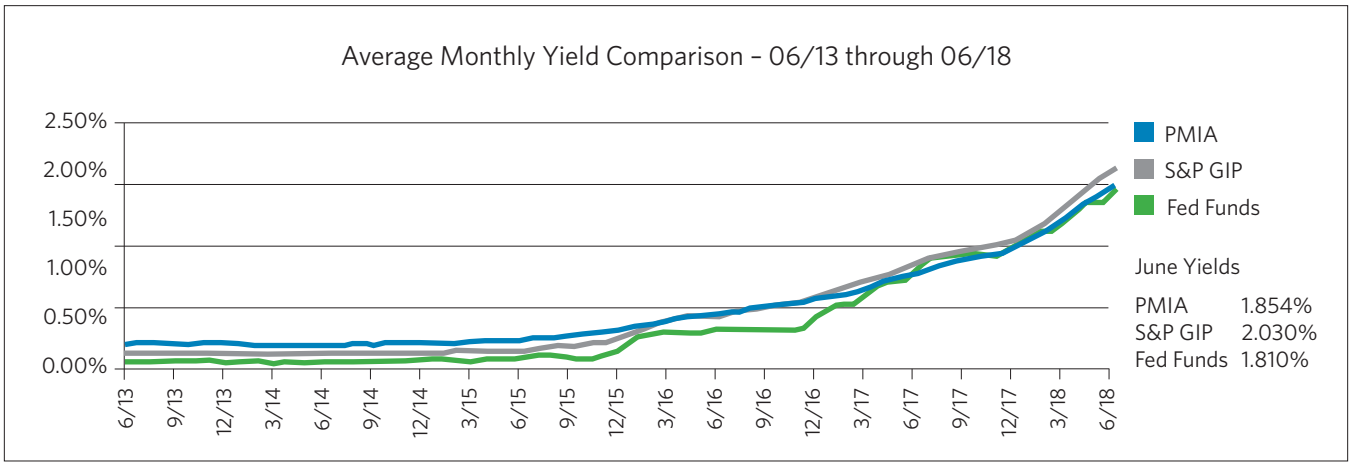


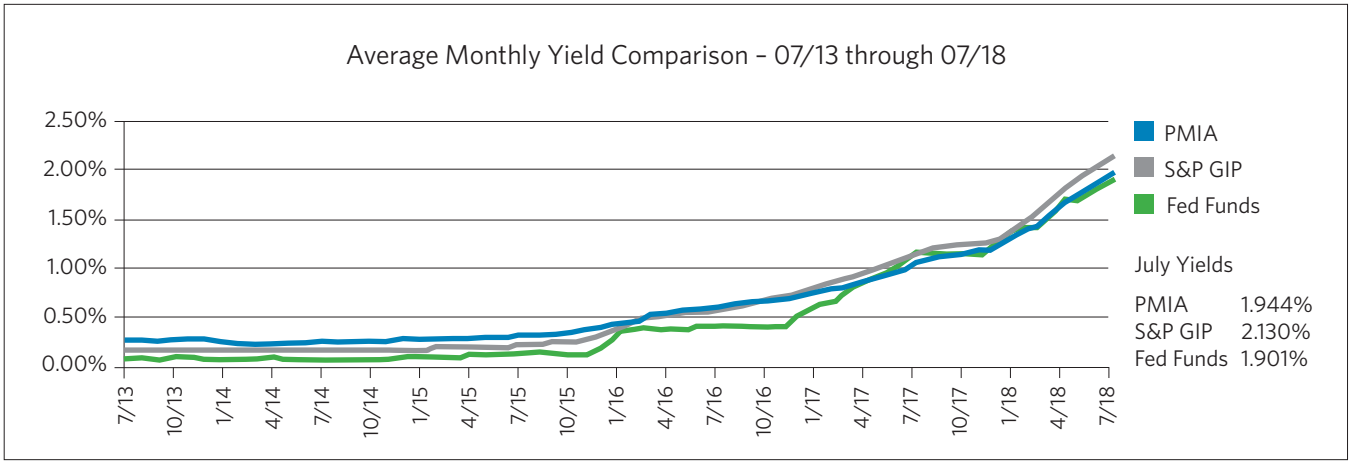


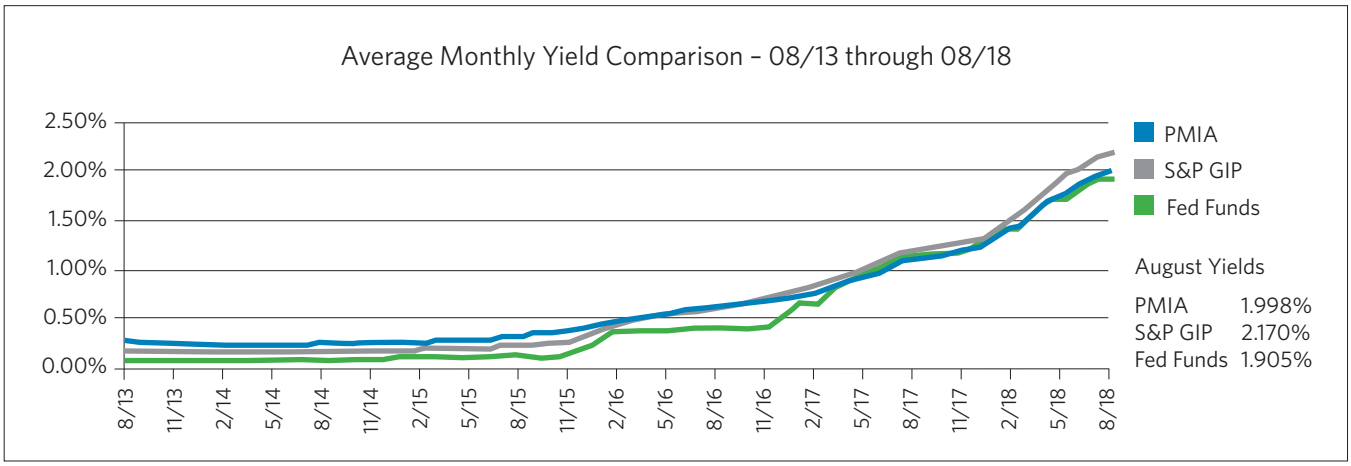
Appendix L – PMIA, S&P GIP, and Federal Funds Average Monthly Yield Comparison, cont.

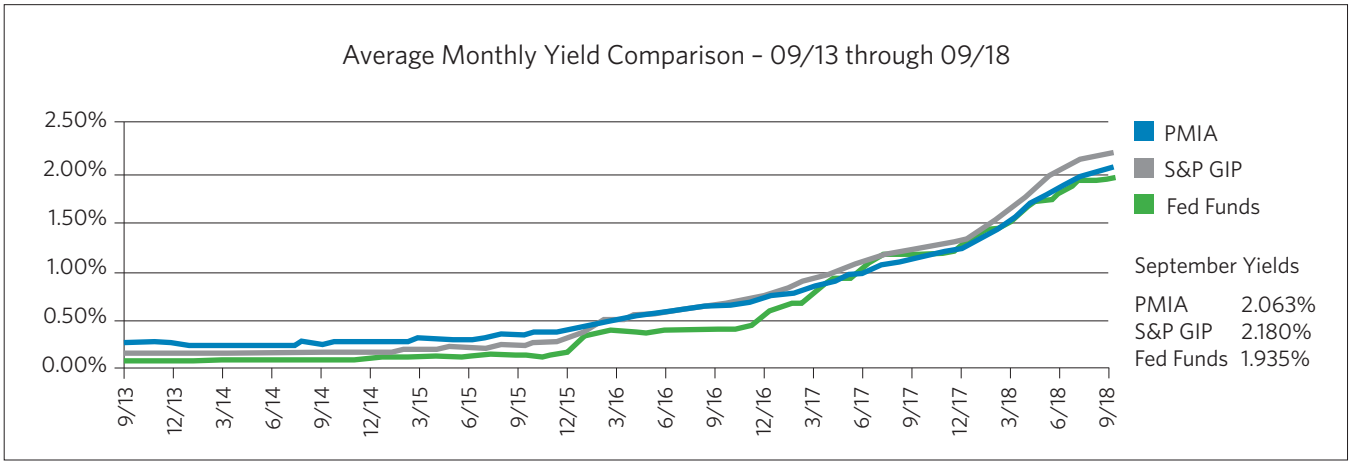




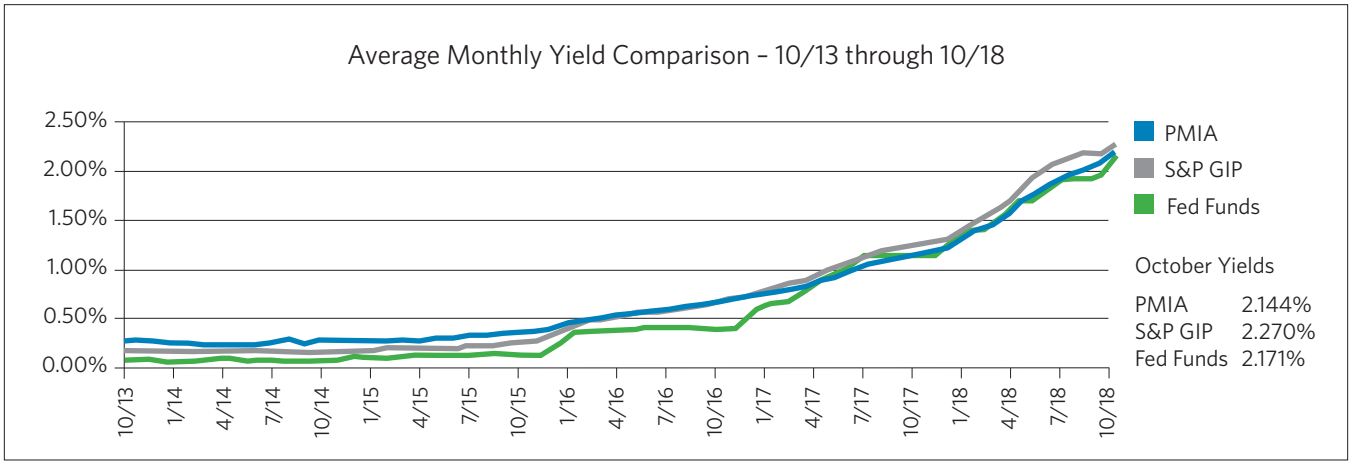


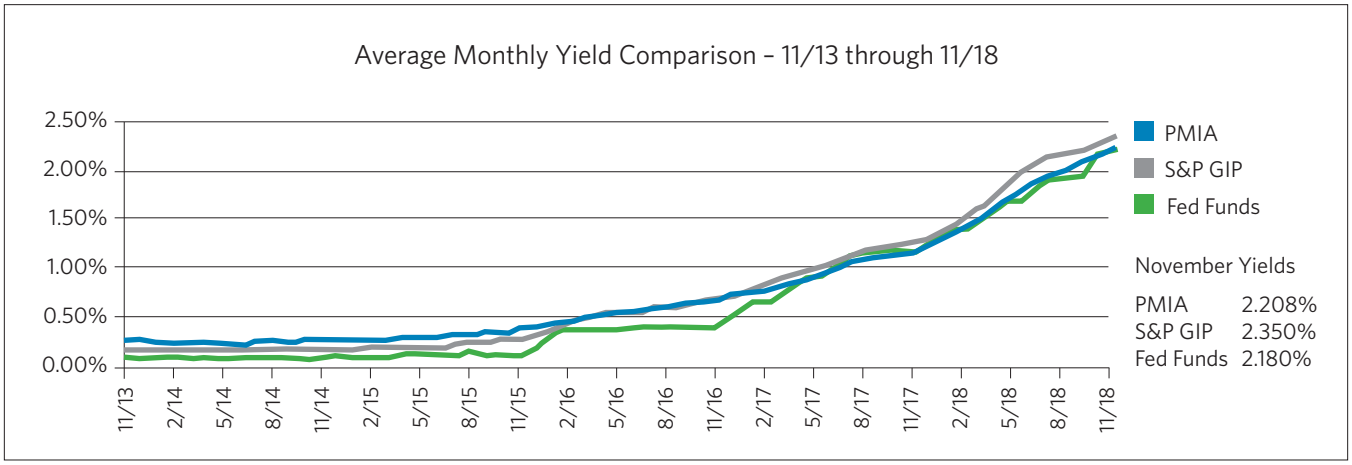

Average Monthly Yield Comparison – 07/13 through 07/18
2.50%
2.00%
1.50%
1.00%
0.50%
0.00%
7/13
10/13
1/14
4/14
7/14
10/14
1/15
4/15
7/15
10/15
1/16
4/16
7/16
10/16
1/17
4/17
7/17
10/17
1/18
4/18
7/18
PMIA
S&P GIP
Fed Funds
July Yields
PMIA 1.944%
S&P GIP 2.130%
Fed Funds 1.901%

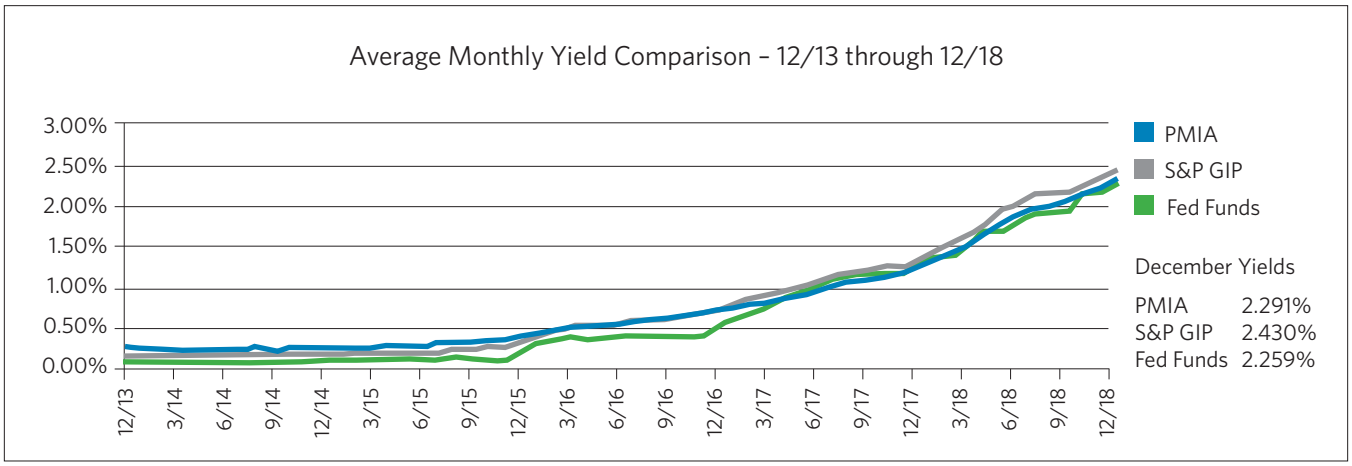

Average Monthly Yield Comparison – 08/13 through 08/18
2.50%
2.00%
1.50%
1.00%
0.50%
0.00%
8/13
11/13
2/14
5/14
8/14
11/14
2/15
5/15
8/15
11/15
2/16
5/16
8/16
11/16
2/17
5/17
8/17
11/17
2/18
5/18
8/18
PMIA
S&P GIP
Fed Funds
August Yields
PMIA 1.998%
S&P GIP 2.170%
Fed Funds 1.905%


Average Monthly Yield Comparison – 09/13 through 09/18
2.50%
2.00%
1.50%
1.00%
0.50%
0.00%
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
12/17
3/18
6/18
9/18
PMIA
S&P GIP
Fed Funds
September Yields
PMIA 2.063%
S&P GIP 2.180%
Fed Funds 1.935%

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







Definition of Terms

Definition of Terms

Affordable Care Act (ACA)
Health care reform enacted in 2010 requiring most Americans to have qualifying health insurance called minimum essential coverage (MEC). All of CalPERS' health plans meet the MEC requirement. Other key provisions of the ACA include allowing dependent children to remain on the parent/subscriber's health plan until the age of 26 and prohibition of annual and lifetime dollar limits for essential health benefits. Prior to the ACA, CalPERS PPO plans had annual and lifetime dollar limits.

Association Plan
Plans available to members who belong to specific employee associations and pay applicable dues. CalPERS does not negotiate rates and is not responsible for the benefit administration of these plans. (e.g., California Association of Highway Patrolmen (CAHP), California Correctional Peace Officers Association (CCPOA), Peace Officers Research Association of California (PORAC)).

Benefits Beyond Medicare
Medically necessary services and supplies that are covered when benefits under Medicare are exhausted or when charges for the services and supplies exceed amounts covered by Medicare.

CalPERS Basic Health Plan
Health benefits coverage for members not enrolled in a CalPERS Medicare health plan.

CalPERS Health Beliefs
A set of six beliefs that serve as a guide for the CalPERS board, executive, leaders, and team members when making decisions for the management and sustainability of the CalPERS Health Benefits Program. The six beliefs are Health Program Sustainability, High Quality Care, Affordability, Comprehensive Care, Competitive Plan Choice, and Quality Program Administration.

CalPERS Medicare Health Plan
Health benefits coverage for members not enrolled in a CalPERS Basic health plan.

Centers for Medicare & Medicaid Services (CMS)
A federal agency created in 1977 under the Department of Health and Human Services, which is responsible for administering the Medicare and Medicaid programs and ensuring that beneficiaries have access to high-quality medical care in appropriate settings.

Co-insurance
In a PPO plan, this is the amount enrolled members are required to pay for a service after the deductible is met (typically identified as a percentage of the allowed amount for the service).

Consolidated Omnibus Budget Reconciliation Act (COBRA)
This Act authorizes continuation of health coverage for a limited time under certain circumstances such as job loss (for reasons other than gross misconduct), reduction in hours worked, death, divorce, and other life events.

Contracting Agency
Qualifying public agencies and school employers that contract with CalPERS to provide health benefits to their employees, retirees, and their eligible dependents regardless of whether they contract for CalPERS retirement program.

Co-payment (Co-pay)
A fixed amount members pay for a doctor visit, covered health service, or prescription.

Deductible
In a PPO plan, the total amount enrolled members pay out-of-pocket for health care services before the health plan pays.

Department of Managed Health Care (DMHC)
The California state agency responsible for administering and enfocing the Knox-Keene Health Care Service Plan Act of 1975. DMHC regulates health care service plans, including all CalPERS' Basic HMO plans.

Dependent
A family member who meets the specific eligibility criteria for health benefits coverage in the CalPERS Health Benefits Program. Dependent types include:

- Spouse
- Registered domestic partner
- Children (natural, adopted, domestic partner's, or step) up to age 26
- Children, up to age 26, if the employee or annuitant has assumed a parent-child relationship and is considered the primary care parent
- Certified disabled dependent children age 26 and older

Essential Health Benefits (EHB)
A set of 10 categories of services individual and small group health insurance plans must cover under the ACA. These include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, pediatric services, including oral and vision care. There are no annual or lifetime dollar limits on EHB.

Exclusive Provider Organization (EPO) Plan
A health benefits plan similar to an HMO plan. An EPO plan requires members to seek services from the plan's network of preferred providers. Members are not required to select a primary care physician.

Health Benefits Program Annual Report (HBPAR)
A report mandated by California Government Code Section 22866 requiring CalPERS to provide information about the CalPERS Health Benefits Program to the California Legislature and Director of Finance.

Health Care Decision Support System (HCDSS)
HCDSS is CalPERS' data warehouse containing 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 and pharmacy costs.

Health Maintenance Organization (HMO) Plan
A health benefits plan that provides health care from specific doctors and hospitals under contract with the plan. Members pay co-payments for some services, and have a geographically restricted service area.

Healthcare Effectiveness Data and Information Set (HEDIS)
Health plan performance measures regarding care and service that is managed by the National Committee for Quality Assurance (NCQA), a non-profit organization.

Medicare
A federal health insurance program for individuals:

- age 65 and older
- under 65 with certain disabilities
- with End Stage Renal Disease (ESRD), after coordination period.

CMS regulates the Medicare program and the Social Security Administration (SSA) is the federal agency responsible for eligibility determination, enrollment, and premiums.

Definition of Terms, cont.

Member Out-of-Pocket Costs
Generally refers to the actual costs members pay to receive medical care and prescription drugs 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.

Open Enrollment Period
A specific period when eligible members can enroll in or change health plans or add eligible dependents who are not currently enrolled in a plan offered under the CalPERS Health Benefits Program.

Pharmacy Benefit Manager (PBM)
A third-party administrator of CalPERS prescription drug benefit for certain health plans. OptumRx is CalPERS' PBM for all health plans except Blue Shield of California, Kaiser, and UnitedHealthcare's Medicare Advantage plan.

Preferred Provider Organization (PPO) Plan
A health benefits plan where enrollees must utilize preferred or in-network providers or pay higher co-payments for certain services and co-insurance (percentage of charges). Enrollees typically meet an annual deductible before some benefits apply. Enrollees are responsible for a specified co-insurance amount and the plan pays the balance up to the allowable amount.

Premium
The monthly amount established by the board to provide a health benefit plan to CalPERS' members.

Public Employees' Contingency Reserve Fund (CRF)
A fund established by statute in PEMHCA that pays administrative costs related to the CalPERS health care programs and provides a contingency reserve for items such as future rates or future benefits.

Public Employees' Medical and Hospital Care Act (PEMHCA)
An Act within the California Government Code governing the CalPERS Health Benefits Program.

Public Employees' Health Care Fund (HCF)
A fund established by statute in PEMHCA to pay for benefits and other costs provided by certain health benefit plans offered by CalPERS. The fund currently pays for benefits and costs for CalPERS PPO plans (PERS Choice, PERSCare, and PERS Select), and flex-funded HMO plans (Anthem Blue Cross, Blue Shield of California, Health Net, Sharp, UnitedHealthcare, and Western Health Advantage).

Regions
Geographic areas used to establish health plan rates for contracting public agency and school employers. Regions and regional health plan pricing was implemented in 2005.

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Ⓓ October 2019