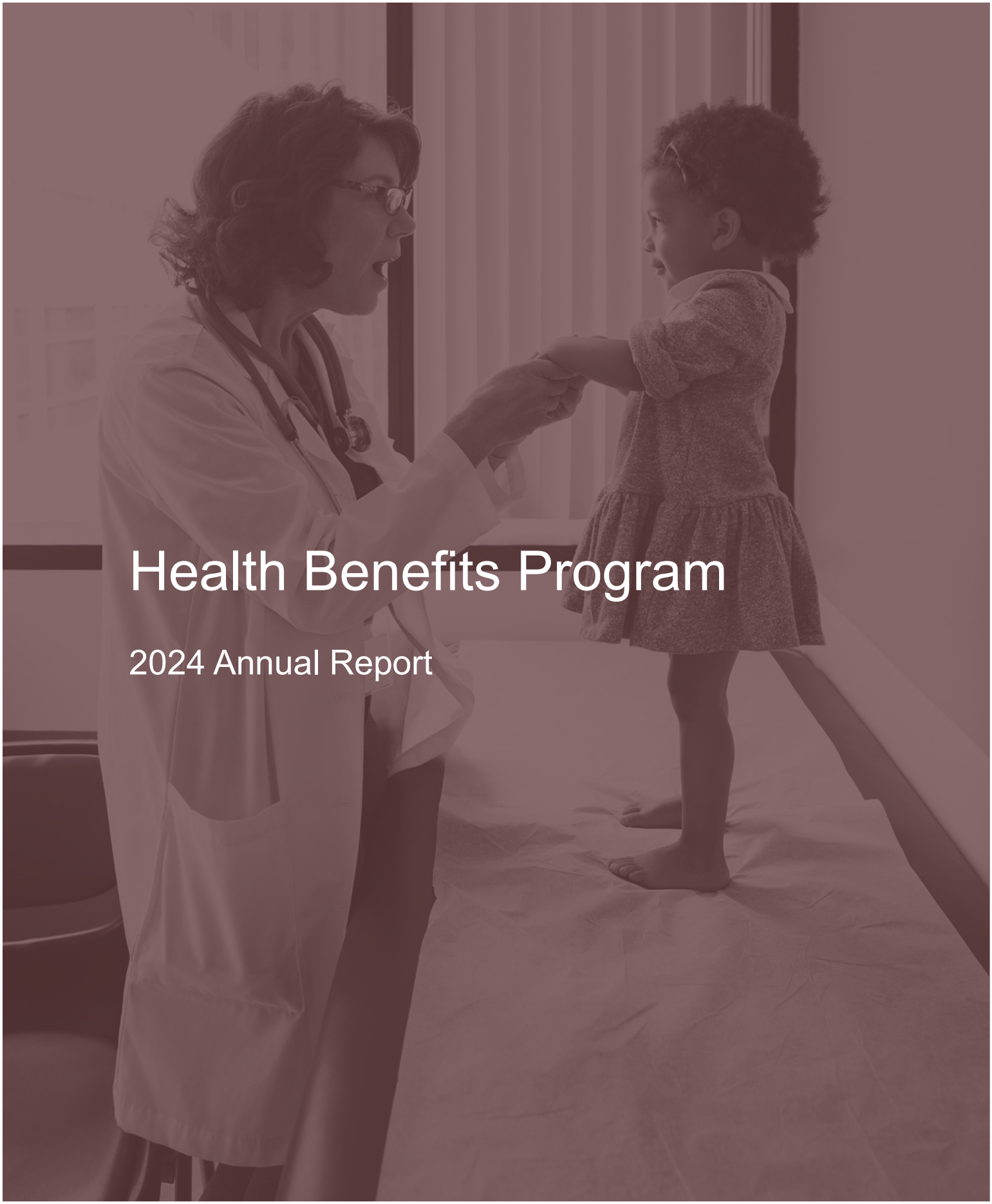

Health Benefits Program

2024 Annual Report

Published November 1, 2025

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, 2024. This publication provides an overview of the Health Benefits Program, as required by California Government Code Section 22866.

Throughout 2024, CalPERS strengthened and expanded its health offerings to meet the evolving needs of our more than 1.5 million members. We prioritized access, affordability, and quality, while advancing long-term initiatives aimed at mitigating risk and stabilizing costs. In this year's annual report, you'll find information about our health plans, geographic coverage, benefit designs, actuarial value, financial information, and member satisfaction results from our annual health plan survey.

In 2024, we saw an overall rate change in our premiums of 10.77%. Basic health maintenance organization (HMO) health plans had a 10.5% overall increase, while Basic preferred provider organization (PPO) plans increased 12.17% overall. Premiums for our Medicare plans increased by 9.55%. Approximately 61,000 members, or about 3.9%, of total members, switched health plans during Open Enrollment, starting 2024 in a new plan.

CalPERS also added high-quality service area expansions and benefits to expand choice and improve members' health. In 2024, we added lower cost HMO and exclusive provider organization (EPO) options to provide members with more plan choices. These expansions included the addition of a new HMO plan in 12 Bay Area counties for public agency and school members, Medicare plans in eight out-of-state regions, and two new supplemental benefits for our Medicare Advantage plans.

As part of our 2024 Business Plan, we successfully completed the PPO health plan contract solicitation effective for the 2025 plan year. Included in the new five-year contracts are substantial performance guarantees on cost and quality, with hundreds of millions of dollars at-risk if the new PPO and population health manager do not meet set goals. The goals align with CalPERS' commitment to provide affordable and sustainable high-quality care, as well as total cost of care targets established by California's Office of Health Care Affordability benchmarks for 2029.

Together with our partners and stakeholders, we are proud to provide our members with affordable, equitable, and high-quality health care. Our work remains mission driven and grounded in the belief that the programs and services we administer reflect the diversity, priorities, and needs of those we serve.

Marcie Frost
Chief Executive Officer

About CalPERS Health Benefits Program

With more than 1.5 million members, CalPERS is the largest purchaser of commercial health benefits in California and the second-largest commercial purchaser in the nation. In 2024, we spent $12.4 billion to secure 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 contracting agencies (public agencies and schools).

Headquartered in Sacramento, we also operate eight Regional Offices located in Fresno, Glendale, Orange, Sacramento, San Bernardino, San Diego, San Jose, and Walnut Creek.

Our 13-member Board of Administration consisting of member-elected, appointed, and ex-officio members, administers the California Public Employees' Medical and Hospital Care Act, which is the primary body of law governing our health program and contracted health plans. Plans are 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, actuarial studies, and rate setting for pension, health, and Long-Term Care Program policies.

Beginning in the 1960s, we became the health benefits purchaser for state employees and participating contracting agencies.

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, high-quality, and equitable health benefits we provide to help our members maintain their quality of life no matter what their age.

Strategic Direction and Policy Initiatives

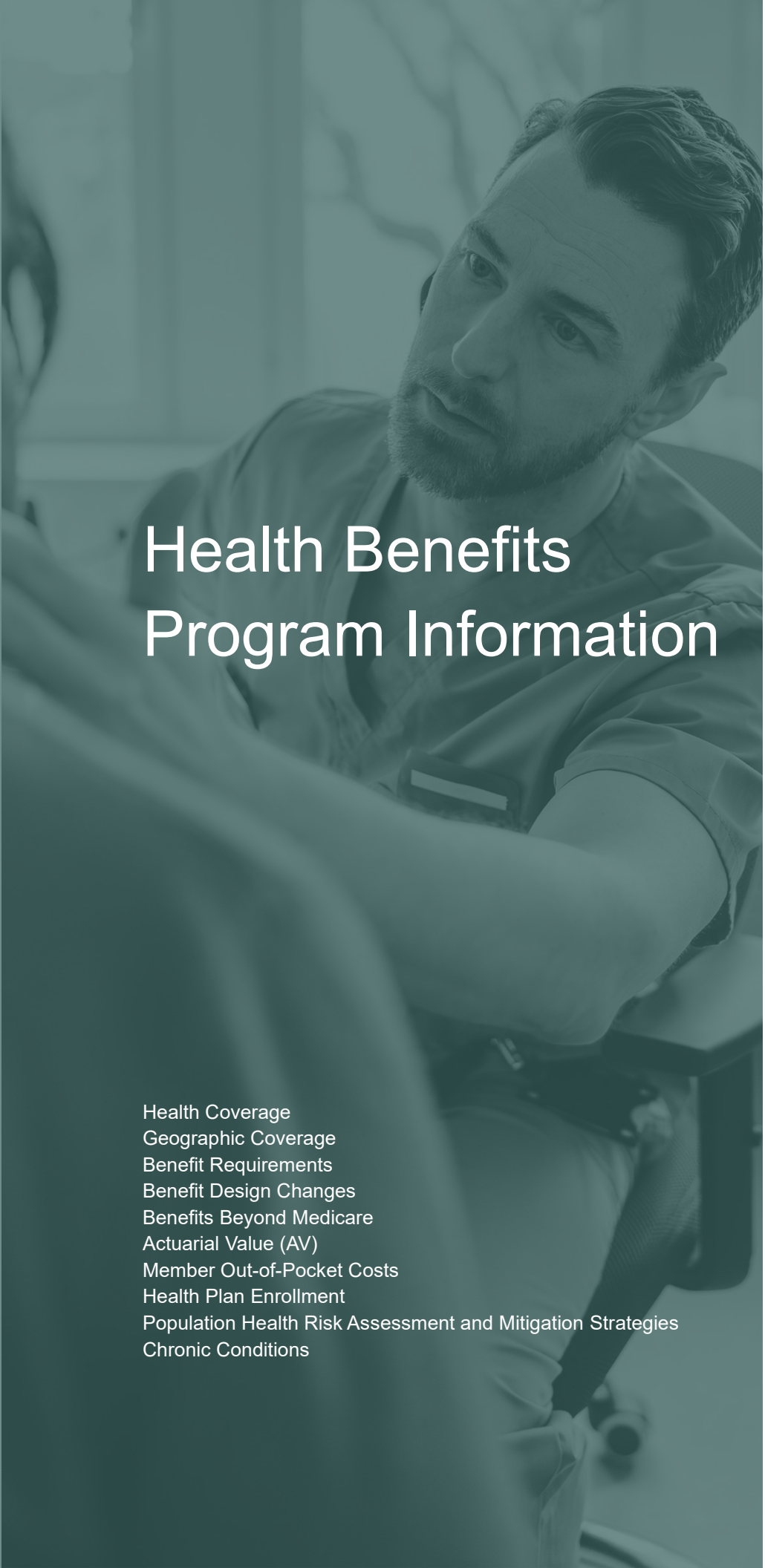
The 2022–27 CalPERS Strategic Plan is the roadmap that guides us to meet the investment, retirement, and health benefit needs of our members and their families. It is the result of a collaborative process between our board and executive team that steers us through June 30, 2027. The Health Policy & Benefits Branch (HPBB) aims to achieve exceptional health care through the following objectives:

- Ensure our members receive high-quality health care
- Ensure our members have access to care when and where they need it
- Ensure the care we provide is affordable
- Ensure all members receive equitable care

Figure 1 shows our health-related business plan initiatives for the 2024–25 Business Plan.[1] Additional information on the strategic plan and business plans are available in **Strategic & Business Plans** at **www.calpers.ca.gov.**

[1] All fiscal year 2024-25 Business Plan Initiatives have a reporting status of on-target.

Figure 1: 2024-25 HPBB Business Plan Initiatives



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Health Coverage

We provide a wide selection of high-quality health plan options to our members and their families. For the 2024 plan year, our Basic health plan offerings included fully insured and flex-funded HMO plans, self-funded PPO plans, and self-insured and fully insured EPO plans.

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

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

We offer Basic health plans and Medicare health plans for our Medicare eligible members.[2] We also offer Association plans[3] for members who pay applicable dues to certain employee associations.

Look ahead: In July 2025, the board approved a new 2026–2030 contract with CVS Caremark (CVS) to provide self-funded pharmacy benefits for some of our Basic and Medicare HMO and PPO members. The five-year contract includes new financial terms with CVS putting $250 million at-risk over the term of the contract for controlling drug costs and improving the health of CalPERS members.

[2] We offer limited Basic and Medicare health plan options for members who live out-of-state.

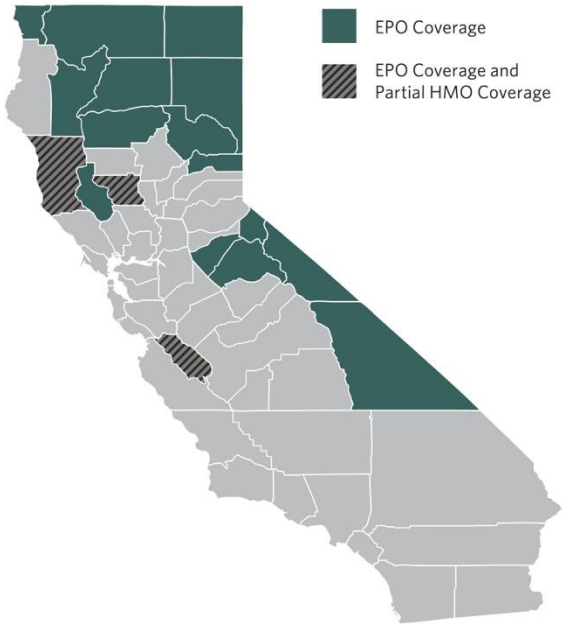
[3] We do not negotiate premiums and are not responsible for the benefit administration of association plans.

Geographic Coverage

Our members have Basic and Medicare health plan options in all 58 California counties and throughout the United States; however, historically, members in some rural[4] areas have had trouble accessing care.

Members in rural areas may experience challenges similar to those in other parts of rural America. There can be shortages of primary care physicians, specialists, and hospitals, and members may need to travel further to seek health care services than those living in urban and suburban areas.

Figure 2: 2024 CalPERS EPO Coverage by County



In recent years, we made significant efforts to further expand access to our members living in rural California counties by adding EPO access to decrease out-of-pocket costs in rural areas. By mirroring the cost-sharing in HMOs, EPOs help decrease financial barriers to care.

An EPO plan provides the same covered services as an HMO plan with the flexibility to visit any doctor or specialist within the plan's preferred provider network without a referral. EPO health plans are an effective tool in counties where it's challenging to put together an HMO.

In 2024, more CalPERS members living in rural California counties were able to access their health benefits through either an EPO or a PPO health plan. We continue to work towards our goal to have an EPO or HMO available in every ZIP code in California. To illustrate coverage in these rural counties, Figure 2 displays a map of California including the 15 rural counties of Alpine, Calaveras, Del Norte, Inyo, Lake, Lassen, Modoc, Mono, Plumas, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne. Members in Colusa and Mendocino counties continued to have access to EPO coverage and also have HMO coverage in partial areas of each county. Additionally, members in San Benito County have access to EPO coverage along with existing HMO coverage.

[4] Rural is defined as a California service area in which members in some rural areas only have access to our PPO and EPO plans.

Benefit Requirements

State Law

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

- Physician services
- Hospital inpatient services and ambulatory care services
- Diagnostic laboratory
- Diagnostic and therapeutic radiologic services
- Home health services
- Preventive health services
- Emergency health care services
- Hospice care

The DMHC and California Department of Insurance do not regulate our self-funded Basic PPO plans, but the PPO benefit designs are very similar to our Knox-Keene Act regulated HMO plans.

Federal Law

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

Under the ACA, 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 the ACA does not require large group health plans to provide EHB, our HMO, EPO, and PPO Basic health plans provide benefits in all required EHB categories except for pediatric dental and vision care. Our health plans do not provide these services because the California Department of Human Resources, the Office of the Chancellor, and each contracting agency administer pediatric dental and vision care for their employees.

Our Basic plans cover the following EHB categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Behavioral health treatment, including mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management

Under the MHPAEA, copays and treatment limitations for medical and behavioral health care treatment must be the same. Additionally, the ACA includes mental health and substance use disorder services as covered benefits. We continue to hold our plans accountable, ensuring that they are improving on behavioral health screening and early intervention services, coordinating care through the integration of primary care and behavioral health services, and improving behavioral health care provider networks through virtual behavioral health services and increased behavioral health network monitoring.

Other Benefits

Our Basic health plans also provide coverage for the following benefits:

- Acupuncture services
- Chiropractic services
- Durable medical equipment
- Emergency Medical Transport Services
- Hearing aid services
- Home Health Care Services
- Nurse Advice Line

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 at the direction of the board.

In the 2024 plan year, we adopted the following board approved benefit design changes:

Site of Care Lab Services Incentive

PERS Gold and PERS Platinum — Basic members can have coinsurance waived when using preferred lab providers for routine lab tests. The potential savings for this program are approximately $9 million annually, with up to $1.5 million of savings going back to members as co-insurance savings, which reduce or eliminate member out-of-pocket expenses.

Pharmacy Mail-Order

Pharmacy mail-order program with opt-out option guiding Basic members to use home delivery for non-specialty maintenance medications implemented for health plans using CalPERS' Pharmacy Benefits Manager.

Emergency Room Visits

UnitedHealthcare Group Medicare Advantage Edge — Copays increased from $0 to $50 for emergency room (ER) visits to encourage members to seek the appropriate level of care and to align our copay structure for ER visits across all our HMO and Medicare Advantage health plans.

Out-of-Network Deductible Change

PERS Gold and Platinum — Basic PPO out-of-network deductible increased from $1000 to $2500 for Gold and from $500 to $2000 for Platinum. The deductible change is projected to reduce the 2024 Basic PPO premium increase by 1.2%.

Personal Emergency Response Systems (PERS) and In-Home Support Services

Anthem Medicare Preferred PPO — New supplemental benefits for PERS devices and in-home support services. These benefits expand the Special Supplemental Benefits for Chronic Illness (SSBCI) offered in Anthem Medicare Preferred PPO plan. The projected cost impact of the PERS device coverage is $2.28 per member per month (PMPM), a 0.55% increase on the projected premium. The projected cost impact of the in-home support services is $2.10 PMPM, a 1.09% increase on the projected premium. These benefits allow older adults to remain safely at home and to avoid unnecessary ER visits and hospitalizations.

Benefits Beyond Medicare

We offer PERS Gold and PERS Platinum PPO Supplement to Original Medicare plans. These plans cover Medicare-approved services with payments supplemented by the plan. These plans also provide coverage for some benefits not covered by Medicare (e.g., acupuncture outside of treatment for chronic low back pain). The plans provide coverage for medically necessary services and supplies when benefits under Medicare are exhausted or when charges for certain services and supplies exceed amounts covered by Medicare. The aggregated cost of benefits beyond Medicare for calendar year 2024 was $14 million.[5]

[5] In prior reports, the aggregated costs of benefits beyond Medicare calculations were overstated. The accounting methodology has been updated for this year's report.

Actuarial Value (AV)

Actuarial Value (AV) represents the percentage of total average costs for covered benefits that a health plan will cover under the Patient Protection and Affordable Care Act (ACA). 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. The ACA groups health plans into four AV metal 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.

CalPERS' Basic HMO, EPO, and PPO plans have a higher AV than most plans sold in the individual, small, and large group markets. CalPERS' Basic HMO and EPO health plans fall in the Platinum tier, while the PPO plans are a combination of Gold and Platinum. The ACA does not require AV ratings for Medicare health plans; therefore, there are no metal tiers for these plans.

For a complete listing of AV metal tiers for our Basic health plans, refer to Appendix C, which also includes the average annual member out-of-pocket costs by health plan.

Member Out-of-Pocket Costs

Member out-of-pocket costs are members' expenses for medical services and prescription drugs not reimbursed by insurance. These costs include deductibles, coinsurance, copays, and other out-of-pocket costs as specified in the CalPERS health plans' Evidence of Coverage booklets. Out-of-pocket expenses do not include health plan monthly premium amounts.

Table 1: 2024 Average Out-of-Pocket Annual Member Costs[6]

Plan Type	$/year
Basic HMO	$133
Basic EPO	$161
Basic PPO	$959
Medicare Advantage	$301
Medicare Supplement	$281
Overall Average	**$309**

Refer to Appendix C for the average annual member out-of-pocket costs by health 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.**

[6] We base these figures on health claims data for the 2024 plan year. We do not collect data on non-covered services such as over-the-counter medications or out-of-network care.

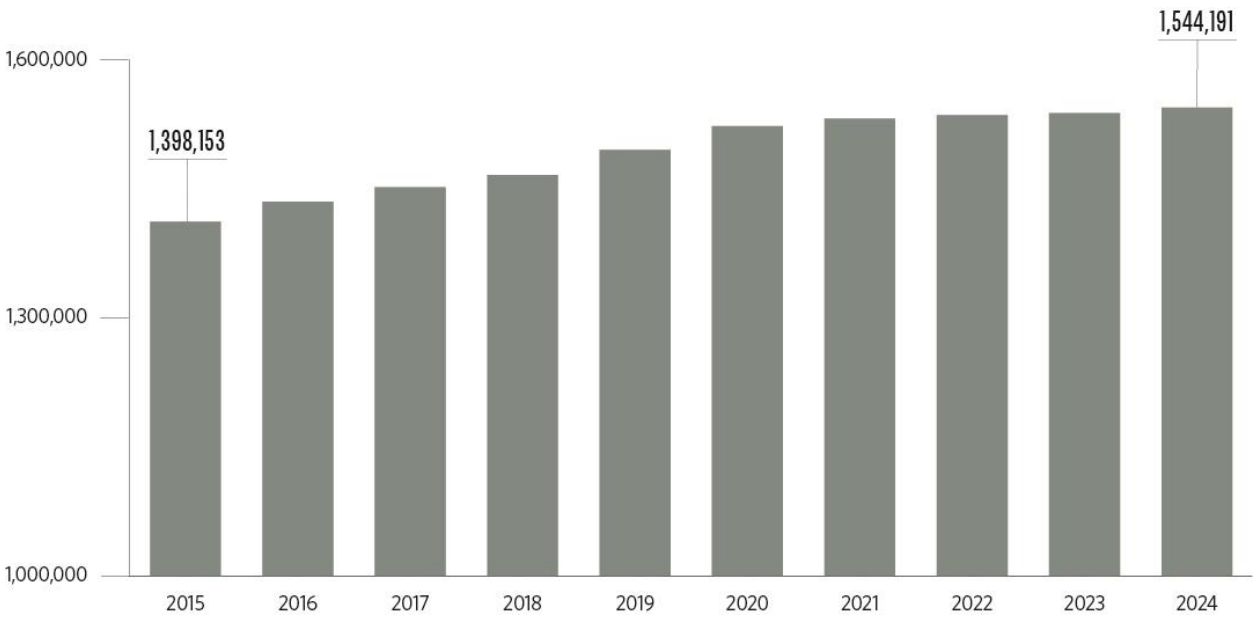
Health Plan Enrollment

We have seen our health plan enrollment grow over the past 10 years. Between 2015 and 2024, CalPERS' total enrollment has increased by 10.5%.[7]

Appendix A displays detailed enrollment data for plan years 2022-2024 by plan name, health coverage type (Basic or Medicare), employer type (state or contracting agency), employment status (active or retired), and subscriber and dependent tier (single, two-party, or family).

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

Figure 3: CalPERS 10-Year Historic Enrollment



[7] Enrollment data is as of January 1, 2024.

Population Health Risk Assessment and Mitigation Strategies

Risk Mitigation for Basic Plans

We use a risk mitigation strategy to risk adjust premiums for the Basic health plans. This strategy manages population health risk within the Basic health plans, promotes efficient care management, and mitigates year-over-year premium volatility and large premium increases. Our risk mitigation strategy also requires health plans to compete based on quality of care rather than a plan's ability to attract a low-risk population.

We do not include Medicare plans in our risk mitigation strategy. This is done by Centers for Medicare and Medicaid Services (CMS) through their own process.

Health Plan Risk Scores

To implement our risk mitigation strategy, we engaged Milliman, an international actuarial and consulting firm, in the development of the health plan risk scores. We base the health plan risk scores on the Milliman Advanced Risk Adjusters (MARA) prospective tool. The MARA tool analyzes each member's medical claim history to produce risk scores that predict their risk of incurring future health care costs.

Development of Risk Adjusted Premiums

We adjust health plan premiums annually based on their respective risk scores. For example, a higher risk score indicates members within a given plan use health care services more than the average member, making its overall costs higher than the value of the plan based on its network. The risk adjustment will then decrease the premium to be lower than the unadjusted premium to better align with the value of the plan and its network.

For more information, visit our **Risk Mitigation for Basic Plans** webpage at **www.calpers.ca.gov.**

Chronic Conditions

We employ several mechanisms to evaluate overall member health, such as examining data on chronic conditions, reviewing population demographics, and analyzing utilization and trend data. For 2024, this evaluation showed that nearly a quarter of our population had one or more of the top chronic conditions.[8,9]

2024 Common Chronic Conditions[8,9,10]

Table 2a: Basic Plan Members

Common Chronic Conditions	2023		2024	
	Population	Prevalence (%)	Population	Prevalence (%)
Hypertension	69,115	5.9%	84,096	7.1%
Depression	72,753	6.2%	80,619	6.8%
Diabetes	61,144	5.2%	75,272	6.4%
Asthma	35,765	3.0%	41,654	3.5%
Coronary Artery Disease	8,454	0.7%	10,149	0.9%
COPD	2,202	0.2%	2,268	0.2%
Congestive Heart Failure	1,658	0.1%	1,896	0.2%

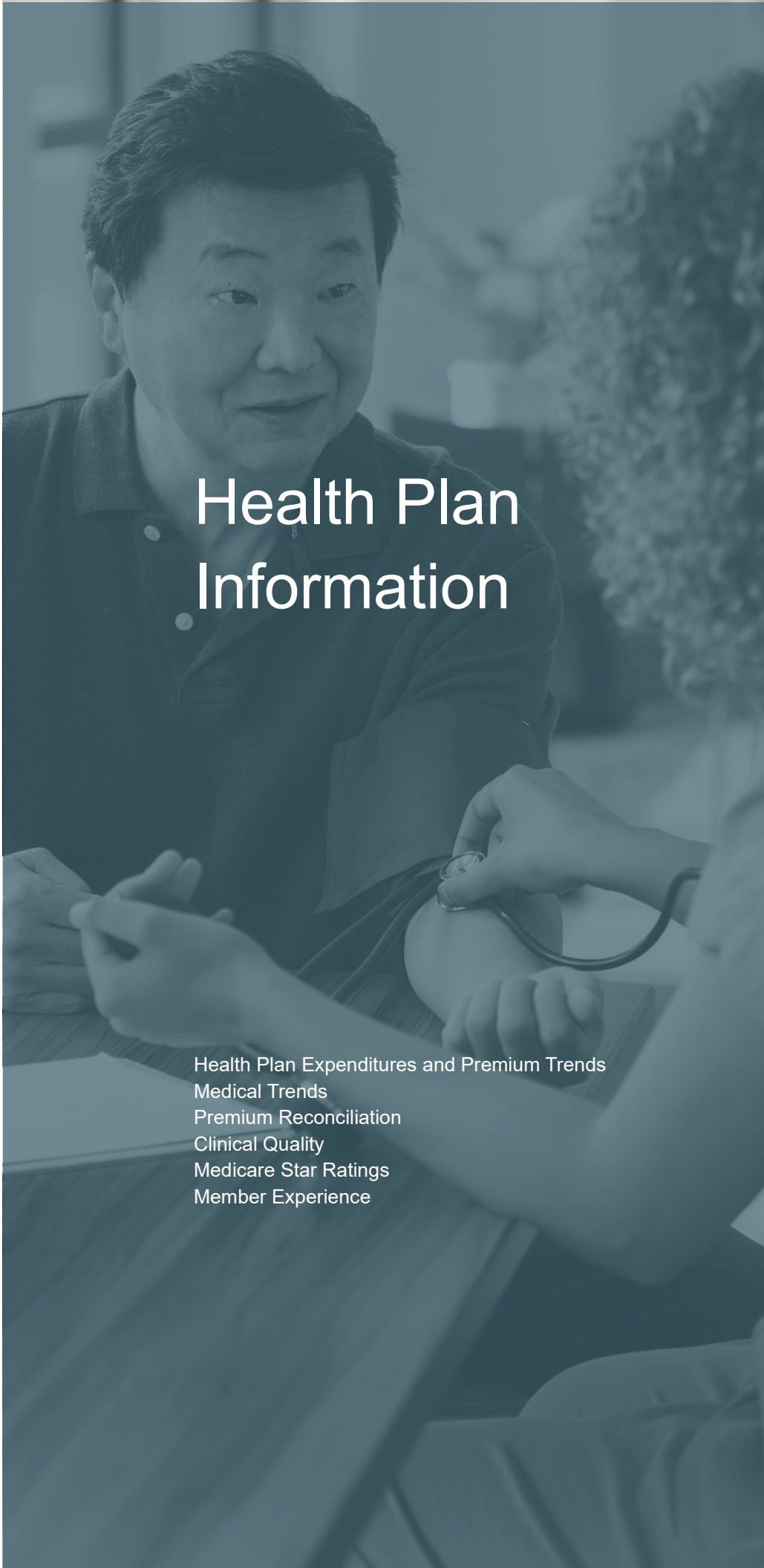
Table 2b: Medicare Plan Members

Common Chronic Conditions	2023		2024	
	Population	Prevalence (%)	Population	Prevalence (%)
Hypertension	65,816	23.2%	69,338	24.1%
Diabetes	37,910	13.4%	41,098	14.3%
Coronary Artery Disease	18,503	6.5%	20,455	7.1%
Depression	14,306	5.0%	15,004	5.2%
Asthma	6,981	2.5%	7,608	2.6%
COPD	6,545	2.3%	6,582	2.3%
Congestive Heart Failure	5,084	1.8%	5,417	1.9%

[8] We use the Health Care Decision Support System (HCDSS) medical episode grouper to measure prevalence of chronic conditions.

[9] Data based on members living in California only and include 1,180,072 Basic members and 287,626 Medicare members.

[10] Some members have more than one common chronic condition; therefore, the same member may be counted in more than one category.



Health Plan Information

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Health Plan Expenditures and Premium Trends

We establish health plan premiums annually through the analysis of approximately 18 months of recent claims data, any changes to benefit design, and estimates for future health care costs. We perform analyses in accordance with generally accepted actuarial standards of practice. The process to establish the 2024 health plan premiums began in 2023 and includes data from 2022 and 2023.

The following factors drive CalPERS' health plan premiums:

- Medical and pharmaceutical cost inflation
- New and high-cost specialty drugs
- Population age and gender
- Population geographic location
- Prevalence of chronic conditions
- Provider contract negotiations

For 2024, the total estimated premium expenditure was nearly $12.4 billion. Premiums increased by 10.77% overall for Basic and Medicare plans combined.[11] CalPERS' Basic HMO plans increased by an average 10.50%. Basic PPO plans increased by an average of 15.76%, Medicare Advantage plans decreased by an average of 13.17%, and Supplement to Original Medicare plans increased by an average of 6.62%.

[11] The Basic and Medicare premium increases reflect average premium changes of CalPERS' plans.

Table 3: Overall Weighted Average Premium Changes by Coverage Type

Coverage Type	2020	2021	2022	2023	2024
Basic HMOs	5.98%	4.44%	4.69%	4.35%	10.50%
Basic PPOs	3.28%	8.54%	8.67%	15.76%	12.17%
Total Basic Plans	**5.35%**	**5.40%**	**5.65%%**	**7.21%**	**10.95%**
Medicare Advantage	6.08%	(4.46%)	(6.37%)	(3.23%)	13.17%
Medicare Supplement	(2.52%)	(0.65%)	5.48%	9.83%	6.62%
Total Medicare Plans	**1.52%%**	**(2.54%)**	**(0.36%)**	**3.69%**	**9.55%**
Overall	**4.84%**	**4.32%**	**4.86%**	**6.75%**	**10.77%**

Table 4: Historic Annual Expenditures by Member Type[12] (in Billions)

Member Type	2020	2021	2022	2023	2024
Active	$6.95	$7.24	$7.57	$8.05	$8.95
Retired	$2.79	$2.93	$3.02	$3.21	$3.49
Total	**$9.74**	**$10.17**	**$10.59**	**$11.25**	**$12.44**

Table 5: Historic Annual Expenditures by Employer Type[12] (in Billions)

Employer Type	2020	2021	2022	2023	2024
State	$5.62	$6.99	$6.05	$6.39	$7.08
Contracting Agency	$4.11	$3.18	$4.54	$4.86	$5.36
Total	**$9.74**	**$10.17**	**$10.59**	**$11.25**	**$12.44**

Appendix B displays detailed premium expenditure data for plan years 2022–2024 by plan name, health coverage type (Basic or Medicare), employer type (state or contracting agency), employment status (active or retired), and subscriber and dependent tier (single, two-party, or family).

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

[12] The numbers presented in tables 4 and 5 are estimated expenditures, not actuals. Since membership fluctuates throughout a calendar year, we use one of month of subscriber enrollment to calculate estimated expenditures.

Medical Trends

Medical trends are generally considered to be composed of two major components: price (unit cost) and utilization. We analyze medical trends for a better understanding of the factors that impact health care premiums. Table 6 to the right shows the trend, or percentage change in cost, for each individual service category from the prior year. The overall cost trend for our Basic health plans increased 12.2% in calendar year 2024 from 2023. All categories experienced an increase. The categories that experienced the largest increases were office visits (16.3%), emergency room (15.1%), and mental health/substance use (14.0%).

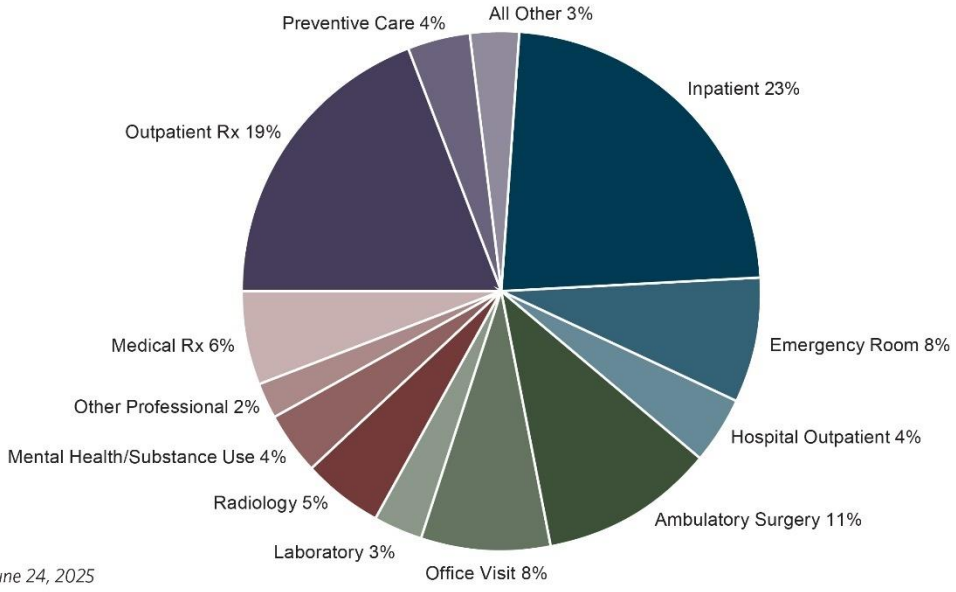
Figure 4 below shows the composition of total allowed Per Member Per Month (PMPM) spend by percentage of each service category in 2024.

Table 6: 2023–2024 Percentage Change Trend in Allowed PMPM, Within Each Service Category[13,14]

Service Category	2023–2024
All Other	8.5%
Ambulatory Surgery	12.3%
Emergency Room	15.1%
Hospital Outpatient	10.8%
Inpatient	12.6%
Laboratory	11.0%
Medical Rx[15]	7.5%
Mental Health/Substance Use	14.0%
Office Visit	16.3%
Other Professional	11.0%
Outpatient Rx[16]	11.3%
Preventive Care	10.8%
Radiology	12.9%

Data as of June 24, 2025

Figure 4: Percentage of PMPM Spend by Service



Data as of June 24, 2025

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

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

[15] Medical Rx refers to drugs administered by a clinician in a medical setting and billed through medical claims.

[16] Outpatient Rx refers to self-administered drugs dispensed by a pharmacy (e.g., retail, mail order, and specialty) and billed though the pharmacy benefit. This category does not include manufacturer rebates.

Premium Reconciliation

We conduct a monthly enrollment reconciliation process with each health plan carrier 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 benefit officers, the State Controller's Office, health plan carriers, and CalPERS.

Table 7 below 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 health plan carrier, based on changes in subscriber enrollment, from January through December 2024. We extracted the health premium data from myCalPERS as of May 7, 2025.

Table 7: Health Premium Management Report for Calendar Year 2024
(Dollars in Thousands)

Health Plan Carriers	Health Premium Amount
Anthem Blue Cross	$3,726,566
Association Plans (CAHP, CCPOA, and PORAC)	$704,360
Blue Shield of California	$1,441,483
Health Net of California	$77,006
Kaiser Permanente	$5,358,908
Sharp Health Plan	$114,815
UnitedHealthcare	$881,578
Western Health Advantage	$169,730
Total	**$12,474,446**

Clinical Quality

We require our health plans to report annually on national, evidence-based clinical performance measures to evaluate and improve the quality of care that health plans provide to our members. In particular, we have established quality performance measures intended to tie direct and substantial financial incentives to improving the quality of healthcare and reducing health disparities for our members. Specifically, the Quality Alignment Measure Set (QAMS) and its related financial incentives focus on improving care for a small number of clinically important conditions for which there are major opportunities for established, evidence-based improvement measures. We require our health plans to also provide data on the full suite Healthcare Effectiveness Data and Information Set (HEDIS®) measures that they report on for the purposes of National Committee for Quality Assurance (NCQA) health plan accreditation. HEDIS® is a set of health plan performance measures designed to provide purchasers and consumers with the information they need for reliable comparisons of health plan performance. Finally, the California Office of the Patient Advocate (OPA) collects and compiles clinical quality performance measure data for each health plan and reports their HMO and PPO Quality Ratings Summary for consumers. Further information on the health plans' OPA quality rating can be found here: **reportcard.opa.ca.gov/HMO_PPO Combined.aspx.**

Medicare Star Ratings

Medicare uses a Star Rating System to measure how well Medicare Advantage and Medicare Prescription Drug (Part D) plans perform.[17] 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.

Due to CMS changes in the Star Ratings methodology, an increase in the performance thresholds utilized by CMS to achieve Star ratings, and an increase in weighting of patient experience and access measures, 2024 ratings were generally lower than in prior years. These changes created a more challenging environment for Medicare Advantage plans to achieve and maintain their Star Ratings.

Table 8: Overall Medicare Star Ratings

Medicare Advantage Plan	2025 Overall Medicare Star Rating*
Anthem Medicare Preferred PPO	4
Blue Shield Medicare PPO	2.5
California Correctional Peace Officers Association**	2.5
Kaiser Permanente Senior Advantage	4.5
Kaiser Permanente Senior Advantage Out-of-State	4.5
Kaiser Permanente Senior Advantage Summit	4.5
Sharp Direct Advantage	4
UnitedHealthcare Medicare Advantage	4
UnitedHealthcare Medicare Advantage Edge	4

**The 2025 overall ratings were released in 2024 and based on 2023 data.*

*** Administered by Blue Shield of California*

[17] How to compare plans using the Medicare Star Rating System. (2025) www.medicareinteractive.org/get-answers/medicare-health-coverage-options/changing-medicare-coverage/how-to-compare-plans-using-the-medicare-star-rating-system.

Member Experience

Each year, we conduct a survey to evaluate members' experience with their health plans during the previous 12-month period. We ask members to rate their health plan satisfaction using a 10-point scale where 0 is the lowest and 10 was the highest possible rating. Please note that health plans with less than 2,000 enrollees were not surveyed.

Health Plan Experience Ratings

Figures 5a–b show the average and overall 2024 health plan experience ratings for the Basic and Medicare health plans surveyed.

Survey question:

"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?"

Figure 5a: Basic Health Plan Experience Ratings

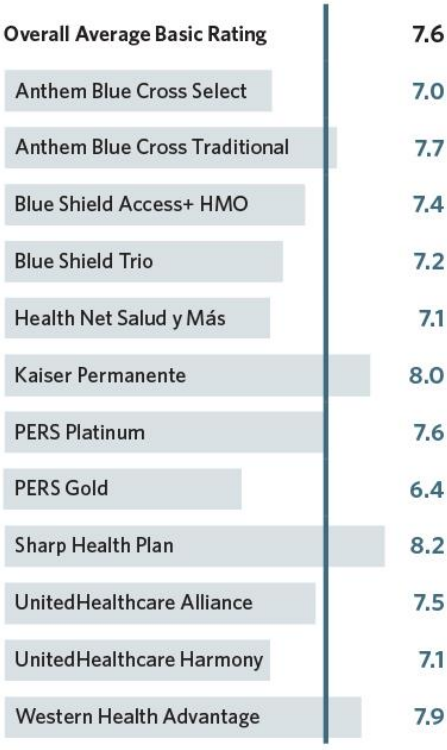
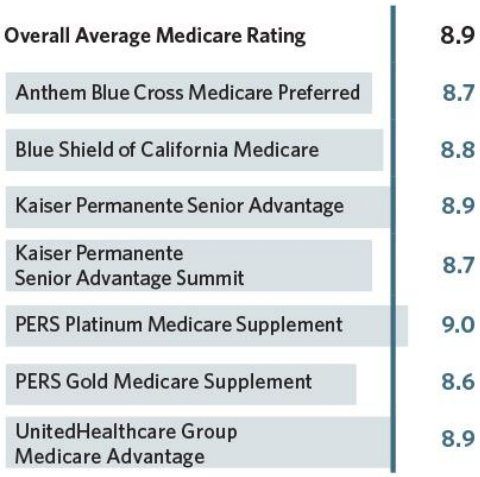


Figure 5b: Medicare Health Plan Experience Ratings



Financial Information

Federal Subsidies
Administrative Expenditures
Reserves
Investment Strategies

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 Pharmacy Benefit Manager (PBM) manage federal eligibility and enrollment, benefits, claims adjudication, and subsidy payments. Federal subsidies that offset the cost of health care include:

- Direct Subsidies
- Catastrophic Reinsurance Payments Subsidies
- Coverage Gap Discounts Subsidies
- Low Income Cost-Sharing Subsidies
- Low Income Premium Subsidies

In 2024, CalPERS collected approximately $544.6 million in federal subsidies.

Direct subsidies represent fixed amounts that the Centers for Medicare and Medicaid Services (CMS) pays to plan administrators to reimburse for Medicare Part D administrative costs. Catastrophic 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 represent pharmaceutical drug discounts paid by pharmaceutical manufacturers to plan administrators to offset the reduced member cost- sharing for eligible members in the coverage gap.

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-Sharing 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. Our health plans administer the LIPS program (also referred to as LIS). The plans 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.

The CMS federal subsidies estimated amount from the prior year reduced the 2024 rates of our Medicare Advantage and the PERS Gold and PERS Platinum Supplement plans to Medicare Part D Employer Group Waiver plans. The premium amount combined with the federal subsidy amount is sufficient to pay medical and pharmacy claims. The premiums for Medicare health plans represent the cost of coverage above the federal subsidies or contributions to Medicare.

Administrative Expenditures

In fiscal year 2024–25, we expended $76.3 million to support our Health Benefits Program. Of our total 2,843 authorized positions 408.3 directly and indirectly support the Health Benefits Program (see Table 9). Direct support positions include those in the Health Policy & Benefits Branch, the Actuarial Office, and Customer Services & Support. In contrast, enterprise support positions indirectly support the program including, but not limited to, positions in the Legal Office, Financial Office, and the Operations & Technology Branch.

Table 9: Staff Levels

Direct Support Positions	247.0
Enterprise Support Operations Positions	161.3
Total Staffing Levels*	**408.3**

Personal services expenditures total $54.2 million in fiscal year 2024–25 (see Table 10).

Table 10: Personal Services

(Dollars in Thousands)

Salary and Wages	$35,774
Staff Benefits	18,421
Total Personal Services	**$54,195**

Operating expenses and equipment costs include internal and external professional consulting services, as well as general operating expenses such as communication, travel, and printing. Further, statewide administrative costs, known as pro-rata, were assessed to the program. Operating expenses and equipment expenses in fiscal year 2024–25 total $22.1 million (see Table 11).

Table 11: Operating Expenses & Equipment

(Dollars in Thousands)

Consultant and Professional Services — Internal	$82
Consultant and Professional Services — External	7,220
General Operating Expenses	10,520
Statewide Administrative Cost (Pro-Rata)	4,305
Total Operating Expenses & Equipment	**$22,127**

Health Benefits Program funding comes from the Public Employees' Contingency Reserve Fund (CRF) and the Public Employees' Health Care Fund (HCF) (see Table 12).

Table 12: Funding Sources

(Dollars in Thousands)

Public Employees' CRF	$34,110
Public Employees' HCF	42,212
Total Funding	**$76,322**

Reserves

Reserve Levels/Adequacy

Actuarial reserve levels are the actuarially prudent threshold for assets to account for worst-case scenarios, including three main components: 1) Medical and pharmacy claims liability, to cover fee-for-service claims that have occurred but are not yet reported; 2) Risk-Based Capital (RBC) reserves, to pay for medical and pharmacy claims in the case of a sudden drop in enrollment, natural disaster, or an unexpected health pandemic; and 3) Other administrative reserves, to cover the wind-down cost should a plan suddenly terminate.

As of December 31, 2024, the actuarial reserve level for the self-funded PPO plans was $761 million. However, the total assets level was $250 million, resulting in a fund balance to actuarial reserve ratio of 33%, which is $511 million lower than the actuarial reserve level.[18] Since plan assets continue to be below 90% of the actuarial reserve amount, the board approved continuing the surcharge for the 2025 plan year premiums and future years' premiums.

For the self-funded pharmacy portion of CalPERS' HMO plans, the actuarial reserve level was $8 million and total assets were $53 million as of December 31, 2024.

Expected Changes in Reserve Levels

As the board approved to include surcharges in the PPO premiums to replenish the reserve, we expect the PPO assets level to increase to the recommended actuarial reserve levels in future years.

Policies to Reduce Surplus Reserves/Rebuild Inadequate Reserves

The main purpose of the HCF reserve policy is 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.

Reinsurance/Other Alternatives to Maintain Reserves

The requirement for RBC in the PPO plans is designed to offer sufficient protection against unfavorable claims experience, thus eliminating the need for reinsurance once assets are replenished to actuarial reserve levels. Additionally, the costs of reinsurance policies are increasing and they do not provide the type of coverage that would benefit our program. In the case of flex-funded HMO plans, there is no need for reinsurance because of the specific nature of flex-funding. Flex-funding involves a health plan arrangement where CalPERS covers both the capitated portion of the health care services, and the fee-for-service portion up to an agreed upon limit. If the expenses for capitation and fee-for-service turn out to be lower than expected, CalPERS keeps that funding in its HCF and can use it to lower premiums in the following years. However, if the capitation and fee-for-service amounts exceed the agreed upon limit, then the contracted health plan covers the excess of both expenses.

[18] The 2024 actuarial reserve level reflects claims processed as of December 31, 2024.

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 13). 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 13: Historical Investment Performance of the SMIF* (Net of Fees)

Fiscal Year End	Allocation	Invested Assets	Annual Return
20–21	SMIF	$728,469,734	0.50%
21–22		756,131,527	0.37%
22–23		720,365,295	2.19%
23–24		874,537,057	3.99%
24–25		1,143,523,000	4.45%

* Annual return is representative of the PMIA of which SMIF is one part

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/pmialaif/pmia/index.asp.**

Public Employees' Health Care Fund

The Public Employees' HCF is invested at the State Treasurer's Office in the SMIF and for FY 2024-25, is invested in the State Street Investment Management (SSIM) Short Term Investment Fund (STIF). This is a change from prior years' allocation in the SSIM US Aggregate Bond Index Fund, which the Board approved on June 10, 2024 (see Table 14). 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.

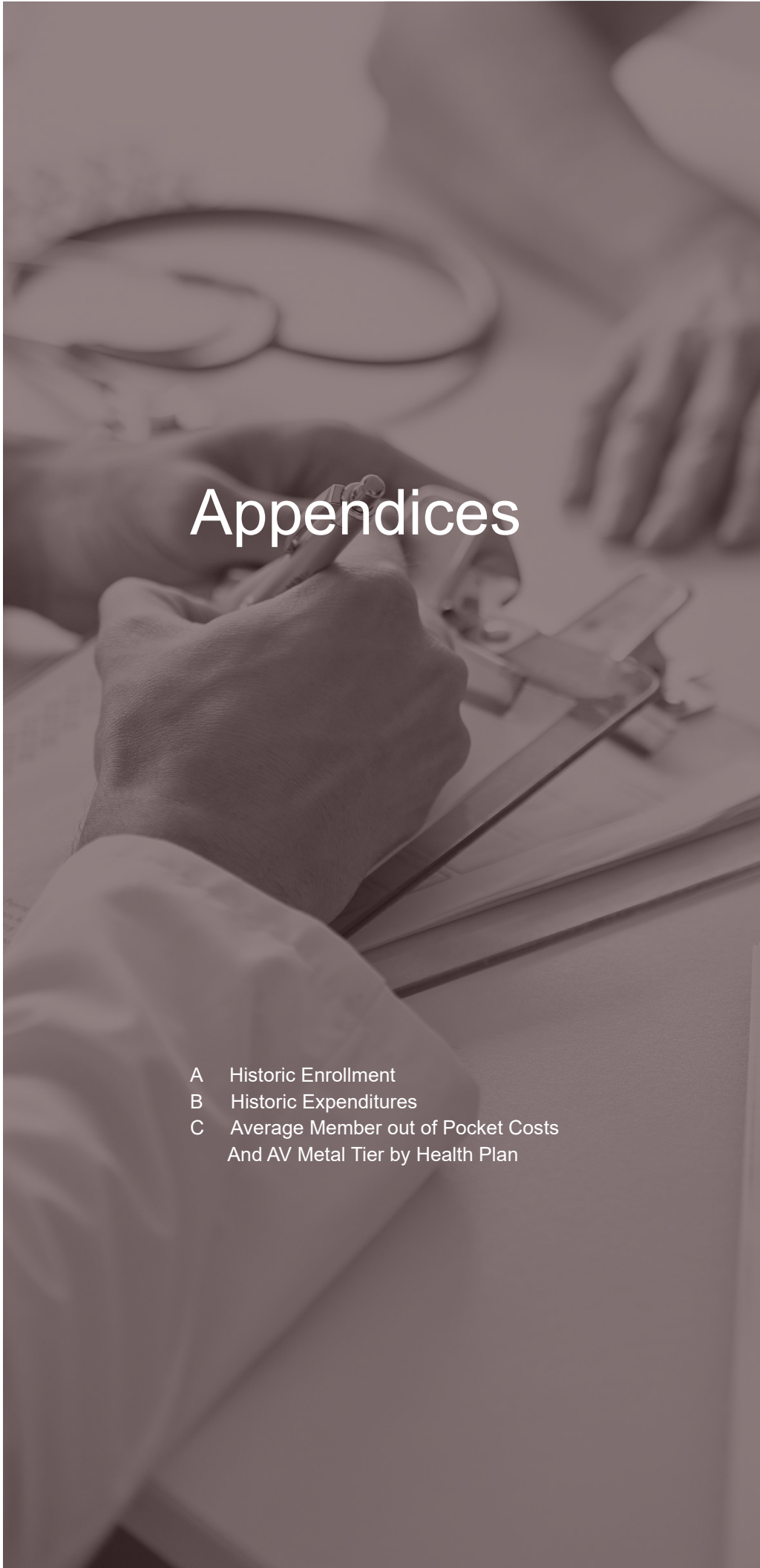
Table 14: Historical Investment Performance of SSIM U.S. Aggregate Bond Index Fund, the SSIM STIF, and the SMIF* (Net of Fees)

Fiscal Year End	Allocation	Invested Assets	Annual Return
20–21	SSIM U.S. Aggregate Bond Index Fund	$518,420,597	(0.39%)
21–22		327,522,392	(10.32%)
22–23		205,091,033	(0.98%)
23–24		73,487,594	2.66%
24–25	SSIM STIF	$77,099,956	4.80%
20–21	SMIF	$151,173,735	0.50%
21–22		116,746,966	0.37%
22–23		194,188,046	2.19%
23–24		346,589,017	3.99%
24–25		622,417,000	4.45%

* Annual return is representative of the PMIA of which SMIF is one part

Expected Investment Returns

The SSIM STIF invests principally in high quality, short-term securities and seeks to provide safety of principal, a high level of liquidity and a competitive yield. While the 10-year historical annualized investment return for the index as of June 30, 2025, is 1.62%, past performance is not a guarantee of future result.



Appendices

A Historic Enrollment
B Historic Expenditures
C Average Member out of Pocket Costs And AV Metal Tier by Health Plan

Appendix A — Historic Enrollment[19]

	2022	2023	2024
Basic HMO Plans			
Anthem Blue Cross Select	48,068	38,652	31,932
Anthem Blue Cross Traditional	11,356	10,887	11,612
Blue Shield Access+	79,153	92,956	121,390
Blue Shield Trio	17,249	29,589	43,702
Health Net — Salud y Más	12,774	12,011	12,500
Health Net — SmartCare	10,856	8,842	–
Kaiser Permanente	555,698	549,876	528,054
Kaiser Out-of-State	1,051	1,031	1,020
Sharp Health Plan	14,790	14,477	14,545
UnitedHealthcare Signature Value Alliance	76,469	72,405	75,955
UnitedHealthcare Signature Value Harmony	2,679	4,285	7,060
Western Health Advantage	13,338	15,848	21,349
Basic EPO Plans			
Anthem Blue Cross Del Norte County	65	61	51
Blue Shield Access+	895	1,454	2,183
Basic PPO Plans			
PERS Gold	123,631	134,242	134,288
PERS Platinum	152,776	130,885	112,313
Basic Association Plans			
California Association of Highway Patrolmen	26,701	26,329	26,649
California Correctional Peace Officers Association North	7,189	6,033	5,177
California Correctional Peace Officers Association South	30,095	29,538	28,723
Peace Officers Research Association of California	21,883	23,288	24,815
Basic Total	**1,206,716**	**1,202,689**	**1,203,318**

[19] A "–" indicates that the plan did not exist in those years.

Appendix A — Historic Enrollment, cont.[19]

	2022	2023	2024
Medicare Advantage Plans			
Anthem Medicare Preferred PPO	5,412	4,949	2,570
Anthem Select Medicare Preferred	—	1,187	3,977
Blue Shield Medicare PPO	591	2,870	5,284
Kaiser Permanente Senior Advantage	110,857	108,068	106,678
Kaiser Permanente Senior Advantage Out-of-State	2,620	2,759	2,646
Kaiser Permanente Senior Advantage Summit	—	5,055	8,228
Kaiser Permanente Out-of-State Senior Advantage Summit	—	—	175
Sharp Direct Advantage HMO	170	317	453
UnitedHealthcare Medicare Advantage	44,661	44,013	42,951
UnitedHealthcare Medicare Advantage Edge	2,061	3,603	5,126
Western Health Advantage MyCare Select	57	270	488
Supplement to Original Medicare Plans			
PERS Gold	3,316	3,954	4,526
PERS Platinum	147,111	148,226	147,709
Medicare Association Plans			
California Association of Highway Patrolmen	4,587	4,630	4,630
California Correctional Peace Officers Association North	744	814	882
California Correctional Peace Officers Association South	992	1,073	1,192
Peace Officers Research Association of California	2,854	3,067	3,260
Medicare Total	**326,033**	**334,855**	**340,873**
Grand Total	**1,532,749**	**1,537,544**	**1,544,191**

[19] A "–" indicates that the plan did not exist in those years.

Appendix A — Historic Enrollment, cont.

	2022	2023	2024
Program			
State	889,577	891,807	900,600
Contracting Agency	643,172	645,737	643,591
Total	**1,532,749**	**1,537,544**	**1,544,191**

Employment Status			
Active	1,021,213	1,019,237	1,024,138
Retired	511,536	518,307	520,053
Total	**1,532,749**	**1,537,544**	**1,544,191**

Subscriber and Dependent Tier			
Single	356,348	367,038	375,770
2-Party	423,554	426,062	429,026
Family	752,847	744,444	739,395
Total	**1,532,749**	**1,537,544**	**1,544,191**

Appendix B — Historic Expenditures[20]

Estimated Expenditures (Dollars in Thousands)

	2022	2023	2024
Basic HMO Plans			
Anthem Blue Cross Select	$374,876	$322,724	$284,163
Anthem Blue Cross Traditional	132,124	121,135	139,965
Blue Shield Access+	675,377	758,613	1,039,901
Blue Shield Trio	125,499	211,920	333,130
Health Net Salud y Más	56,960	70,022	76,046
Health Net SmartCare	100,188	83,044	—
Kaiser Permanente	4,233,197	4,467,925	4,872,509
Kaiser Out-of-State	13,014	13,061	14,534
Sharp Health Plan	96,055	103,248	113,373
UnitedHealthcare SignatureValue Alliance	571,307	562,932	627,757
UnitedHealthcare SignatureValue Harmony	18,799	29,084	51,131
Western Health Advantage	94,098	114,914	164,102
Basic EPO Plans*			
Anthem Blue Cross Del Norte County	$589	$601	$606
Blue Shield Access+	8,382	12,681	19,902
Basic PPO Plans*			
PERS Gold	$753,696	$960,896	$1,086,313
PERS Platinum	1,414,699	1,396,702	1,367,294
Basic Association Plans			
California Association of Highway Patrolmen	$162,386	$161,698	$178,661
California Correctional Peace Officers Association North	55,318	50,057	45,131
California Correctional Peace Officers Association South	187,731	195,041	203,282
Peace Officers Research Association of California	154,122	168,832	203,799
Basic Total	**$9,228,887**	**$9,805,129**	**$10,821,599**

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

Appendix B — Historic Expenditures, cont.[20]

	2022	2023	2024
Medicare Advantage Plans			
Anthem Medicare Preferred PPO	$24,494	$31,133	$32,371
Blue Shield Medicare PPO	5,568	14,114	26,972
Kaiser Permanente Senior Advantage	406,390	368,856	416,656
Kaiser Permanente Senior Advantage Out-of-State	9,437	9,158	10,046
Kaiser Permanente Senior Advantage Summit	—	21,283	39,247
Kaiser Permanente Senior Advantage Summit Out-of-State	—	—	871
Sharp Direct Advantage HMO	681	1,025	1,478
UnitedHealthcare Medicare Advantage	157,552	158,343	175,848
UnitedHealthcare Medicare Advantage Edge	9,625	15,946	22,958
Western Health Advantage MyCare Select	446	1,184	1,670
Supplement to Original Medicare Plans			
PERS Gold	$15,860	$19,171	$22,596
PERS Platinum	676,992	748,592	794,688
Medicare Association Plans			
California Association of Highway Patrolmen	$27,178	$27,343	$33,782
California Correctional Peace Officers Association North	4,836	3,980	6,099
California Correctional Peace Officers Association South	6,323	7,049	8,399
Peace Officers Research Association of California	16,265	22,377	23,935
Medicare Total	**$1,361,647**	**$1,449,554**	**$1,617,616**
Grand Total	**$10,590,534**	**$11,254,683**	**$12,439,215**

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

Appendix B — Historic Expenditures, cont.

	2022	2023	2024
Program			
State	$6,047,556	$6,393,375	$7,083,700
Contracting Agency	4,542,978	4,861,309	5,355,515
Total	**$10,590,534**	**$11,254,684**	**$12,439,215**

Employment Status			
Active	$7,572,505	$8,047,626	$8,947,690
Retired	3,018,029	3,207,057	3,491,525
Total	**$10,590,534**	**$11,254,683**	**$12,439,215**

Subscriber and Dependent Tier[21]			
Single	$2,706,733	$2,926,861	$3,306,527
2-Party	3,147,352	3,346,285	3,690,278
Family	4,736,449	4,981,537	5,442,410
Total	**$10,590,534**	**$11,254,683**	**$12,439,215**

[21] In the 2023 report, totals for Subscriber and Dependent Tier expenditures were displayed correctly, although amounts were misallocated across Single, 2-Party, and Family categories. This has been identified and corrected in the current report.

Appendix C — Average Member Out-of-Pocket Costs[22] and AV Metal Tier by Health Plan

Basic HMO Plans	2024	AV Metal Tier
Anthem Blue Cross Select	$197	Platinum
Anthem Blue Cross Traditional	240	Platinum
Blue Shield Access+	168	Platinum
Blue Shield Trio	123	Platinum
Health Net Salud y Más	102	Platinum
Kaiser Permanente	111	Platinum
Sharp Health Plan	154	Platinum
UnitedHealthcare SignatureValue Alliance	175	Platinum
UnitedHealthcare SignatureValue Harmony	129	Platinum
Western Health Advantage	179	Platinum
Average Member Out-of-Pocket for Basic HMO Plans	**$133**	

Basic EPO Plans		
Anthem Blue Cross Del Norte County	$173	Platinum
Blue Shield Access+	160	Platinum
Average Member Out-of-Pocket for Basic EPO Plans	**$161**	

Basic PPO Plans		
PERS Gold	$881	Gold
PERS Platinum	1,056	Platinum
Average Member Out-of-Pocket for Basic PPO Plans	**$959**	

[22] Average annual costs rounded to nearest dollar.

Appendix C — Average Member Out-of-Pocket Costs[22] and AV Metal Tier by Health Plan[23], cont.

Medicare Advantage Plans	2024	AV Metal Tier
Anthem Medicare Preferred PPO	$441	—
Blue Shield Medicare PPO	330	—
Kaiser Permanente Senior Advantage	268	—
Kaiser Permanente Senior Advantage Summit	214	—
Sharp Direct Advantage HMO	136	—
UnitedHealthcare Group Medicare Advantage PPO	389	—
UnitedHealthcare Group Medicare Advantage Edge PPO	241	—
Western Health Advantage MyCare Select HMO	219	—
Average Member Out-of-Pocket for Medicare Advantage Plans	**$301**	**—**

Supplement to Original Medicare Plans		
PERS Gold	$208	—
PERS Platinum	284	—
Average Out-of-Pocket for Supplement to Original Medicare Plans	**$281**	**—**

[22] Average annual costs rounded to nearest dollar.

[23] A"—" indicates that AV Metal Tiers are not provided for Medicare plans.

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