Health Benefits Program | 2019 Annual Report

Published November 1, 2020

CalPERS

Table of Contents

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, 2019. This report provides an overview of the Health Benefits Program, pursuant to California Government Code Section 22866 (see Appendix A).

This year's annual report contains information about health plans, geographic coverage, benefit designs, actuarial value (AV), overall member health with data on chronic conditions, and the results of the annual member satisfaction survey.

Historic enrollment, health plan premium trends, and medical trends are also highlighted. Financial information includes historic expenditures, actuarial reserve levels, administrative expenditures, and historic investment performance for the program's two funding sources, the Public Employees' Contingency Reserve Fund (CRF) and the Public Employees' Health Care Fund (HCF).

In 2019, the overall premium increase of 1.16% was the lowest in 20 years. Basic health maintenance organization (HMO) health plans had a 0.37% average increase, while Basic preferred provider organization (PPO) plans increased 2.83% overall. Medicare plans increased by an average 1.37%. Amid volatility in the health care market, we negotiated historically competitive rates for our members.

We embarked on important initiatives focused on health care quality and affordability. Our work included a new five-year contract for a third-party PPO plan administrator, a new value-based insurance design plan, improving behavioral health care access and treatment, and managing prescription drug costs.

In 2020, as the COVID-19 pandemic creates uncertainty throughout the health care system, we have ensured our members have access to free testing, mental health services, and quality care. We continue to put our expertise and influence to work as we deliver high-quality, affordable health care to our members when and where they need it.

Marcie Frost
Chief Executive Officer

About CalPERS

We are the largest purchaser of public employee health benefits in California and the second largest public purchaser in the nation after the federal government. In 2019, we spent over $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, we provide health benefit services to nearly 1.5 million covered lives for state, school, and public employers. We also operate eight Regional Offices located in Fresno, Glendale, Orange, Sacramento, San Diego, San Bernardino, San Jose, and Walnut Creek.

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

Beginning in the 1960s, we became the health benefits purchaser for state employees and participating public agencies and schools. We have 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 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 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. The 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.

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 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, we annually develop business plan initiatives, strategic plan measures, and key performance indicators to monitor specific items that will achieve overarching goals.

Strategic Direction and Policy Initiatives

The 2017-22 Strategic Plan 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 and describes changes in strategic direction and major policy initiatives for the 2019 health plan year. It includes content from our 2017-22 Strategic Plan, 2019-20 Business Plan, and relevant board agenda items. These plans and agenda items are inter-related, complement each other, and focus on quality, access and affordability. Additional information on the strategic plan and business plan initiatives are available in **Strategic & Business Plans** at **www.calpers.ca.gov**.

Table 1: 2019 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.	Repealed [1]
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.	Completed [2]
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.	Completed [3]
Research and Expand Evidence-Based Medicine	Apply outcome-based medical strategies to provide affordable and high value care.	Completed [4]
Value-Based Insurance Design (VBID)	Research and develop health benefit design strategies to improve member health, and value of care, while decreasing costs in PPO plans.	Ongoing
Medical Pharmacy Site of Care Management	Leverage current Integrated Health Care and Population Health delivery models to contain health care costs in PPO plans by evaluating HMO plans site of care management.	Ongoing
Pharmacy Benefits Management	Develop and implement strategies to align our pharmacy benefit manager (PBM) with our reference pricing model.	Ongoing [5]
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
Health Stakeholder Outreach and Awareness	Conduct stakeholder outreach and awareness of wellness programs and disease management programs which create a culture of good health.	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 [6]
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, Cesarean sections, and spinal/back disorders.	Ongoing

[1] On December 20, 2019, several ACA taxes were repealed as part of the *Further Consolidated Appropriations Act 2020*, including the excise tax on high cost employer-sponsored health coverage. https://www.congress.gov/bill/116th-congress/house-bill/1865/text

[2] On July 16, 2019, we presented research and analysis at the Board of Administration Offsite. https://www.youtube.com/watch?v=K32j1JAJfFE. We subsequently incorporated this initiative into our ongoing staff workload.

[3] We incorporated this initiative into our ongoing staff workload.

[4] We incorporated this initiative into our ongoing staff workload.

[5] On November 19, 2019, we announced our intent to proceed with a phased reference pricing program for outpatient pharmaceuticals. https://www.calpers.ca.gov/docs/board-agendas/201911/pension/transcript-phbc_a.pdf. On April 21, 2020, we announced a postponement of certain pharmacy benefit initiatives as a result of the COVID-19 pandemic. https://www.calpers.ca.gov/docs/board-agendas/202004/pension/transcript-phbc_a.pdf.

[6] We incorporated this initiative into our ongoing staff workload.

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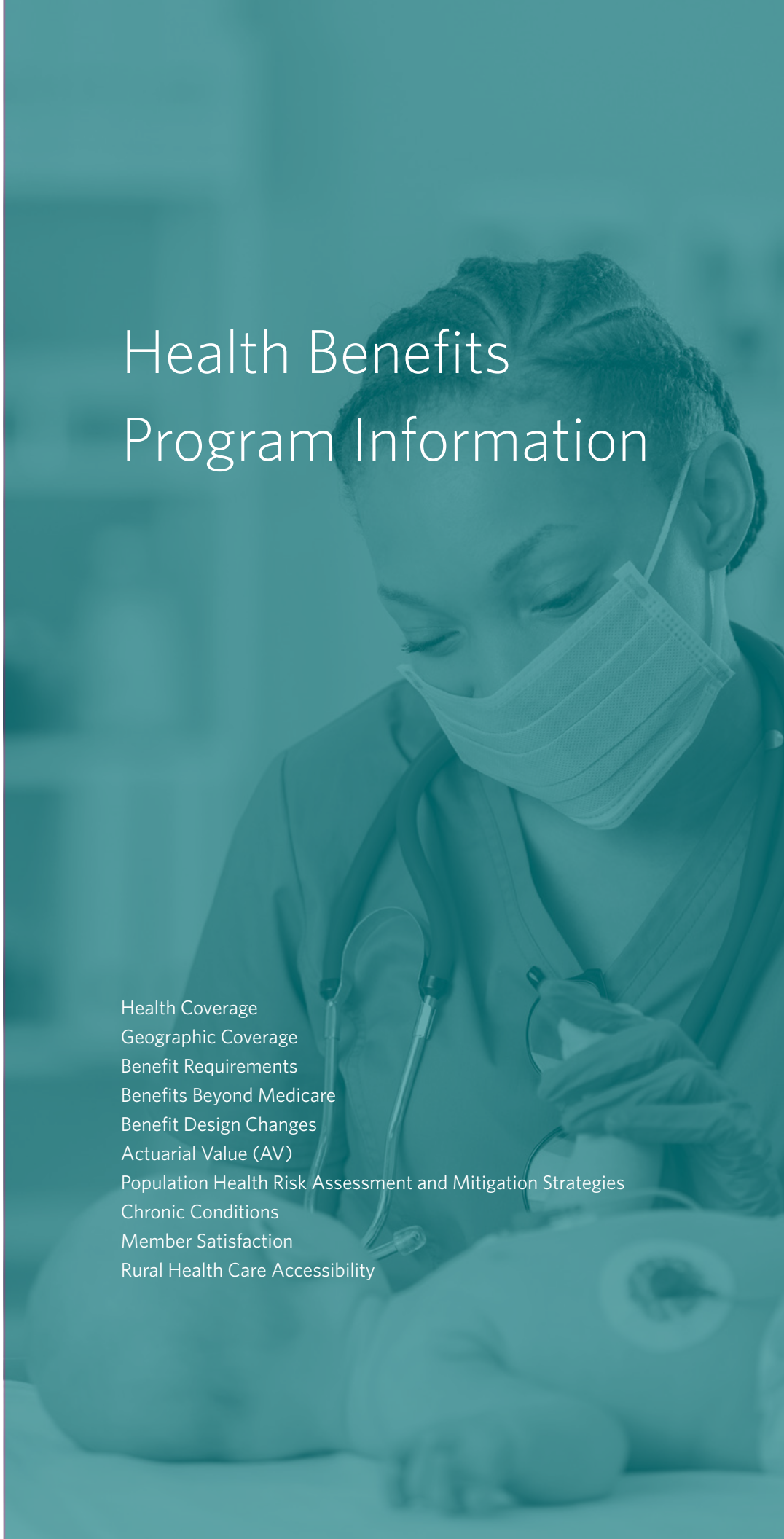


Health Benefits Program Information

Health Coverage
Geographic Coverage
Benefit Requirements
Benefits Beyond Medicare
Benefit Design Changes
Actuarial Value (AV)
Population Health Risk Assessment and Mitigation Strategies
Chronic Conditions
Member Satisfaction
Rural Health Care Accessibility

Health Coverage

As the purchaser of health benefits for the State of California (including the California State University) and almost 1,200 contracting public agencies and schools, we provide a wide selection of high-quality health plan options to our members and their families. For the 2019 plan year, our Basic health plan offerings included fully-insured and flex-funded HMO plans, self-insured PPO plans, and self-insured and fully-insured exclusive provider organization (EPO) plans.

We contracted with the following carriers to provide or administer these plans:

- Anthem Blue Cross
- Blue Shield of California
- Health Net of California
- Kaiser Foundation Health Plan
- Sharp Health Plan
- UnitedHealthcare
- Western Health Advantage

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

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

We also contracted with Anthem Blue Cross to administer the following Supplement to Original Medicare plans:

- PERS Select
- PERS Choice
- PERSCare

Three association plans are available to members who pay applicable dues to the following employee associations. We do not negotiate rates and are not responsible for the benefit administration of these association plans:

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

For the 2019 plan year, the PERS Select Basic plan was redesigned to be a value-based insurance design plan. The plan provides incentives for members to become more involved in their health decisions and earn credits to reduce their annual deductible costs.

OptumRx administered prescription drug benefits for the following Basic and Medicare health plans:

Basic health plans:

- Anthem Blue Cross
- Health Net of California
- Sharp Health Plan
- UnitedHealthcare
- Western Health Advantage

Medicare health plan:

- Anthem Medicare Preferred (PPO)

Basic and Medicare health plans:

- PERS Select
- PERS Choice
- PERSCare

Geographic Coverage

We offer 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 our PPO plans. We also offer limited Basic and Medicare health plan options for members who live out-of-state.

Each year during Open Enrollment, members can log in to their myCalPERS account to explore health plan options. Members can access customized health information as well as tools and resources to help with their open enrollment decisions. Members can use the Search Health Plans tool to discover health plans and monthly premium rates based on their eligibility ZIP code. Members also have access to geographic coverage charts to assist in the selection of a Basic or Medicare health plan where they live or work.

For further information on the Health Plan Availability by County charts, review our publication, ***Health Benefit Summary*** (HBD-110), in **Forms & Publications** at **www.calpers.ca.gov**.

Benefit Requirements

State Law

Our Basic HMO health plans, regulated by the Department of Managed Health Care 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

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

Federal Law

Our HMO and PPO Basic plans meet ACA, Public Health Service Act, and Mental Health Parity and Addiction Equity Act (MHPAEA) requirements.

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). Although large group health plans are not required to provide EHB, our HMO and PPO Basic health plans provide benefits in all required EHB categories except for pediatric dental and vision care.[7]

[7] For state employees, dental and vision care for children and adults is administered separately through the California Department of Human Resources. The California State University's dental and vision benefits are administered through the Office of the Chancellor. Each public agency and school employer is responsible for its own dental and vision benefits.

In addition, our HMO and PPO Basic health plans include California's EHB benchmark plan required 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

Under the MHPAEA, copayments and treatment limitations for medical and mental health care treatment must be the same. Additionally, the ACA includes mental health and substance abuse among the requirements that must be covered. We are holding our plans accountable and are ensuring they are improving screening and early intervention services, coordinating care through the integration of primary care and mental health services, and improving mental health care provider networks through tele-behavioral health services and increased therapist staffing.

Other Benefits

Our Basic health plans also provide the following benefits that are not considered EHB:

- Biofeedback
- Chiropractic services
- Hearing aid services

Benefits Beyond Medicare

In 2019, we offered PERS Select, PERS Choice, and PERSCare PPO Supplement to Original Medicare plans. These plans covered Medicare-approved services with payment supplemented by the plan. These plans, however, provided coverage for some benefits not covered by Medicare (e.g., acupuncture and chiropractic services). 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 aggregated cost of benefits beyond Medicare for calendar year 2019 was $75.1 million.

Benefit Design Changes

Each year we 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.

In 2018, the board adopted the following benefit changes for the 2019 health plan year:

Value Based Insurance Design (VBID)

The board elected to incorporate VBID into the PERS Select PPO Basic plan. VBID is designed to improve coordination of care through engagement with a personal doctor and uses incentives to improve member health and wellness.

Castlight

The board elected to discontinue the Castlight tool for PPO Basic plan members due to low participation. Castlight is an online search and transparency tool designed to educate members about price variation across medical procedures.

Copay changes for PERS Choice and PERSCare

The board elected to increase specialist and urgent care visit copays for members in PERS Choice and PERSCare PPO plans. Unchanged since 2005, the copays increased from $20 to $35 per visit to incent members to utilize a primary care physician to manage their medical needs. The copay change affects members out-of-pocket costs at the point of service; however, members monthly health premiums were lowered to offset the increase.

Actuarial Value (AV)

AV is the percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an AV of 90%, on average, plan members would be responsible for 10% of the costs of all covered benefits. Plans with a higher AV typically have higher premiums because they shield members from out-of-pocket costs, while plans with lower AVs tend to have lower premiums because members experience higher out-of-pocket costs.

The ACA groups health plans into four AV tiers: Bronze, with an AV of 60%-69%; Silver, with an AV of 70%-79%; Gold, with an AV of 80%-89%; and Platinum, with an AV of 90% or above. Our Basic HMO and PPO plans have a higher AV than many plans sold in the individual, small and large group markets. Our Basic HMO, EPO, and association health plans fall in the platinum tier, and our PPO plans are a combination of Gold and Platinum. Tables 2a-c show the metal tiers for the 2019 Basic health plans.

Table 2a: Metal Tiers for 2019 HMO Health Plans

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

Table 2b: Metal Tiers for 2019 EPO and PPO Health Plans

EPO and PPO Plans	Actuarial Value	Metal Tier
Anthem Blue Cross Del Norte EPO	98%	Platinum
PERS Select	87%	Gold
PERS Choice	89%	Gold
PERSCare	91%	Platinum

Table 2c: Metal Tiers for 2019 Association Health Plans

Association Plans	Actuarial Value	Metal Tier
California Association of Highway Patrolmen	93%	Platinum
California Correctional Peace Officers Association	97%	Platinum
Peace Officers Research Association of California	92%	Platinum

Population Health Risk Assessment and Mitigation Strategies

Our health plan portfolio offers a menu of different cost sharing obligations, benefit designs, and provider network choices to accommodate a geographically dispersed population and members' purchasing preferences. The portfolio can be considered a fragmented risk pool in which each health plan is rated individually, based on its own membership and experience. We use age, gender, geographic, and diagnosis data from up to the past 18-months to assess the risk of current health plan enrollees and to predict future expected cost and utilization trends. Our portfolio continuously faces challenges related to risk concentration and adverse selection.

We implemented a risk adjustment program in 2014 to encourage health plans to compete on medical and administrative efficiency and quality of care rather than on their ability to select low-risk, healthy members. The intent of the risk adjustment program was to control cost trend, provide better data and transparency, and better disease management. However, due to the complexity of the risk adjustment process and lack of transparency with the model that was used, the results were problematic. Consequently, we ended risk adjustment beginning with the 2019 plan year.

In the absence of risk adjustment, the lack of competition for efficiency and quality leads to pricing based upon the concentration of healthy or unhealthy lives in the plans. As the percentage of unhealthy lives increase in a plan and risk becomes more concentrated, premiums increase and members in these plans are required to either assume a greater financial burden or leave their health plan, thereby creating adverse selection. We have used reserves and buy-downs in the rate setting process to attempt to shield the portfolio and membership from the effects of adverse selection, however without intervention at some point the unmitigated pricing of health plans can increase risk concentration, which can accelerate plans becoming unviable.

We continuously work with consulting actuaries and internal actuaries to assess the health plan portfolio and determine the appropriate mix of plan type and plan offering to minimize risk concentration and adverse selection. They review risk mitigation approaches, risk adjustment models, and portfolio rating alternatives to incorporate into potential risk mitigation strategies. Various options, with modeling on how they impact the portfolio, are periodically presented to the Pension & Health Benefits Committee for approval and any approved changes are reflected in the subsequent plan years' health plan premium rate development processes.

Chronic Conditions

We employ several mechanisms to evaluate overall member health as reflected by data on chronic conditions, review of population demographics, and analysis of member health. This evaluation showed that, for 2019, approximately 24% of our California population had 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

Our population, on average, is older and has a higher prevalence of chronic conditions when compared to other insured populations.

Table 3 provides a breakdown of chronic condition prevalence statewide, based on information from our Health Care Decision Support System (HCDSS) for 2019. 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 2019.

Table 3: 2019 Chronic Conditions Prevalence Among CalPERS Members*

	California	
	Percentages based on 1,407,430 members	
Chronic Condition	Population	Prevalence (%)
Hypertension	107,087	7.6%
Diabetes	77,514	5.5%
Depression	66,341	4.7%
Asthma	40,988	2.9%
Coronary artery disease	24,707	1.8%
COPD	10,936	0.8%
Congestive heart failure	4,777	0.3%

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

Member Satisfaction

Each year, we conduct a survey to evaluate members' experience with their health plan during the previous 12-month period. The 2020 CalPERS Health Plan Member Survey, evaluating plan year 2019 experiences, ran from January 10 through March 3, 2020. Members were asked to rate their health plan and overall health care satisfaction using the 10-point scale where 0 was the lowest and 10 was the highest possible rating.

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

Figures 1a-b show the average and overall health plan satisfaction ratings for the Basic and Medicare health plans surveyed.

Figure 1a:
Basic Health Plan Satisfaction Ratings

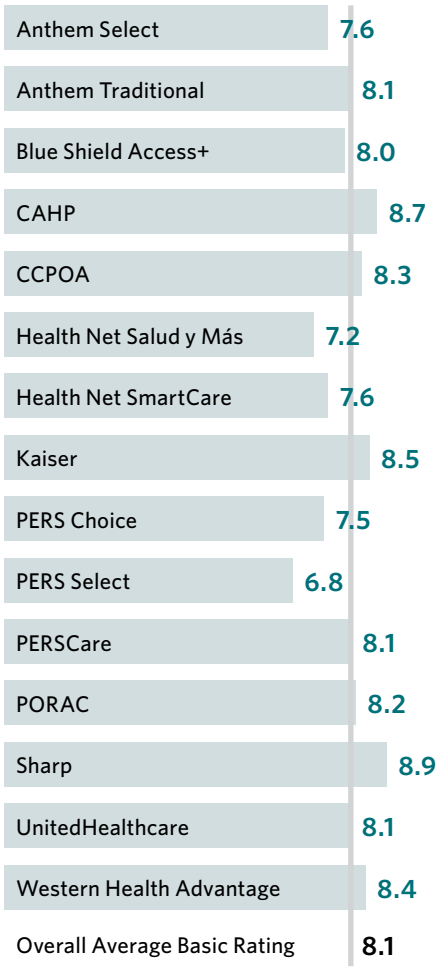
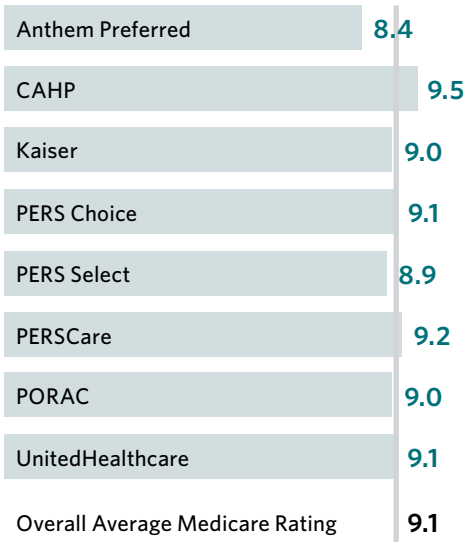


Figure 1b:
Medicare Health Plan Satisfaction Ratings



Members were asked: Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 12 months?

Figures 2a-b show the average and overall health care satisfaction ratings for the Basic and Medicare health plans surveyed.

Figure 2a:
Basic Health Care Satisfaction Ratings

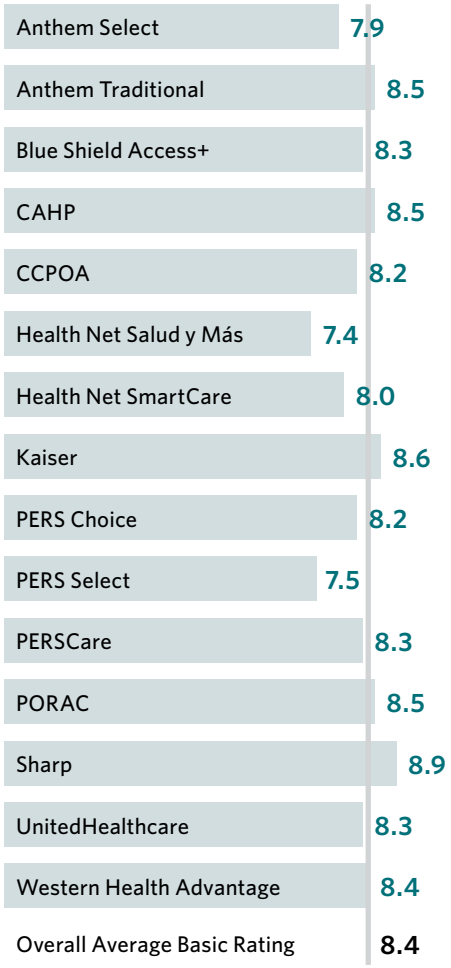
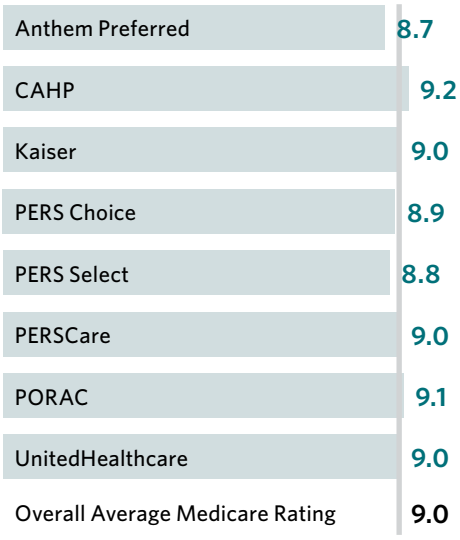


Figure 2b:
Medicare Health Care Satisfaction Ratings



Rural Health Care Accessibility

The annual survey asked Basic plan members to report their level of accessibility. According to survey data, 192 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 our Medicare plan subscribers had access to a Medicare Advantage plan in all 58 counties in California.

Emergency Room Care

Out of the 192 respondents living in a rural area, 49 utilized the emergency room to get care for themselves.

Of those 49 respondents, six responded that they went to the emergency room because there were no urgent care services within 15 miles/30 minutes of their homes. These individuals resided in Lake, Mariposa, Modoc, Plumas, and Siskiyou counties.

After Hours Care

Out of the 192 respondents living in a rural area, 13 responded that it was not easy to get after hours care.

Of these 13 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 Calaveras, Lassen, and Plumas counties.

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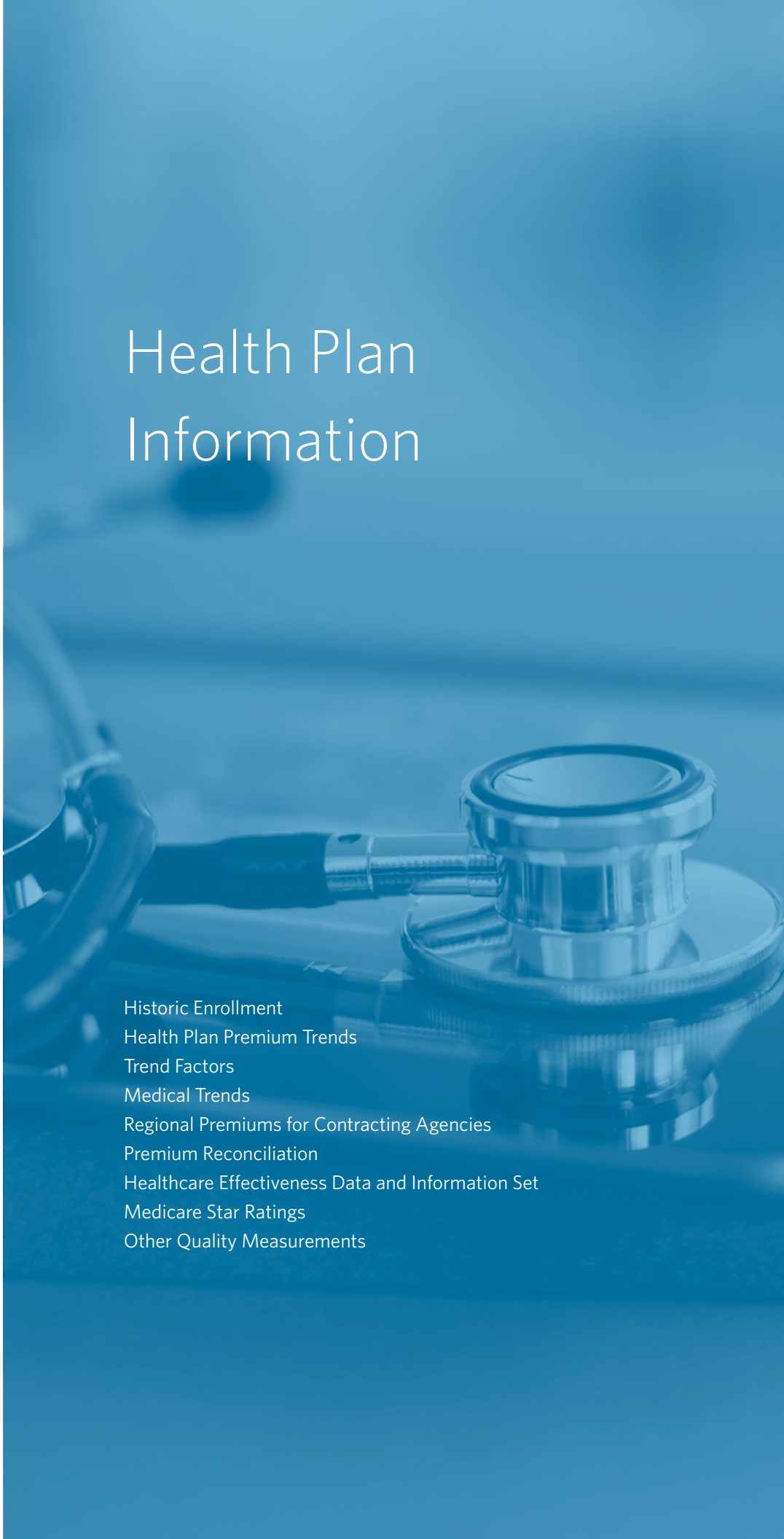
Health Plan Information



Historic Enrollment
Health Plan Premium Trends
Trend Factors
Medical Trends
Regional Premiums for Contracting Agencies
Premium Reconciliation
Healthcare Effectiveness Data and Information Set
Medicare Star Ratings
Other Quality Measurements

Historic Enrollment

We have seen our health plan enrollment grow over the past 10 years. Between 2010 and 2019, our total enrollment has increased by over 12%.

The information in this section was derived from myCalPERS, which is the "system of record" for all Health Benefits Program enrollment information. The enrollment count totals reflect changes made during Open Enrollment in the prior year. Changes outside of Open Enrollment are minimal and include adding new employees or qualifying life events such as the birth or adoption of a child, marriage or divorce, moving outside a plan's coverage area, etc.

The Historic Enrollment tables (see Appendix B) provide enrollment data for plan years 2017-19. The total enrollment count, derived from myCalPERS as of January 1, 2019, includes state, public agency, and school members, excluding individuals on Consolidated Omnibus Budget Reconciliation Act (COBRA). Appendix B 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).

Additional historical enrollment information can be found in previous editions of the ***Health Benefits Program Annual Report*** in **Forms & Publications** at **www.calpers.ca.gov**.

Health Plan Premium Trends

Health plan premiums are set annually through the analysis of approximately 18-months of recent claims data, any changes to benefit design, and estimates for future health care costs. These analyses are performed in accordance with generally-accepted actuarial standards of practice. The process to establish the 2019 health plan premiums was started in 2018 and used data from 2017 and 2018.

Health care costs are rising due to a number of factors, including increases in hospital admissions, outpatient surgical procedures, and pharmacy costs. We use innovation to keep costs low while upholding quality health care.

The board approved health care rate and plan changes for 2018 that included an average 2.33% overall premium increase, the lowest in 20 years. For 2019, the program had an average 1.16% overall premium increase, marking the lowest health premium increase we have negotiated in over two decades. Amid increasingly volatile health care markets across the industry, we achieved historically competitive prices.

Trend Factors

We have been successful in moderating premium trend increases without compromising quality health care. We mitigate 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 our health plan premiums:

- Population age and gender
- Prevalence of chronic conditions
- Hospital utilization
- Pharmaceutical utilization
- Population geographic location
- Competition within a geographic area

Fluctuations (increases and decreases) in premiums result from a number of factors including higher medical and pharmaceutical costs and benefit design changes. For 2019, premiums increased by 1.16% for all Basic and Medicare plans combined. Basic HMO plans increased by an average of 0.37%, Basic PPO plans increased by an average of 2.83%, and Medicare plans increased by an average of 1.37%.

Medical Trends

The overall cost trend for our HMO, PPO, EPO, and association Basic health plans increased 4.5% in calendar year 2019. 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 drug
- Preventative care
- All other

Analysis of trends allows a better understanding of the factors that impact health care premiums. The 2019 trend in service category costs varied, with inpatient care, prescription drug, and ambulatory surgery categories continuing as the largest contributors. Utilization rate increases occurred in all key service categories for calendar year 2019 except inpatient admissions and prescription drug days. See Appendix C for graphs displaying these medical trend changes.

Regional Premiums for Contracting Agencies

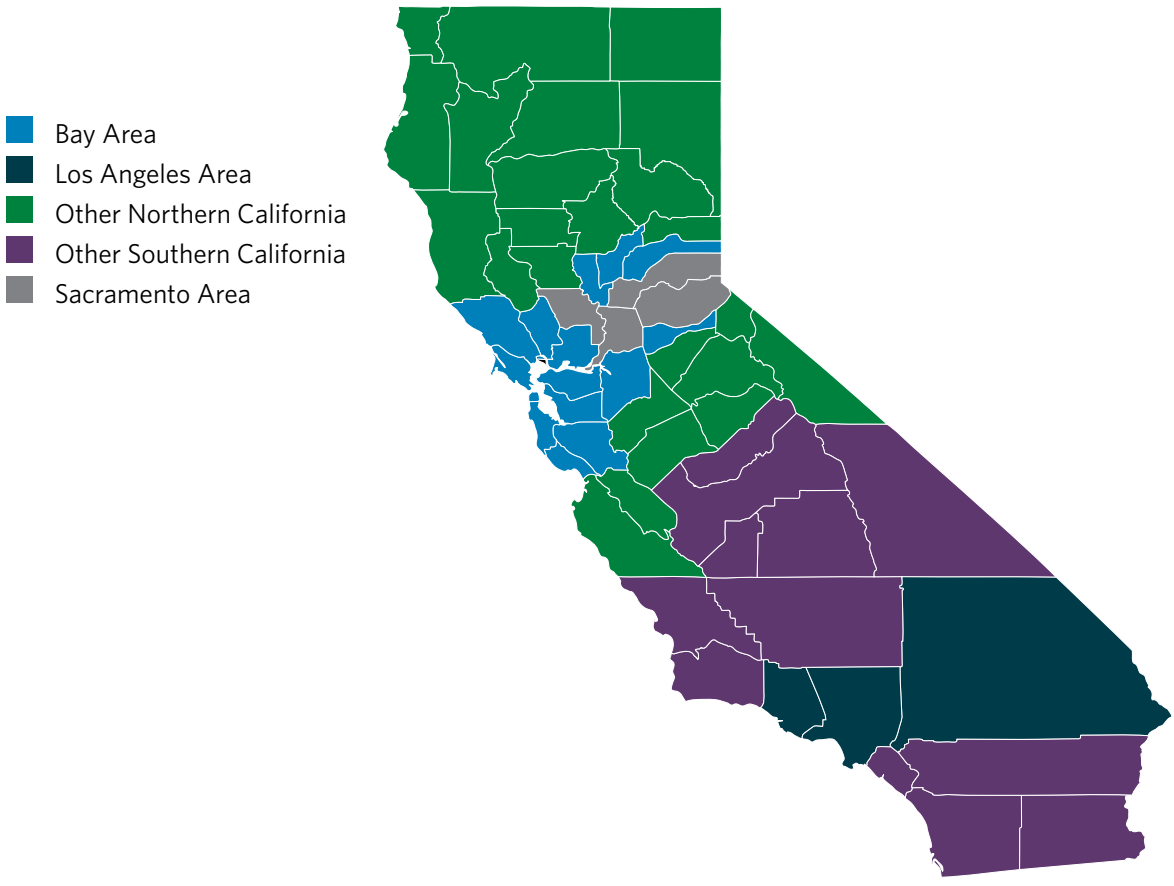
The cost of health care is impacted by many factors including geographic costs, provider and hospital consolidation or competition, and health care delivery system efficiencies. Regional premiums are health plan premiums set for a defined geographic area, and the differences between regional premiums reflect geographic differences in these factors. We implemented geographic regions and regional pricing for Basic health plan premiums for our public agencies and school employers in 2005.

Each year, we set one statewide premium per health plan for state employees and set regional Basic plan premiums for contracting agencies.

2019 Basic premiums for contracting agencies were priced based on five regions. Based on our 2018 assessment of region and cost alignment, a three-region model will be implemented for the 2020 health plan year.

Additional information on premium increases or decreases between plan years 2018 and 2019 are available in the June 19, 2018, Pension & Health Benefits Committee agenda items in **Board Meetings** at **www.calpers.ca.gov**.

Figure 3: 2019 Health Plan Regions for Contracting Agencies



Premium Reconciliation

We perform a monthly enrollment reconciliation process with each health plan to ensure accuracy of enrollment information. The data in myCalPERS is entered and/or validated by various sources including the state, public agencies and schools, health benefits officers, the State Controller's Office, health plan carriers, and CalPERS.

Table 4 is derived from information from myCalPERS that originated at the subscriber enrollment level by coverage month, plan code, and health plan. It reflects the amount owed to each carrier from January through December 2019. The premium information was extracted from a point in time from myCalPERS as of June 14, 2020.

Table 4: Health Premium Management Report for Calendar Year 2019
(Dollars in Thousands)

Health Plan Carriers	Health Premium Amount
Anthem Blue Cross	$2,762,069
Associations (CAHP, CCPOA, and PORAC)*	576,787
Blue Shield of California	923,854
Health Net of California	214,633
Kaiser Foundation Health Plan*	3,990,308
Sharp Health Plan	70,324
UnitedHealthcare	659,480
Western Health Advantage	65,836
Total	**$9,263,291**

* Kaiser and association plan premiums are outside of our financial data, and therefore are not validated or reconciled by us.

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.[8] The current set of HEDIS® measures address "preventive services, chronic disease management, behavioral health care, appropriateness/overuse of services, and value."[9]

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% 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.[10] Other organizations such as Consumers Union and the California Office of the Patient Advocate disseminate HEDIS® data as well.

On an annual basis, large health plan carriers that contract with us are required to submit HEDIS® data to us on our membership on an annual basis. Data analysis and reporting during the reporting year[11] is based on data collected from health plans during the measurement year.[12]

The Centers for Medicare & Medicaid Services (CMS) will use the previous year's HEDIS measures scores and ratings from the 2020 Star ratings (based on care delivered in 2018) for the 2021 star ratings due to the COVID-19 pandemic. NCQA will not release 2020-21 Health Plan Ratings for any product line due to COVID-19. Accredited commercial plans must still submit the required HEDIS measures, but organizations will not be rated on measure results. We will not be reporting NCQA HEDIS measures this year due to the COVID-19 changes for health plan reporting. Our health plans are also facing delays in submitting Certified HEDIS measures to us in time for this report, due to COVID-19.

Medicare Star Ratings

Medicare uses a Star Rating System to measure how well Medicare Advantage and Medicare Prescription Drug (Part D) plans perform.[13] 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 our Supplement to Original Medicare plans because they are neither Medicare Advantage plans nor Part D plans.

[8] HEDIS and Performance Measurement. (2020) https://www.ncqa.org/hedis/

[9] HEDIS Measures and Technical Resources. (2020) https://www.ncqa.org/hedis/measures/

[10] NCQA Health Insurance Plan Ratings 2019-2020 – Summary Report (Private/Commercial). (2020) http://healthinsuranceratings.ncqa.org/2019/Default.aspx

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

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

[13] How to compare plans using the Medicare Star Rating System. (2020) 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 5) contained in the board's health plan carrier contracts include the following:

Table 5: 2019 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.
Quality Management and Improvement	Review, measure, and improve the quality of services provided and the clinical practices of its participating providers and provide reports.
Reporting and Public Regulatory Studies	Submit 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 Accreditation Commission (URAC)).

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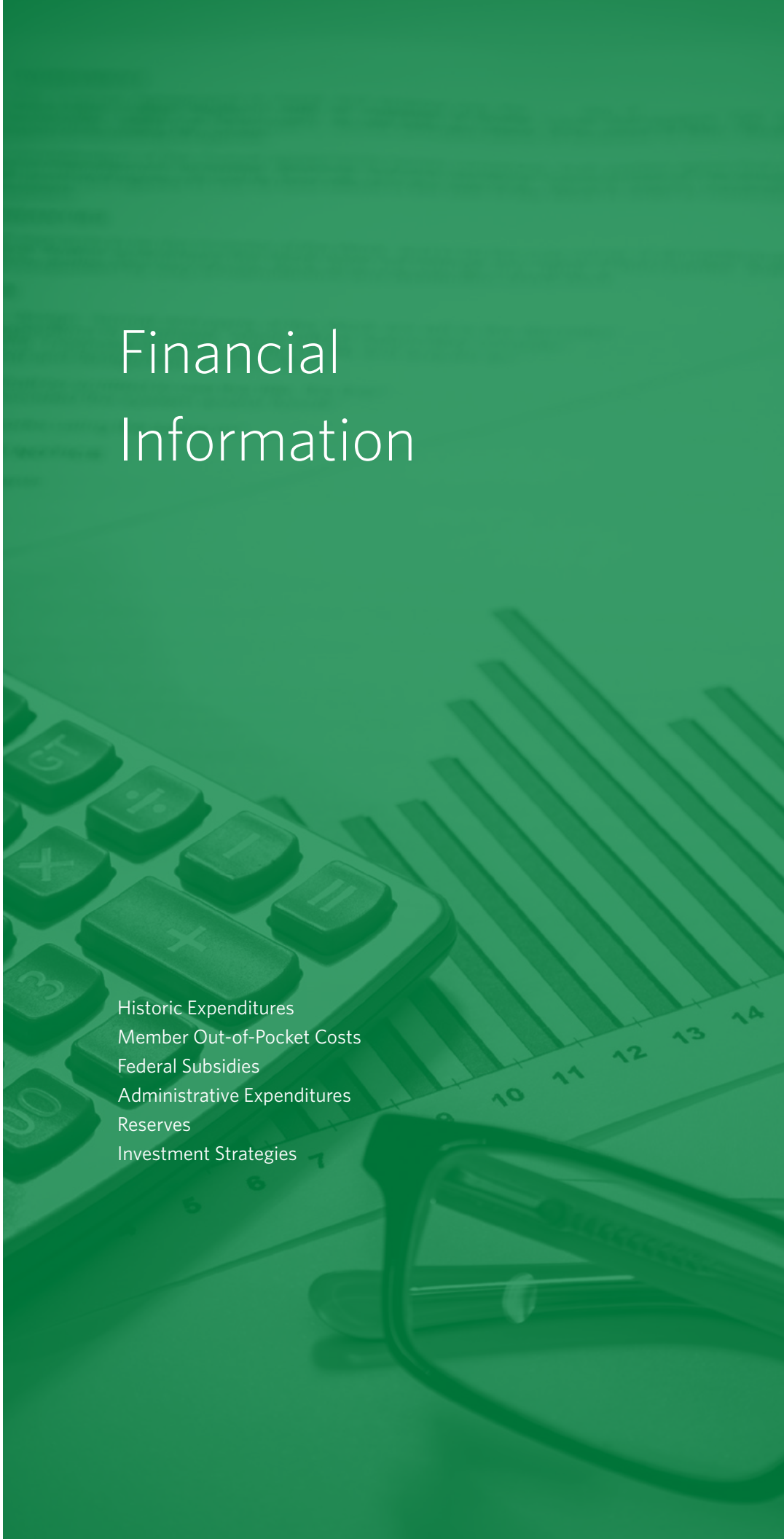
Financial Information



Historic Expenditures
Member Out-of-Pocket Costs
Federal Subsidies
Administrative Expenditures
Reserves
Investment Strategies

Historic Expenditures

The Health Benefits Program total estimated expenditure in 2019 exceeded $9.2 billion.

The Historic Expenditures tables (see Appendix D) are estimated expenditures for plan years 2017-19. Since actual membership fluctuates during any given month, the numbers presented in the Historic Expenditures tables 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., 2019 expenditures were calculated based on 2019 premiums and January 2019 enrollment counts).

Appendix D also displays expenditures 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).

Additional historical expenditure information can be found in previous editions of the ***Health Benefits Program Annual Report*** in **Forms & Publications** at **www.calpers.ca.gov**.

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, coinsurance, copayments, and other out-of-pocket costs as specified in our health plans' Evidence of Coverage booklets. Member out-of-pocket costs are provided as an average and may vary from year to year due to benefit design or policy changes. A member may experience significantly different costs from the averages depending on their overall utilization of medical services and the number of prescriptions filled each year.

Considering our entire membership, in 2019 our members paid on average $329 out-of-pocket for health care services and prescription drugs. On average, a member in a Basic HMO plan paid $138 in out-of-pocket costs, while a member in a Medicare Advantage plan paid $312. On average, a member in a Basic PPO plan paid $979 in out-of-pocket costs, while a member in a Medicare PPO plan paid on average $301. The average out-of-pocket costs are calculated on an annual basis utilizing submitted health claims data. We do not collect data on non-covered services such as over-the-counter medications or out-of-network care.

Although benefit design was standard across our health plans, health care and prescription drug out-of-pocket costs in 2019 varied depending on whether the member chose an HMO or PPO or was enrolled in a Basic or Medicare health plan. A typical copayment for a physician office visit for members enrolled in a Basic HMO plan was $15. For members enrolled in Basic PPO plans, the copay was $20 for PERSCare and PERS Choice, and $35 (reduced to $10 if a member enrolled with a personal doctor under VBID) for PERS Select. For members enrolled in a Medicare Advantage plan, the copay was $10, and no charge for members enrolled in a Supplement to Original Medicare plan. A typical deductible for members enrolled in a Basic PPO plan was $500[14] for individuals and $1,000 for a family. There were no deductibles for members enrolled in a Basic HMO plan or a Medicare plan.

For further details about plan benefits, copays, and deductibles, review our publication, ***Health Benefit Summary*** (HBD-110), in **Forms & Publications** at **www.calpers.ca.gov**.

[14] Deductibles for PERS Select members were $1,000 for individuals and $2,000 for a family. The PERS Select VBID health plan offered incentives to reduce individual deductibles (max. $500) or family deductibles (max. $1,000).

Federal Subsidies

Federal subsidies or contributions have a positive impact on the overall affordability of health care for our Medicare members. Our health plan carriers and PBM manage federal eligibility and enrollment, benefits, claims adjudication, and subsidy payments. Federal subsidies that we receive 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 2019, we collected nearly $19 million in federal subsidies, which makes up less than one percent of total health premiums collected.

Direct subsidies are fixed amounts that 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.

Our 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 our 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 our 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. Our role is to review the enrollee data and provide additional information to the carriers as needed.

Administrative Expenditures

In fiscal year 2019-20, we expended $73.3 million to support our 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 positions, 446.8 directly and indirectly supported the Health Benefits Program in fiscal year 2019-20 (see Table 6). Direct support positions include those in the Health Policy & Benefits Branch, the Actuarial Office, the Legal Office, and Customer Services & 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 & Technology Branch. Personal services expenditures totaled $53.5 million in 2019-20 (see Table 7).

Table 6: Staff Levels

Direct Support Positions	263.2
Enterprise Support Operations Positions	183.6
Total Staffing Levels	**446.8**

Table 7: Personal Services
(Dollars in Thousands)

Salary and Wages	$34,687
Staff Benefits	18,785
Total Personal Services	**$53,472**

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 2019-20 totaled $19.8 million (see Table 8).

Table 8: Operating Expenses & Equipment
(Dollars in Thousands)

Consultant and Professional Services – Internal	$241
Consultant and Professional Services – External	6,591
General Operating Expenses	8,352
Statewide Administrative Cost (Pro-Rata)	4,650
Total Operating Expenses & Equipment	**$19,834**

Funding to support our Health Benefits Program comes from the Public Employees' CRF and the Public Employees' HCF (see Table 9).

Table 9: Funding Sources
(Dollars in Thousands)

Public Employees' CRF	$30,802
Public Employees' HCF	42,504
Total Funding	**$73,306**

Reserves

Reserve Levels/Adequacy

As of December 31, 2019, the actuarial reserve level for the self-funded PPO plans was $556.4 million,[15] and the total assets level was $578.3 million.[15] 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 our HMO plans, total assets were $21.7 million[15] as of December 31, 2019.

The total assets level accounts for encumbered dollars for premium rate buy-downs for the 2020 and 2021 plan years.

Expected Changes in Reserve Levels

We forecast 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

We implemented our 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.

The total PPO assets are 104% of the actuarial reserves as of December 31, 2019.

Decisions to Lower Premiums with Excess Reserves

In June 2018, the board approved the use of $120 million in excess reserves. Approximately half of the excess reserves were used to lower the 2019 PERSCare Basic premiums; the remaining balance was used to smooth the 2020 and 2021 premiums for the PPO Basic and Medicare plans.

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.

Similarly, for the flex-funded HMO plans, reinsurance is not needed due to the nature of the flex-funding arrangement. In this contract funding arrangement, we negotiate a flat per member per month administrative services fee with all flex-funded HMO plans. In addition, capitation costs are paid to the plan and fee-for-service claims are paid as they are incurred up to the contracted maximum amount. If the plan underestimates these fee-for-service claims, the plan pays for any additional costs. However, if the fee-for-service claims are lower than expected, we retain the savings and uses those savings to reduce premiums in subsequent years.

[15] The 2019 actuarial reserve level reflects claims processed as of March 31, 2020.

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 10). 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 10: Historical Investment Performance of the Surplus Money Investment Fund*
(Net of Fees)

Fiscal Year End	Allocation	Invested Assets	Annual Return
15/16	Surplus Money Investment Fund (SMIF)	$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%
19/20		728,825,669	1.95%

* See Appendix E 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 by the Office of the State Treasurer. For further information on the PMIA, visit **www.treasurer.ca.gov/pmia-laif/pmia/index.asp**.

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 11). 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.

Table 11: 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
15/16	State Street Global Advisors (SSGA) U.S. Aggregate Bond Index Fund	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%
19/20		520,391,768	8.82%
15/16	Surplus Money Investment Fund (SMIF)	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%
19/20		277,031,123	1.95%

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

Expected Investment Returns

The SSGA U.S. Aggregate Bond Index Fund is passively managed to follow the Bloomberg Barclays U.S. Aggregate Bond Index. While the 10-year historical annualized investment return for the index as of June 30, 2020 is 3.82%, past performance is not a guarantee of future results. The SMIF does not follow a benchmark.

Appendices

Table of Contents

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 – Historic Enrollment

Enrollment as of January 1 of Each Reported Year[16]

	2017	2018	2019
Basic HMO Plans			
Anthem Blue Cross Select	29,278	24,059	33,305
Anthem Blue Cross Traditional	13,576	13,079	15,709
Blue Shield Access+	163,915	168,998	128,795
Health Net Salud y Más	5,617	8,413	9,446
Health Net Smartcare	36,517	19,107	26,155
Kaiser	502,757	517,206	529,710
Kaiser Out-of-State	573	664	789
Sharp Health Plan	10,313	11,316	12,576
UnitedHealthcare	73,258	76,612	79,034
Western Health Advantage	—	5,955	9,788
Basic EPO and PPO Plans			
Anthem Blue Cross Del Norte EPO	107	139	107
Anthem Blue Cross Monterey EPO	3,760	—	—
PERS Choice	159,314	151,784	148,957
PERS Select	46,092	50,168	70,215
PERSCare	30,926	38,622	31,782
Basic Association Plans			
California Association of Highway Patrolmen	28,604	28,743	28,403
California Correctional Peace Officers Association North	10,705	9,449	8,693
California Correctional Peace Officers Association South	31,373	31,582	31,667
Peace Officers Research Association of California	24,889	23,718	21,454
Basic Total	1,171,574	1,179,614	1,186,585

[16]This table represents "points-in-time" data which is the best description of enrollment on a typical day. A "—" indicates that the plan did not exist in those years.

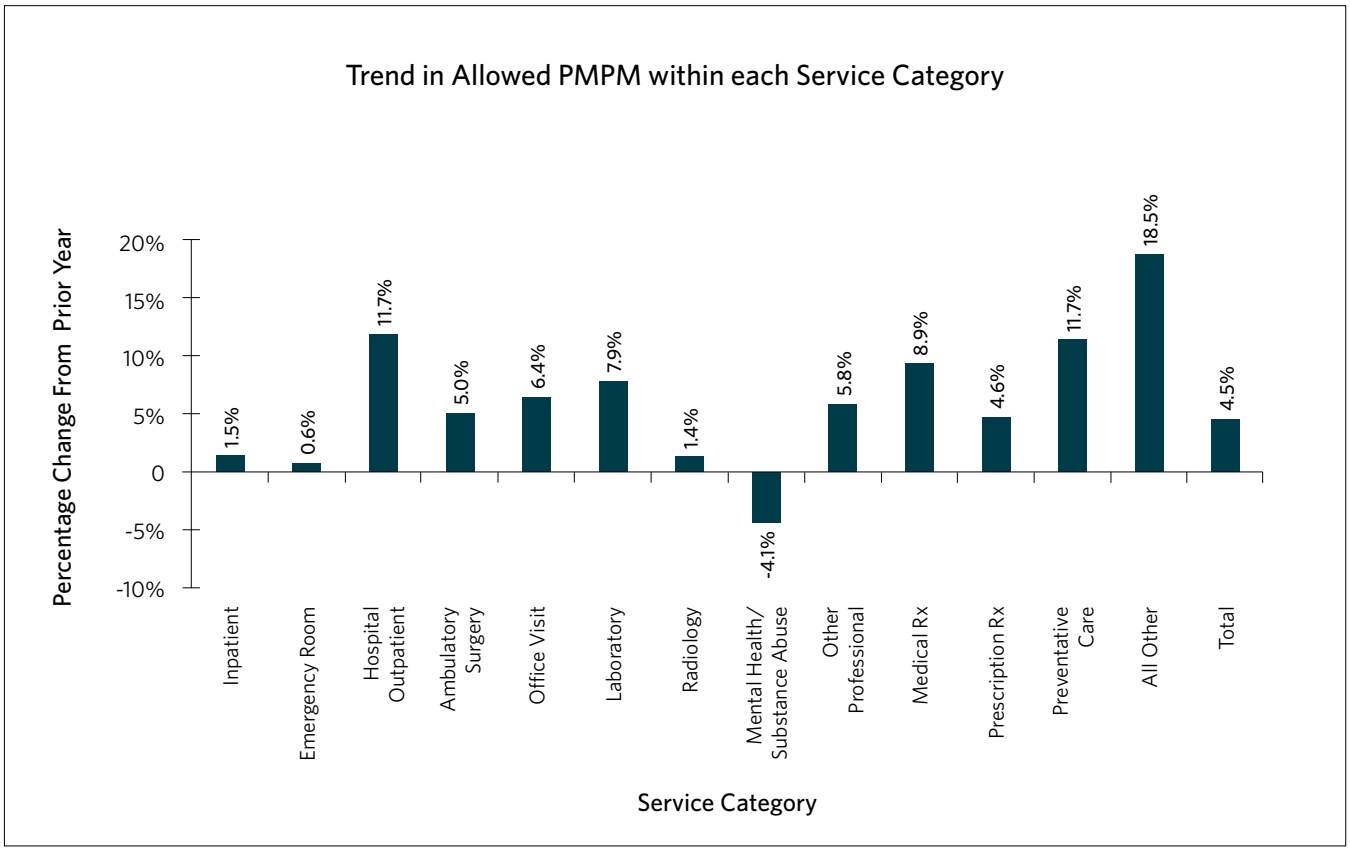
	2017	2018	2019
Medicare HMO Plans			
Anthem Traditional HMO	—	459	1,799
Kaiser Permanente Senior Advantage	90,805	95,063	99,111
Kaiser Permanente Senior Advantage Out-of-State	1,878	2,014	2,220
UnitedHealthcare	38,232	39,631	41,039
Medicare PPO Plans			
PERS Choice	67,258	69,545	72,260
PERS Select	1,792	1,939	2,136
PERSCare	58,361	60,796	62,653
Medicare Association Plans			
California Association of Highway Patrolmen	4,286	4,343	4,415
California Correctional Peace Officers Association North	447	511	581
California Correctional Peace Officers Association South	567	626	694
Peace Officers Research Association of California	2,160	2,265	2,425
Medicare Total	265,786	277,192	289,333
Grand Total	**1,437,360**	**1,456,806**	**1,475,918**
Program			
State	846,175	857,733	870,085
Contracting Agency	591,185	599,073	605,833
Total	1,437,360	1,456,806	1,475,918
Employment Status			
Active	986,223	994,481	1,001,983
Retired	451,137	462,325	473,935
Total	1,437,360	1,456,806	1,475,918
Subscriber and Dependent Tier			
Single	312,386	318,586	326,040
2-Party	392,805	400,827	407,846
Family	732,169	737,393	742,032
Total	1,437,360	1,456,806	1,475,918

Appendix C – Medical Trends

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

The trend in allowed PMPM [17] cost [18] is examined across 13 service categories,[19] revealing the key drivers of medical trend changes for the last year.

The chart below shows the trend for each individual service category. The largest increase was with claims not assigned to a service category (All Other) at 18.5%.



Data as of June 22, 2020

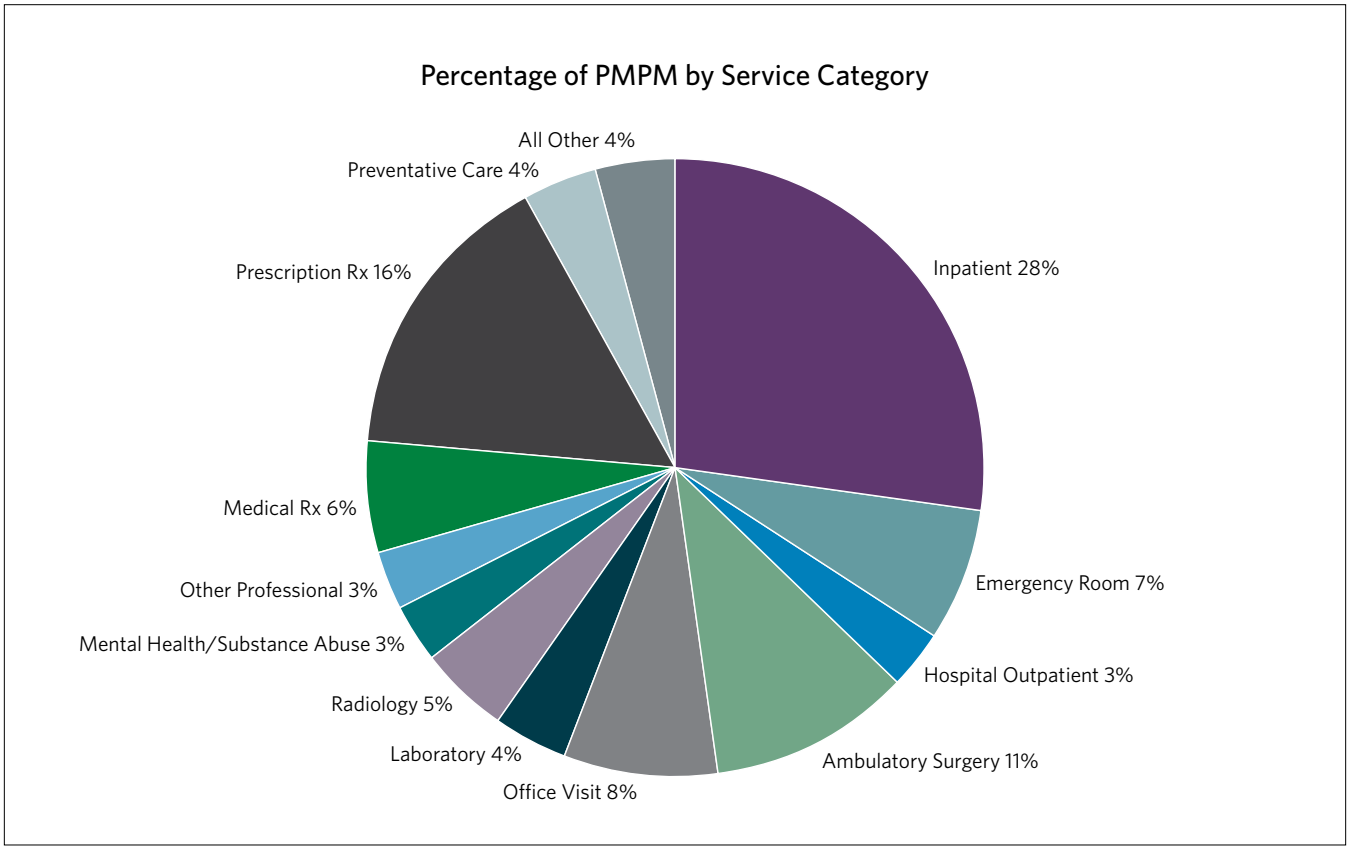
[17] Allowed cost divided by sum of member months in period, adjusted for population size.

[18] Contractual "allowed amounts" due to providers inclusive of member out-of-pocket obligations such as co-insurance, copays, deductibles, etc. Report shows "allowed" rather than "net" to provide easier comparisons between plans with different benefit designs (e.g., HMO plans vs. PPO plans).

[19] The Prescription Rx service category data does not include rebates.

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

The chart below shows the composition of total allowed PMPM by percentage of each service category.[20] The three major drivers that account for 55% of the total allowed PMPM are inpatient (28%), prescription drug (Prescription Rx) (16%), and ambulatory surgery (11%).[21]



Data as of June 22, 2020

[20]The Prescription Rx service category data does not include rebates.

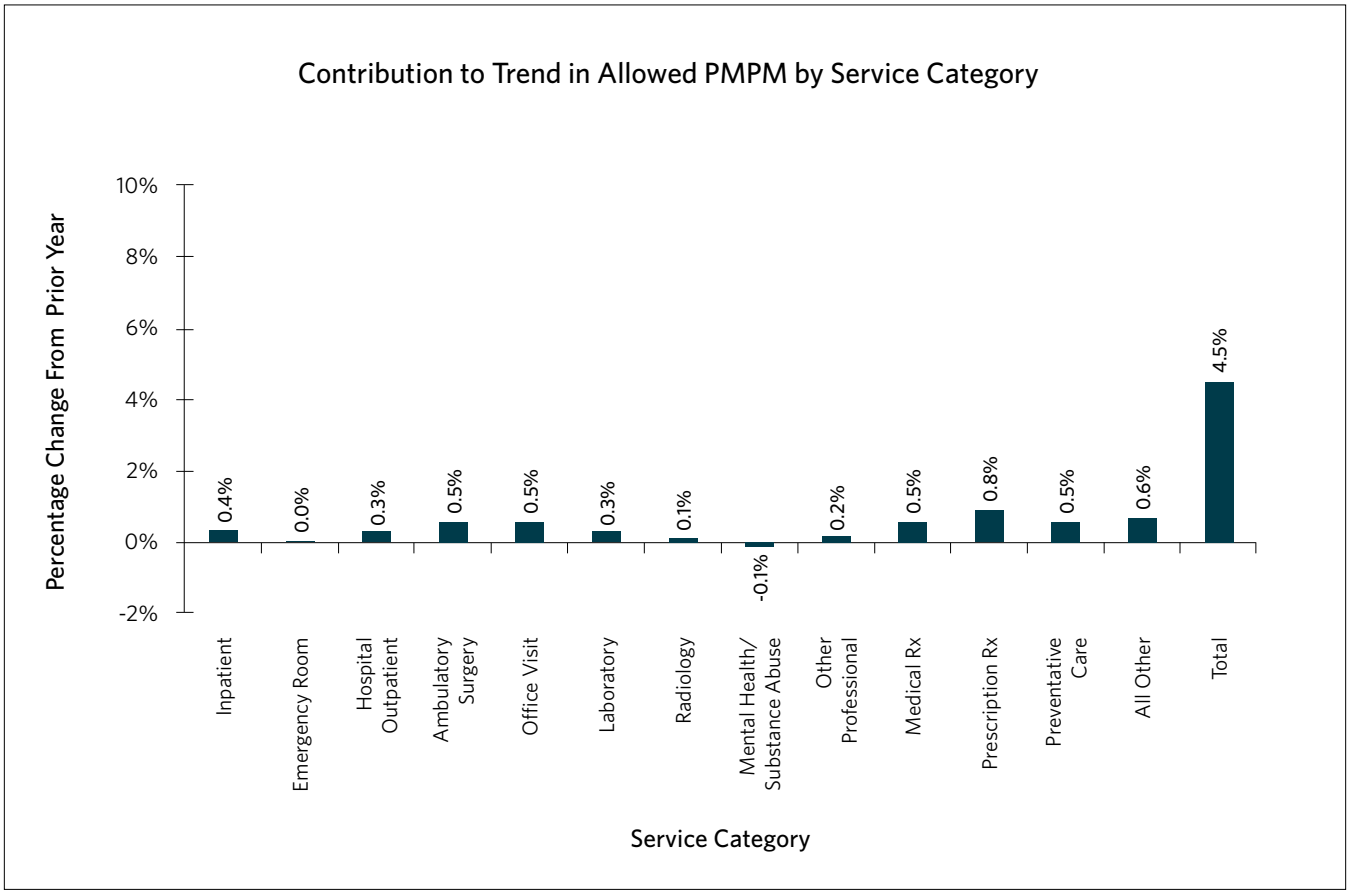
[21]The sum of the Percentage of PMPM by Service Category is greater than 100% due to rounding.

Appendix C – Medical Trends, cont.

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

In calendar year 2019, the total allowed PMPM increased 4.5% across all service categories. [22]

The chart below shows the major drivers that contributed to trend in allowed PMPM for calendar year 2019. Prescription drug (Prescription Rx) accounted for 0.8%, ambulatory surgery was 0.5%, and inpatient was 0.4%.[23]



Data as of June 22, 2020

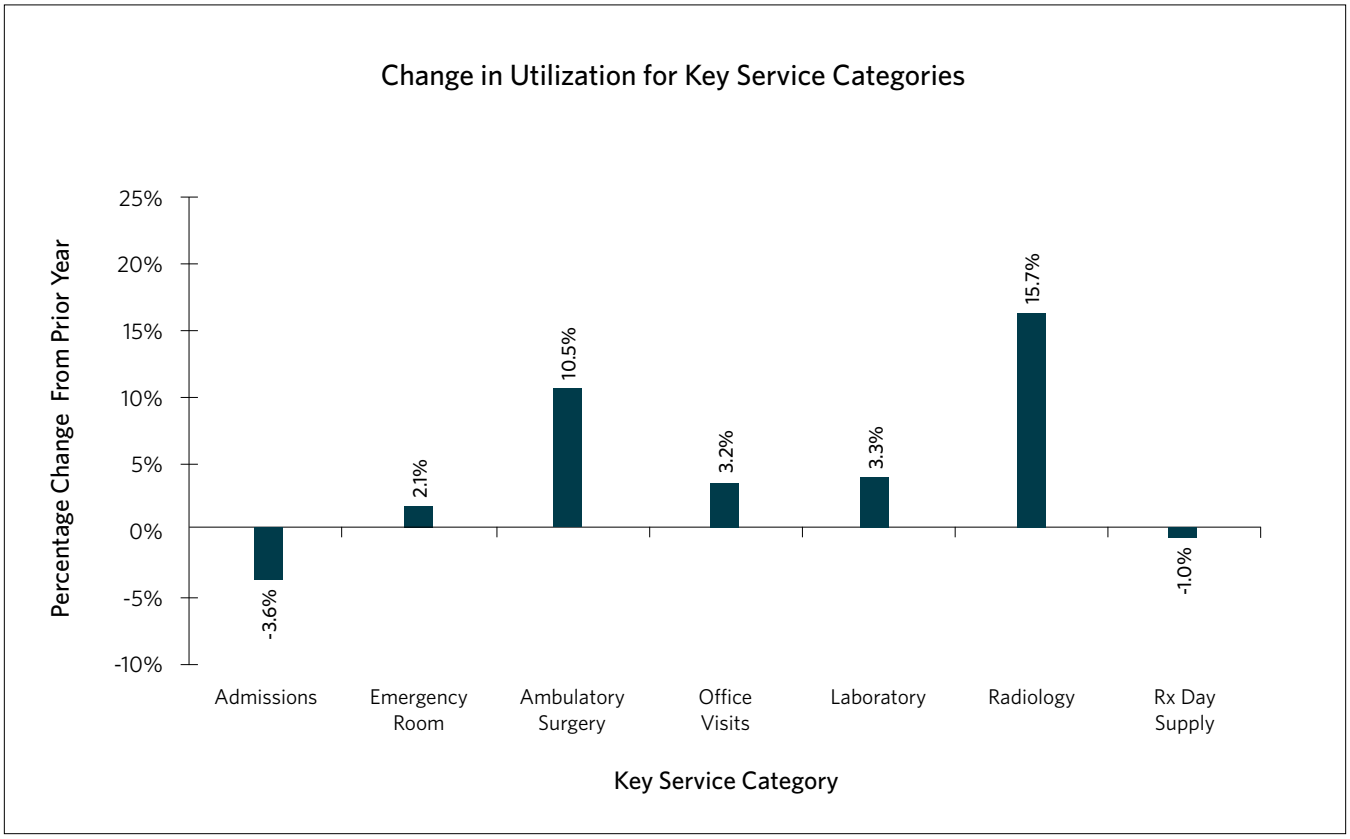
[22] The Prescription Rx service category data does not include rebates.

[23] Total may not equal the sum of the Contribution to Trend in Allowed PMPM by Service Category totals due to rounding.

Change in Utilization by Key Service Categories

Among the largest service categories,[24] allowed PMPM is driven by change in utilization per unit.

- Increases in utilization occurred in number of radiology services by 15.7%, number of ambulatory surgeries by 10.5%, number of laboratory services by 3.3%, the number of office visits by 3.2% and the number of emergency room by 2.1%.
- Decreases in utilization occurred in number of admissions by 3.6% and prescription drug days (Rx Days Supply) by 1.0%.



Data as of June 22, 2020

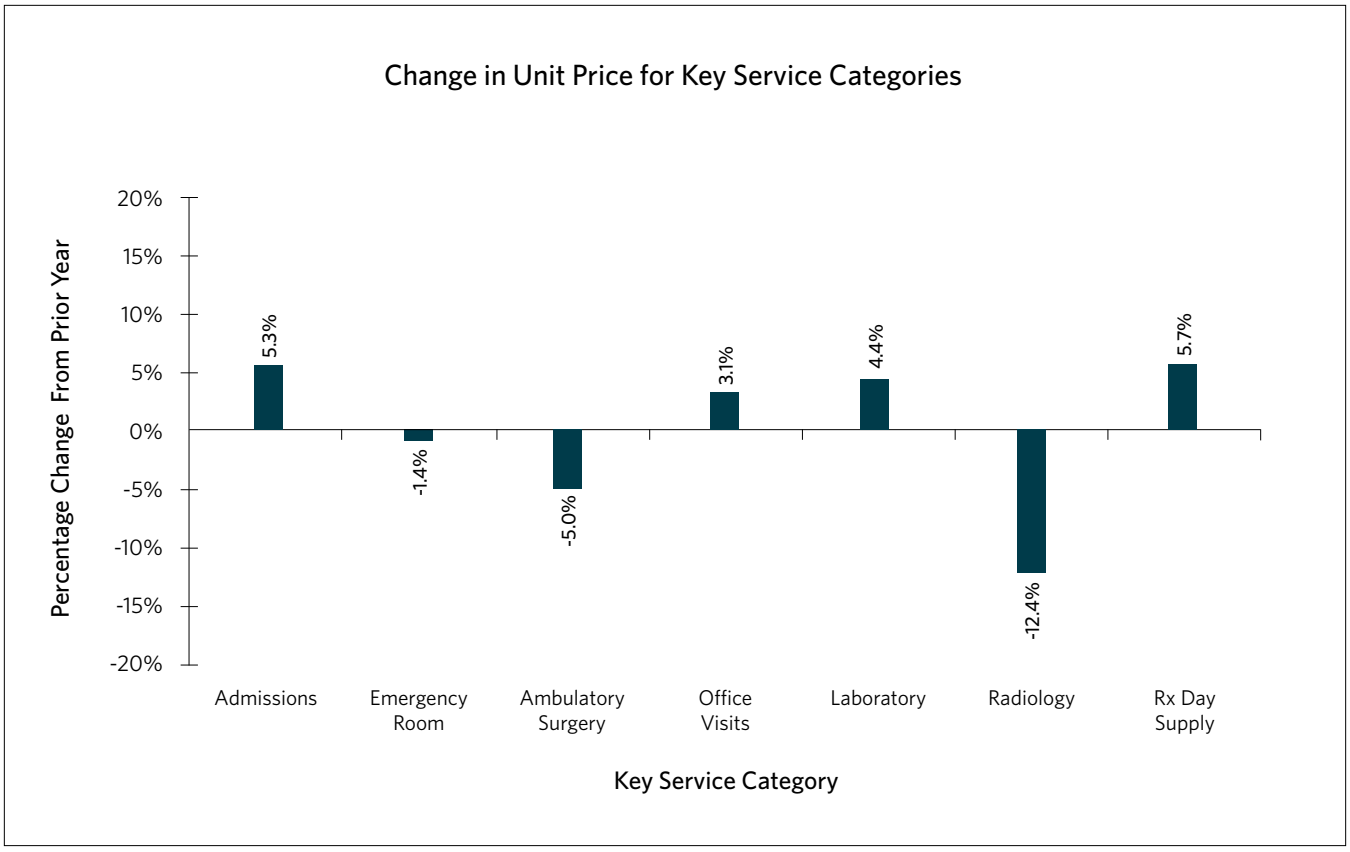
[24]The Prescription Rx service category data does not include rebates.

Appendix C – Medical Trends, cont.

Change in Unit Price by Key Service Categories

Among the largest service categories,[25] allowed PMPM is driven by change in price per unit.

- Unit price increased for prescription drug days (Rx Days Supply) by 5.7%, admissions by 5.3%, laboratory by 4.4% and office visits by 3.1%.
- Unit price decreased for radiology services by 12.4%, ambulatory surgeries by 5.0%, and emergency room by 1.4%.



Data as of June 22, 2020

[25]The Prescription Rx service category data does not include rebates.

Appendix D – Historic Expenditures

Estimated Expenditures (dollars in thousands)[26]

	2017	2018	2019
Basic HMO Plans			
Anthem Blue Cross Select	$198,485	$179,429	$227,092
Anthem Blue Cross Traditional	116,810	108,476	162,288
Blue Shield Access+	1,282,944	1,183,603	948,644
Health Net Salud y Más	23,380	34,176	33,023
Health Net SmartCare	223,271	131,035	184,787
Kaiser	3,180,572	3,536,700	3,562,206
Kaiser Out-of-State	5,919	6,964	8,386
Sharp Health Plan	58,848	65,318	69,283
UnitedHealthcare	440,616	489,667	506,862
Western Health Advantage	—	39,250	64,119
Basic EPO and PPO Plans			
Anthem Del Norte EPO	611	814	689
Anthem Monterey EPO	27,852	—	—
PERS Choice	1,159,173	1,077,571	1,121,899
PERS Select	291,357	311,141	318,984
PERSCare	261,089	301,576	305,912
Basic Association Plans			
California Association of Highway Patrolmen	140,966	148,809	157,930
California Correctional Peace Officers Association North	63,709	61,699	57,541
California Correctional Peace Officers Association South	150,087	165,021	167,591
Peace Officers Research Association of California	158,212	158,807	152,782
Basic Total	$7,783,901	$8,000,056	$8,050,018

[26]A "—" indicates that the plan did not exist in those years.

Appendix D – Historic Expenditures, cont.

	2017	2018	2019
Medicare HMO Plans			
Anthem Traditional HMO	—	2,040	7,712
Kaiser Permanente Senior Advantage	327,399	360,840	385,023
Kaiser Permanente Senior Advantage Out-of-State	6,772	7,645	8,624
UnitedHealthcare	148,711	157,284	147,423
Medicare PPO Plans			
PERS Choice	285,384	288,701	312,532
PERS Select	7,604	8,050	9,242
PERSCare	272,947	278,880	296,904
Medicare Association Plans			
California Association of Highway Patrolmen	18,109	19,236	20,952
California Correctional Peace Officers Association North	2,289	2,760	3,384
California Correctional Peace Officers Association South	2,903	3,381	4,042
Peace Officers Research Association of California	11,994	13,201	14,895
Medicare Total	$1,084,112	$1,142,018	$1,210,734*
Grand Total	**$8,868,013**	**$9,142,074**	**$9,260,752**
Program			
State	$5,127,141	$5,292,417	$5,374,622
Contracting Agency	3,740,872	3,849,657	3,886,130
Total	$8,868,013	$9,142,074	$9,260,752
Employment Status			
Active	$6,375,273	$6,581,150	$6,598,806
Retired	2,492,740	2,560,924	2,661,946
Total	$8,868,013	$9,142,074	$9,260,752
Subscriber and Dependent Tier			
Single	$2,165,345	$2,231,747	$2,228,237
2-Party	2,708,354	2,789,267	2,863,765
Family	3,994,314	4,121,060	4,168,751
Total	$8,868,013	$9,142,074	$9,260,752

* Total may not equal the sum of Medicate totals due to rounding.

Appendix E – 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
3/31/2009	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%*
12/31/2013	0.248%	9/30/2019	2.042%*
3/31/2014	0.222%	12/31/2019	1.856%*
6/30/2014	0.228%	3/31/2020	1.650%*
9/30/2014	0.234%	6/30/2020	1.236%*

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

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

D November 2020