Health Benefits Program | 2022 Annual Report

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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, 2022. This report provides an overview of the Health Benefits Program, as required by California Government Code Section 22866 (see Appendix A).

In 2022, the health care landscape remained challenging as the pandemic continued then subsided, more people returned to routine care, and medical costs increased. However, this did not deter our continued focus to provide access to high-quality, equitable care that aims to improve health outcomes for our members.

We continued our strategy to add lower cost Health Maintenance Organization (HMO) and Exclusive Provider Organization (EPO) options to provide our members with more choices for affordable health plans. We also expanded Medicare Advantage plans to provide more members with the ability to remain with their same health carrier when transitioning into Medicare plans.

Overall health plan premiums increased 4.86%. This equated to a 4.69% increase for Basic HMO plans, an 8.67% increase for Preferred Provider Organization (PPO) Basic plans, a decrease for Medicare Advantage plans, and a 5.48% increase for Medicare Supplement plans. More than 80,000 members, or about 5% of total members, switched to a new health plan during Open Enrollment, starting 2022 in a new plan.

Included in the 2022 premiums was the CalPERS Board-approved risk mitigation for Basic health plans. This strategy stabilized the Basic portfolio by pricing plans based on the value of their benefits and networks rather than their mix of healthy or unhealthy lives. Along with this change, our Basic PPOs moved from three plans to two – PERS Platinum and PERS Gold.

We extended our acquisition-based contract with OptumRx, our pharmacy benefits manager (PBM), that included strong price guarantees and best in market pricing.

For Open Enrollment, we enhanced technology capabilities that enabled active members to submit their changes online through their myCalPERS account as retirees have been able to do for years. If their employer's process allowed, active members were able to change plans, add and remove dependents, and provide documentation online, eliminating paper processes and increasing efficiency.

We held a successful Health Equity campaign to encourage members to complete their Health Demographic profile and in December 2022 had more than 185,000 completed profiles, exceeding our 100,000 profile goal. Knowing more about who our members are will help us identify where we may need to make changes to ensure that care is equitable for all our members.

Marcie Frost
Chief Executive Officer

About CalPERS Health Benefits Program

With more than 1.5 million members, CalPERS is the largest purchaser of public employee health benefits in California and the second largest public purchaser in the nation after the federal government. In 2022, we spent nearly $10.6 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 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 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.

2022–27 Strategic Plan

The 2022–27 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 steers us through June 30, 2027. In developing the five goals within the plan, we went through an extensive process to gain an understanding of the major risks and opportunities facing CalPERS. 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

Member Experience: Ensure member satisfaction through accuracy, responsiveness, and respect

- Deliver accurate benefits to our members and their beneficiaries
- Ensure that our members and their beneficiaries receive benefit payments on time
- Provide timely response and appropriate action to inquires
- Enhance services, communication, and education tools for our members

Stakeholder Engagement: Promote collaboration, support, and transparency

- Educate and engage stakeholders on system impacts including policy and program changes, risks, and mitigations
- Enhance services, communication, and education tools for our partners

Exceptional Health Care: Ensure our members have access to equitable, high-quality, affordable health care

- 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

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

- Balance the cost of future pension payments with the expected future investment risks and returns through the Asset Liability Management process
- Mitigate the risk of significant investment loss while balancing contribution levels and volatility
- Deliver risk-adjusted investment returns to meet or exceed the expected rate of return
- Integrate sustainable investment strategies

Organizational Excellence: Cultivate a diverse, risk-intelligent, and innovative culture through our team and processes

- Improve processes, operations, and advance technologies to gain efficiencies and effectiveness
- Cultivate compliance and risk functions throughout the enterprise
- Recruit and retain diverse talent
- Enhance team member engagement and employment experience
- Integrate and sustain leadership competencies to promote behaviors that retain and engage a high-performing workforce
- Cultivate diversity, equity, & inclusion through culture, talent, investments, health equity, and supplier diversity

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

2022 included the completion of the 2017-22 CalPERS Strategic Plan and initiatives [1], as well as the development of new initiatives for the 2022-27 CalPERS Strategic Plan [2] and the 2022-23 CalPERS Business Plan. [3]

The CalPERS 2022-27 Strategic Plan has a stated goal to ensure our members have access to equitable, high-quality, affordable 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

Table 1, on the following page, provides the status of health-related business plan initiatives [4] and describes changes in strategic direction and major policy initiatives for the 2022 health plan year. It includes content from the CalPERS 2017–22 Strategic Plan, CalPERS Business Plans, and relevant CalPERS quarterly reports.

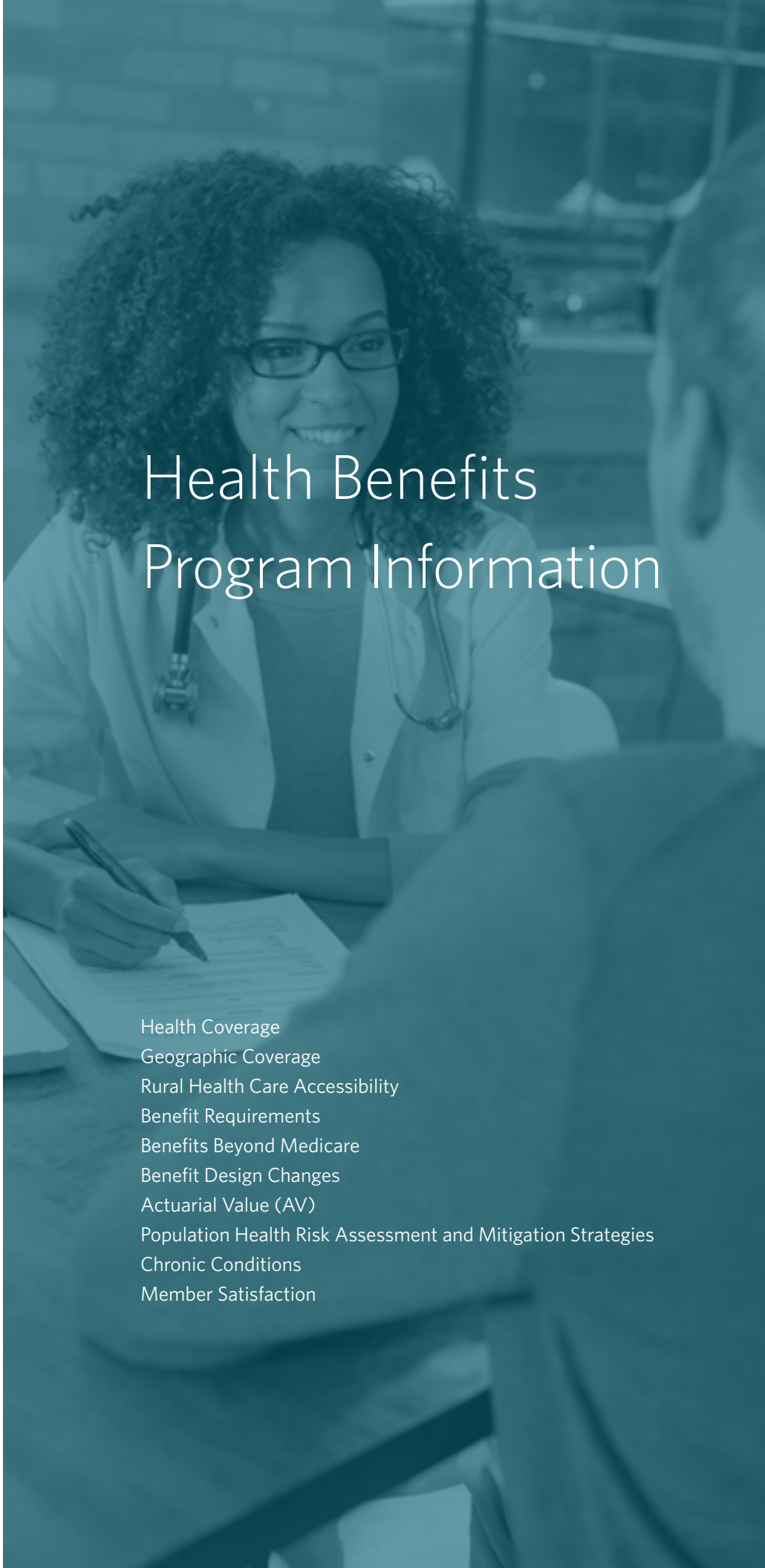
These plans and reports are inter-related, complement each other, and focus on quality, equity, accessibility, and cost. Additional information on the strategic plan and business plans are available in Strategic & Business Plans at **www.calpers.ca.gov**.

[1] FY 2021-22 – Fourth Quarter Report, August 5, 2022. https://www.calpers.ca.gov/docs/2021-22-epr-q4-report.pdf
[2] CalPERS 2022-27 Strategic Plan. https://www.calpers.ca.gov/docs/forms-publications/2022-27-strategic-plan.pdf
[3] CalPERS 2022-23 Business Plan. https://www.calpers.ca.gov/docs/forms-publications/2022-23-business-plan.pdf
[4] CalPERS 2021-22 Business Plan. https://www.calpers.ca.gov/docs/forms-publications/2021-22-business-plan.pdf

Table 1: 2022 Health Program Business Plan Initiatives

Initiative Title	Description	Status
Clinical Quality Improvement Programs	Assess the effectiveness of current quality requirements and implement strategies to ensure CalPERS health plans effectively engage their provider networks to support continuous quality improvement opportunities and activities so CalPERS health care members can receive high-quality clinical care.	Complete [5]
Telehealth Access	Study the utilization and quality of telehealth to improve access and quality of care provided to CalPERS health care members.	Complete [5]
Advanced Primary Care	Develop, implement, and participate in strategies that aim to improve quality and access to primary care services for CalPERS health care members.	New
Expand Member Outreach and Education	Implement an outreach strategy to improve our membership's knowledge and engagement in the health benefits and options available to them.	New
Quality Alignment	Establish improved performance measures in our health plan contracts.	Ongoing [5]
Improve Health Data Quality and Application	Collaborate with CalPERS health plans to develop and implement data quality improvement plans to improve the quality, relevancy, and consistency of the data in the Health Care Decision Support System (HCDSS).	Ongoing
Behavioral Health Screening and Treatment	Assess the feasibility of health plan contractual opportunities, identify partnerships, and develop recommendations to improve behavioral health treatment for CalPERS health care members.	Ongoing
Promote and Improve Health Equity	Develop and implement a health equity strategy that will aim to improve overall clinical quality for CalPERS health care members.	Ongoing
Increase Health Care Competition	Improve provider competition to mitigate costs in low competition areas.	Ongoing
Improve Pharmaceutical Strategies	Develop formulary management strategies that balance member choice, quality, safety, affordability and prescription drug access using expert clinical input from nationally-recognized organizations and CalPERS utilization data.	Ongoing

[5] Quality Alignment Initiative is a hybrid continuation that includes the Update Health Plan Contract Measures, Clinical Quality Improvement Programs, and Telehealth Access initiatives from the 2017-2022 Strategic Plan. https://www.calpers.ca.gov/docs/2021-22-q4-bpi.pdf



Health Benefits Program Information

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

Health Coverage

As the purchaser of health benefits for the State of California (including the California State University) and almost 1,200 public agencies and schools, we provide a wide selection of high-quality health plan options to our members and their families. For the 2022 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 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 of California
- Western Health Advantage

Our Medicare health plan offerings include both Medicare Advantage and Medicare Supplement plans.

The following Medicare Advantage plans were available to our Medicare eligible members:

- Anthem Medicare Preferred (PPO)
- Blue Shield Medicare (PPO)
- Kaiser Permanente Senior Advantage (HMO)
- Sharp Direct Advantage (HMO)
- UnitedHealthcare Group Medicare Advantage (PPO)
- UnitedHealthcare Group Medicare Advantage Edge (PPO)
- Western Health Advantage MyCare Select (HMO)

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

- PERS Gold
- PERS Platinum

Three association plans are available to members who pay applicable dues to the following employee associations. We do not negotiate premiums 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)

OptumRx, CalPERS' pharmacy benefit manager, 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 of California
- Western Health Advantage

Medicare health plans:

- Anthem Medicare Preferred (PPO)
- Western Health Advantage MyCare Select (HMO)

Basic and Supplement to Original Medicare health plans:

- PERS Gold
- PERS Platinum

Geographic Coverage

Our members have Basic and Medicare health plan options in all 58 California counties; however, members in some rural areas 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, and access customized health information, tools, and resources to help with their Open Enrollment decisions. They can use the Search Health Plans tool to evaluate health plans and monthly premium costs based on their eligibility ZIP code. myCalPERS also allows retirees and active employees – with their employer's approval – to submit health enrollment changes, along with supporting documentation, online using their myCalPERS account.

In addition, 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**.

Rural Health Care Accessibility

Our members in rural areas of California 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.

To illustrate health care accessibility in rural communities, this report explores our Basic plan members' PPO provider network access.

Our Basic PPO health plans, PERS Gold and PERS Platinum, provide statewide coverage through Anthem Blue Cross' Select PPO Preferred Provider Network and Prudent Buyer Plan Network, respectively.

We use enrollment data from myCalPERS, our "system of record" for all CalPERS Health Benefits Program enrollment information. In 2022, there were more than 31,600 CalPERS members living in 15 rural counties who accessed their healthcare benefits through either our PERS Gold or PERS Platinum health plans, which provide coverage throughout all 58 counties. These members resided in the following 15 counties: Alpine, Calaveras, Del Norte, Inyo, Lake, Lassen, Modoc, Mono, Plumas, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne. In recent years, CalPERS has made significant efforts to further expand access to our members living in rural counties by adding Exclusive Provider Organization (EPO) access. EPO health plans are an effective tool in counties where it's challenging to put together an HMO network. In 2022, EPO access was expanded to include Lassen and Shasta counties, joining Del Norte and Sierra counties. This comes after the Board approved EPO expansions into 11 rural counties without HMO access in 2021.

Provider Network Access

In situations where a rural area has no in-network provider available, there are out-of-network referral options, which means a non-PPO provider is covered by the in-network PPO benefit. Referrals may also be granted if: (1) there are no providers in the network who are accepting new patients; (2) participating providers are too far away for the member to see conveniently; (3) the member needs to see a specialist that is not available in the PPO network; or (4) the member wants specific treatments that do not exist in-network.

Telehealth Access

Telehealth can reduce barriers to receiving services and expand access to care. Our PPO plans utilize telehealth to provide 24/7 online access to board-certified clinicians for their members, including those living in rural areas. Using telehealth in rural areas to deliver and assist with the delivery of health care services can reduce or minimize challenges and burdens members encounter, such as transportation issues related to traveling for specialty care. Telehealth services expanded during the COVID-19 pandemic and continue to be an important way to supplement members' access to care.

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
- 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

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 Affordable Care Act (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, EPO, and PPO Basic health plans provide benefits in all required EHB categories except for pediatric dental and vision care.[6]

[6] 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.

The following EHB categories are covered by our Basic plans:

- 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 mental health care treatment must be the same. Additionally, the ACA includes mental health and substance use disorder services 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 behavioral health services, and improving behavioral 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:

- COVID-19 diagnostic and screening testing
- Chiropractic services
- Hearing aid services

Benefits Beyond Medicare

In 2022, we offered PERS Gold and PERS Platinum 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 2022 was $150 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 at the direction of the board.

In 2021, we adopted the following benefit changes for the 2022 health plan year:

Copay Changes

Reduced copays to $0 for office visits and urgent care for the following Medicare plans:

- Blue Shield Medicare PPO
- Sharp Direct Advantage
- UnitedHealthcare Group Medicare Advantage Edge
- Western Health Advantage MyCare Select

Additional Medicare Benefits

Non-Emergency Medical Transportation:

- Anthem Medicare Preferred – 12 one-way trips for non-emergency medical transportation, up to 60 miles per trip, for medical appointments, visits to SilverSneakers locations, and to the pharmacy.
- Blue Shield Medicare PPO – 24 one-way trips for non-emergency medical transportation.

Nutritional Counseling

Anthem Medicare Preferred – 12 telephonic nutritional counseling sessions and one monthly shipment of healthy non-perishable staples recommended for specific condition(s).

Over the Counter Drug Benefit

Blue Shield Medicare PPO - $80 quarterly over the counter (OTC) drug allowance.

Personal Emergency Response System

Blue Shield Medicare PPO – One Personal Emergency response system to provide medical alert monitoring and access to help 24/7.

Post Discharge Meals

Blue Shield Medicare PPO – Home Meal Delivery upon discharge from an inpatient hospital or skilled nursing facility stay.

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, EPO, 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 2022 Basic health plans.

Table 2a: Metal Tiers for 2022 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
Blue Shield Trio	98%	Platinum
Health Net Salud y Más	98%	Platinum
Health Net SmartCare	98%	Platinum
Kaiser Permanente	99%	Platinum
Sharp Health Plan	98%	Platinum
UnitedHealthcare Signature Value Alliance	98%	Platinum
UnitedHealthcare Signature Value Harmony	98%	Platinum
Western Health Advantage	98%	Platinum

Table 2b: Metal Tiers for 2022 EPO and PPO Health Plans

EPO and PPO Plans	Actuarial Value	Metal Tier
Anthem Blue Cross Del Norte EPO	99%	Platinum
Blue Shield EPO	98%	Platinum
PERS Gold	88%	Gold
PERS Platinum	92%	Platinum

Table 2c: Metal Tiers for 2022 Association Health Plans

Association Plans	Actuarial Value	Metal Tier
California Association of Highway Patrolmen	91%	Platinum
California Correctional Peace Officers Association	98%	Platinum
Peace Officers Research Association of California	92%	Platinum

Population Health Risk Assessment and Mitigation Strategies

Our health plan portfolio offers a variety of different cost sharing structures, benefit designs, and provider network choices to accommodate a geographically dispersed population and members' purchasing preferences. In earlier years, the Basic plan portfolio was a fragmented risk pool in which each health plan was individually rated, based on its own membership and experience.

In 2014, we implemented a risk adjustment program 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. 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 challenges to risk concentration and adverse selection. We have used reserves and buy-downs in the premium 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 unsustainable.

In 2020, CalPERS worked with consulting actuaries to assess the Basic health plan portfolio and determine the appropriate mix of plan type and plan offering to minimize risk concentration and adverse selection. We reviewed risk mitigation approaches, risk adjustment models, and portfolio rating alternatives to incorporate into potential risk mitigation strategies.

The final portfolio rating approach was presented and approved by the board in November 2020. Implementation began January 1, 2022 with a two-year phase in. The portfolio rating approach manages population health risk within the portfolio of Basic health plans, promotes efficient care management, and mitigates year-over-year premium volatility and large premium increases. Furthermore, portfolio rating requires health plans to compete based on quality of care rather than on a plan's ability to attract healthier lives. Medicare and association health plans are not included in portfolio rating. The Medicare program is already risk adjusted by the federal government and association health plans premiums are negotiated by their respective associations.

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 as reflected by data on chronic conditions, review of population demographics, and analysis of member health. For 2022, this evaluation showed that approximately 22% 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.

We require our health plans to continuously monitor and improve on the quality and efficiency of chronic care management and the effectiveness of preventive care, which are crucial to improving the quality of life for members with chronic conditions. Routine preventive care, participation in programs to help manage chronic diseases, and diabetes prevention programs are critical components to managing chronic conditions, which consequently help to improve the overall health and well-being of our members, and lower the overall cost burden associated with chronic disease.

Table 3 provides a breakdown of chronic condition prevalence statewide, based on information from our HCDSS for 2022. Note that some members may have had more than one chronic condition, so the same member may occur in more than one category below, and these numbers do not account for any enrollment changes that may have occurred during 2022. While we do not include obesity prevalence in Table 3, because it is calculated differently and is based on information from the HCDSS for all CalPERS members (not only those living in California), it is estimated to be approximately 31% for our membership.

Table 3: 2022 Chronic Conditions Prevalence Among CalPERS Members*

	California	
	Percentages based on 1,450,015 members	
Chronic Condition	Population	Prevalence (%)
Hypertension	120,208	8.3%
Diabetes	95,549	6.6%
Depression	71,125	4.9%
Asthma	37,942	2.6%
Coronary artery disease	27,727	1.9%
COPD	8,951	0.6%
Congestive heart failure	5,210	0.4%

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

Member Experience

Each year, we conduct a survey to evaluate members' experience with their health plan during the previous 12-month period. The CalPERS Health Plan Member Survey, evaluating plan year 2022 experiences, was conducted January to March 2023. Members were asked to rate their health plan and overall health care satisfaction using a 10-point scale where 0 was 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 1a-b show the average and overall 2022 health plan experience ratings for the Basic and Medicare health plans surveyed.

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?

Figure 1a: Basic Health Plan Experience Ratings

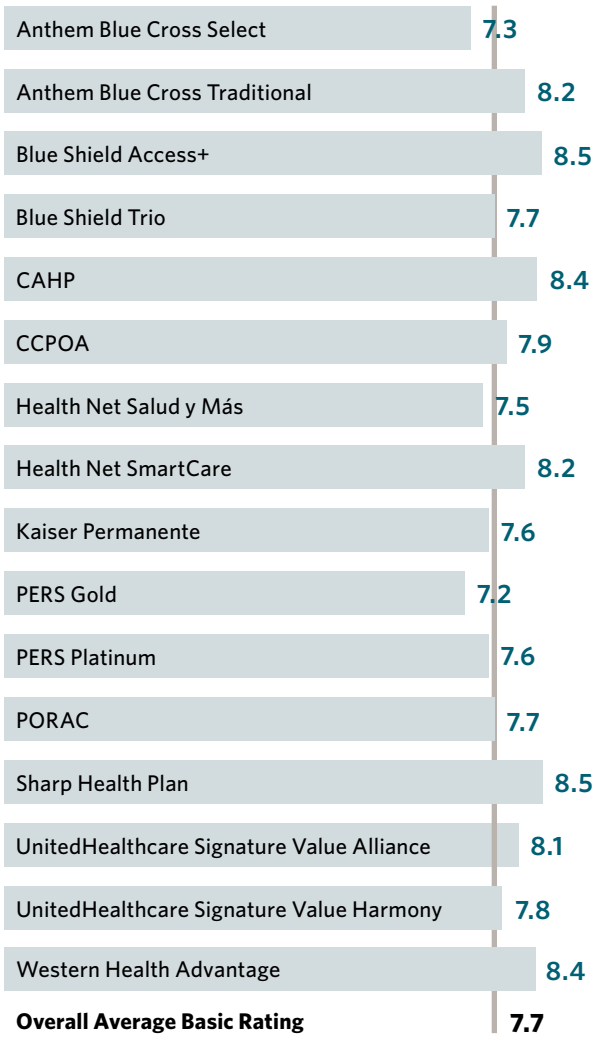
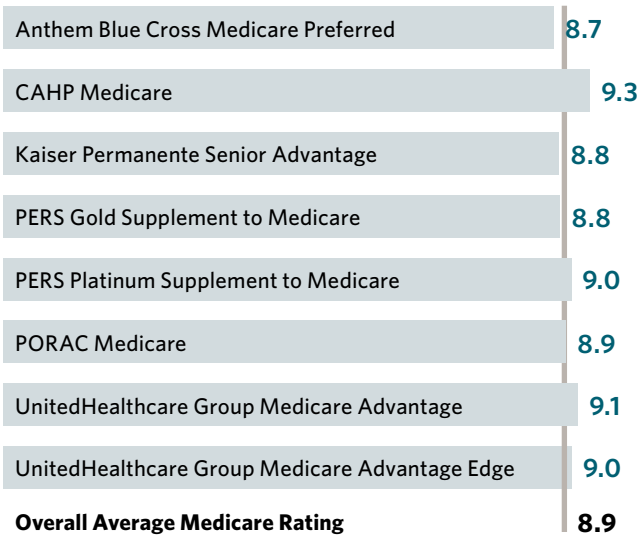


Figure 1b: Medicare Health Plan Experience Ratings



Health Care Experience Ratings

Figures 2a-b show the average and overall 2022 health care experience ratings for the Basic and Medicare health plans surveyed.

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?

Figure 2a: Basic Health Care Experience Ratings

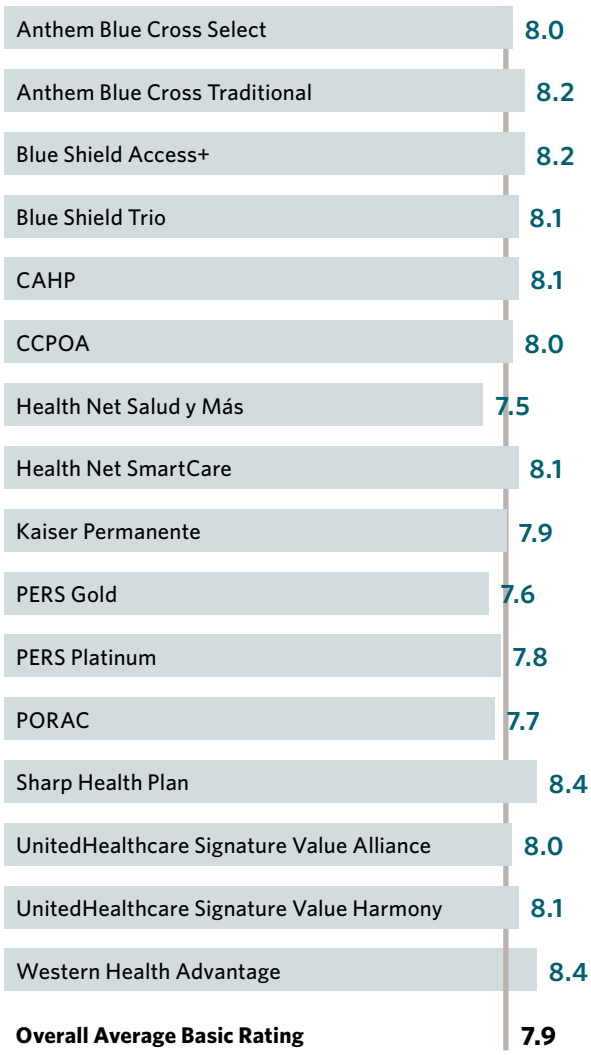
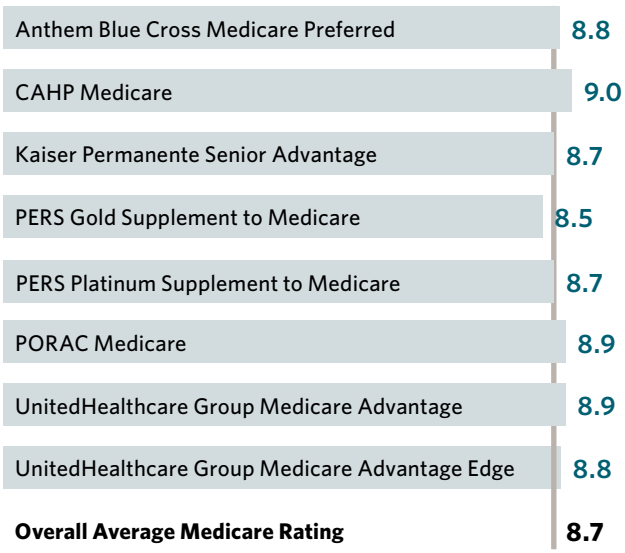
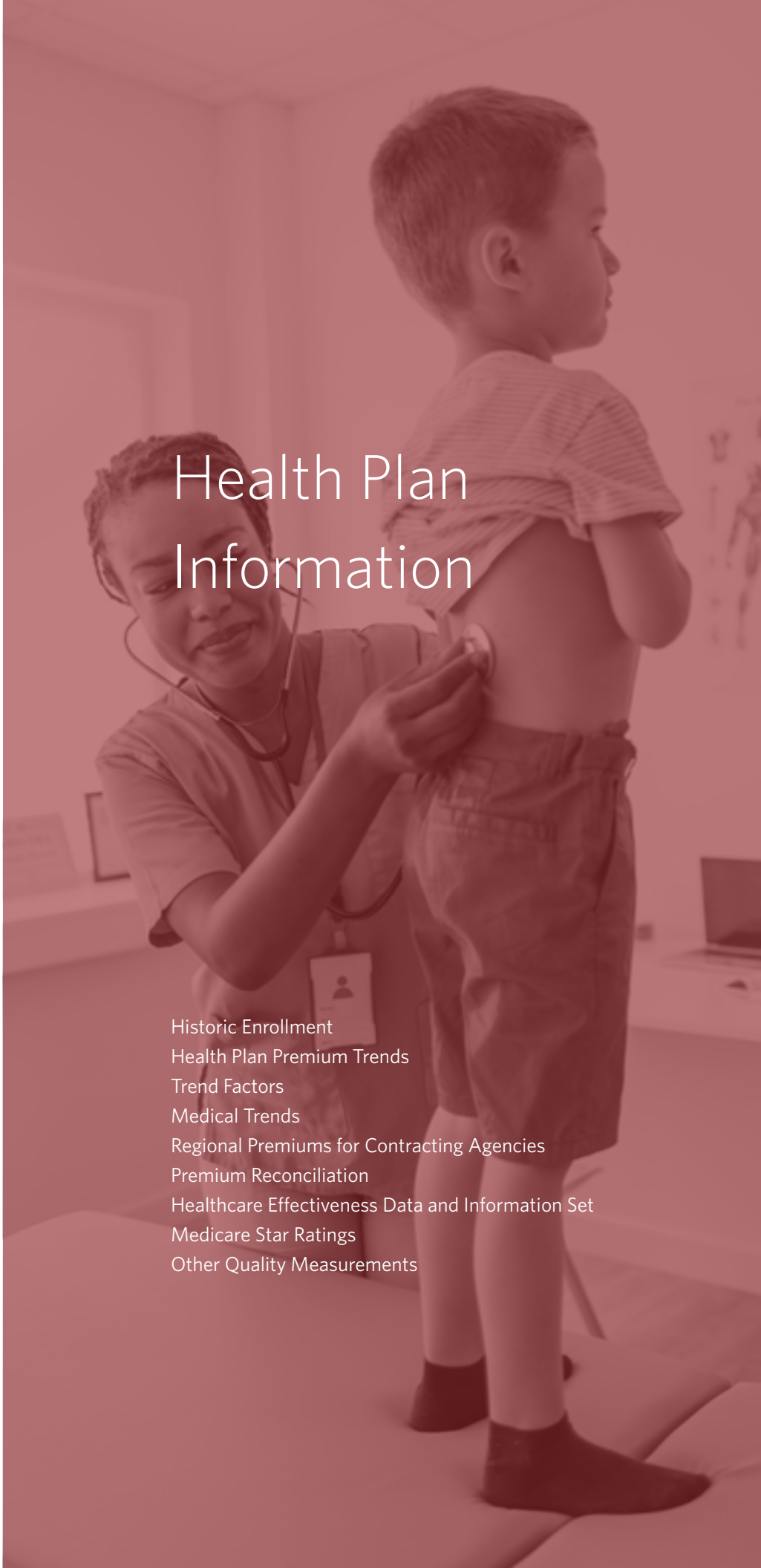


Figure 2b: Medicare Health Care Experience Ratings





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Other Quality Measurements

Historic Enrollment

We have seen our health plan enrollment grow over the past 10 years. Between 2013 and 2022, CalPERS' total enrollment has increased by 9.38%.

The enrollment totals reflect changes made during the Open Enrollment period from the prior year. Changes outside of Open Enrollment are minimal and include adding new employees, and qualifying life events such as the birth or adoption of a child, change in marital or domestic partnership status, change in Medicare eligibility status, etc.

The Historic Enrollment tables (see Appendix B) provide enrollment data for plan years 2020-2022. The CalPERS total enrollment count, derived from myCalPERS as of January 1, 2022, includes state, public agency, and school members, excluding individuals on Consolidated Omnibus Budget Reconciliation Act (COBRA). Appendix B also displays enrollment by plan, 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 2022 health plan premiums was started in 2021 and used data from 2020 and 2021.

Health care costs rose due to a number of factors, including increases in hospital expenditures, outpatient surgical procedures, and pharmacy costs. We continued to look for ways to keep costs low while maintaining high-quality health care.

For further information on our rate development process, visit **How CalPERS Sets Health Premiums** at **www.calpers.ca.gov**.

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 CalPERS' health plan premiums:

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

The estimated future health care costs used to set our rates are based on the data available during the rate development process. Actual costs are affected by numerous factors occurring in the time between rate setting and the conclusion of the plan year. Some factors occurring in the intervening time, such as the COVID-19 pandemic impact on health care during 2021 and 2022, may not be anticipated. We use third party verified actuarial models to account for anticipated factors, but the models cannot predict the future with certainty. This uncertainty results in the year-over-year fluctuations in rates and premiums. Any variation between forecasted and actual costs will impact the percent change between years.

Fluctuations in premiums result from a number of factors including higher medical and pharmaceutical costs, and benefit design changes. For 2022, premiums increased by 4.86%[7] overall for Basic and Medicare plans combined. CalPERS' Basic HMO plans increased by an average of 4.69%, Basic PPO plans increased by an average of 8.67%, Medicare Advantage plans decreased by an average of 6.37%, and Medicare Supplement plans increased by an average of 5.48%.

Medical Trends

The overall cost trend for our Basic health plans increased 2.9% in calendar year 2022 from 2021. 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
- Preventive care
- All other

Analysis of trends allows a better understanding of the factors that impact health care premiums. The 2022 trend in allowed Per Member Per Month (PMPM) increased overall and for each individual category with the exceptions of inpatient and preventive care services.

The utilization trend increased for all key service categories except inpatient admissions and office visits. Unit price decreased for all key service categories except ambulatory surgery, office visits, and prescription days' supply.[8] See Appendix C for graphs displaying these medical trend changes.

[7] Note that the average overall 4.86% increase in premiums for 2022 does not include association plans. The Basic and Medicare premium increases reflect average premium changes of CalPERS' plans.

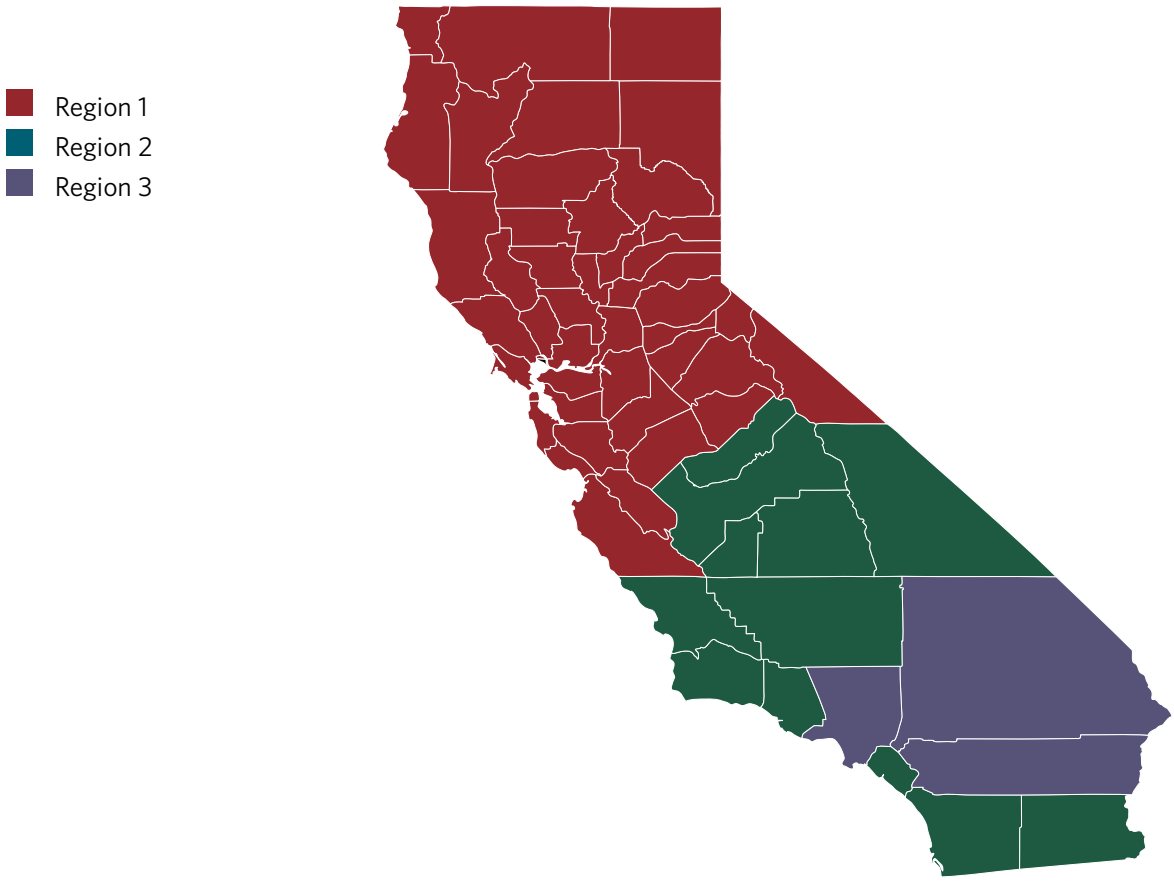
[8] Prescription Days' Supply is the number of days that the drug will last if taken at the prescribed dose.

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. Therefore, we implemented geographic regions and regional pricing for Basic health plan premiums for our contracting public agencies and schools in 2005. We set regional health plan premiums for a defined geographic area, and the differences between regional premiums reflect geographic differences in these factors. Medicare health plan premiums are excluded from regional pricing.

Each year during the annual rate development process, we set regional Basic plan premiums for contracting public agencies and schools. Additional information on premium increases or decreases between plan years 2021 and 2022 are available in the July 13, 2021, Board of Administration Offsite agenda items in Board Meetings at **www.calpers.ca.gov**.

Figure 3: 2022 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 benefit 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 health plan carrier from January through December 2022. The premium information was extracted from a point in time from myCalPERS as of June 15, 2023.

Table 4: Health Premium Management Report for Calendar Year 2022
(Dollars in Thousands)

Health Plan Carriers	Health Premium Amount*
Anthem Blue Cross	$3,395,074
Associations (CAHP, CCPOA, and PORAC)	614,073
Blue Shield of California	817,913
Health Net of California	155,774
Kaiser Permanente	4,663,902
Sharp Health Plan	96,451
UnitedHealthcare	754,711
Western Health Advantage	95,590
Total	**$10,593,488**

* Premiums may not sum to total due to rounding.

Healthcare Effectiveness Data and Information Set

The National Committee for Quality Assurance (NCQA), a not-for-profit organization, develops and manages the Healthcare Effectiveness Data and Information Set (HEDIS®), 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.[9] The current set of HEDIS® measures address effectiveness of care, including preventive care services, chronic disease management and behavioral health care; access and availability of care; experience of care; appropriateness/utilization of services; and risk adjusted utilization.[10]

Employers, consultants, regulators, and consumers use HEDIS® results to help them evaluate and 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.[11]

Other organizations such as the Consumers Reports Advocacy 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. Data and reporting during the contract year[12] reflects services that were performed in the prior measurement year or calendar year.[13]

Appendices D displays the Basic health plans' California book of business data[14] for measurement year 2022.

Medicare Star Ratings

Medicare uses a Star Rating System to measure how well Medicare Advantage and Medicare Prescription Drug (Part D) plans perform.[15] 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.

[9] HEDIS and Performance Measurement. (2023) https://www.ncqa.org/hedis/

[10] HEDIS Measures and Technical Resources. (2023) https://www.ncqa.org/hedis/measures/

[11] NCQA Health Insurance Plan Ratings (2023) https://www.ncqa.org/hedis/reports-and-research/ncqas-health-plan-ratings-2023/

[12] The contract year in which data are analyzed and reported.

[13] The contract year preceding the reporting year, during which the events measured actually occurred.

[14] The total of all commercial insurance accounts written by the plans, both CalPERS and non-CalPERS.

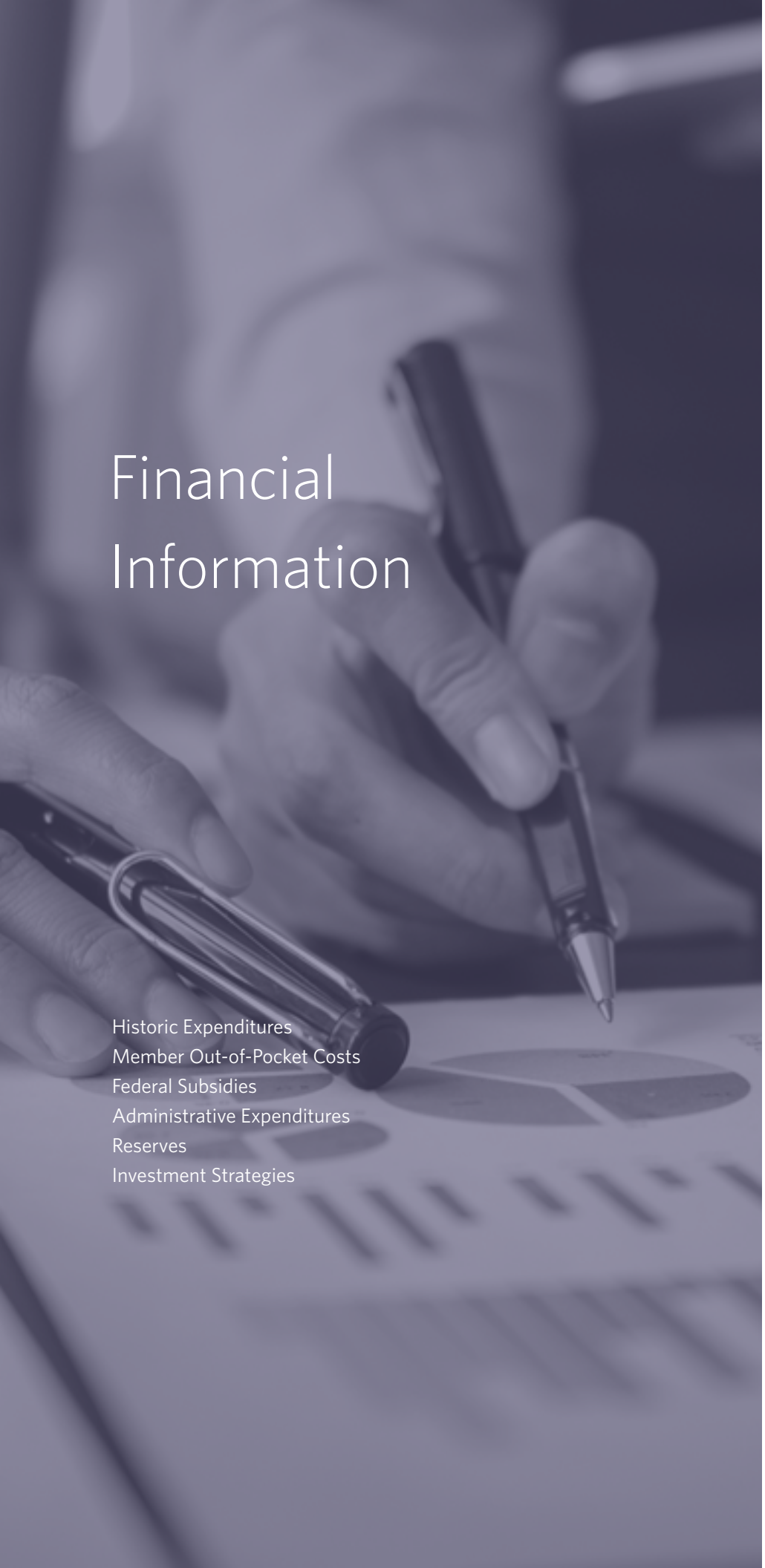
[15] How to compare plans using the Medicare Star Rating System. (2023) https://www.medicareinteractive.org/get-answers/medicare-health-coverage-options/changing-medicare-coverage/how-to-compare-plans-using-the-medicare-star-rating-system

Other Quality Measurements

Other quality measurements (see Table 5) contained in the board's health plan carrier contracts include the following:

Table 5: 2022 Health Plan Contract Quality Measures

Item	Health Plan Contractor Requirements
Behavioral Health Program	Provide a behavioral health program for mental health and substance use disorder treatment designed to objectively monitor and evaluate the efficiency, appropriateness and quality of mental health and substance use disorder 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, Milliman, etc.).
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 three-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 claims administration 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).



Financial Information

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

Historic Expenditures

For the 2022 plan year, the total estimated expenditure was nearly $10.6 billion.

The Historic Expenditures tables (see Appendix E) are estimated expenditures for plan years 2020-2022. 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., 2022 expenditures were calculated based on 2022 premiums and January 2022 enrollment counts).

Appendix E 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 services and prescription drugs that are not reimbursed by insurance. These costs include deductibles, coinsurance, copays, and other out-of-pocket costs as specified in CalPERS' health plans' Evidence of Coverage booklets.

The average member out-of-pocket costs are annual and are based on submitted health claims data. We do not collect data on non-covered services such as over-the-counter medications or out-of-network care. Averages 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.

There was considerable variation in medical services and prescription drugs out-of-pocket costs in 2022 depending on whether a CalPERS Basic or Medicare member chose and was enrolled in an HMO, PPO, or EPO health plan. A typical copay for a physician office visit for members enrolled in a Basic HMO or EPO plan was $15. For members enrolled in Basic PPO plans, the copay was $20 for PERS Platinum. For PERS Gold the copay was $35 and reduced to $10 if the member was seen by their primary physician. For members enrolled in a Medicare Advantage plan, the copay was $10 and no charge for members enrolled in a Medicare Supplement plan. A typical deductible for members enrolled in a Basic PPO plan was $500[16] for individuals and $1,000 for a family. There were no deductibles for members enrolled in a Basic HMO or EPO 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**.

In 2022, our members paid $309 out-of-pocket for medical services and prescription drugs, on average. A member in a Basic HMO or EPO plan paid $117 in out-of-pocket costs, on average, while a member in a Medicare Advantage plan paid $288, on average. A member in a Basic PPO plan paid $895 in out-of-pocket costs, on average, while a member in a Medicare Supplement plan paid on average $285 annually (see Appendix G Annual Average Member Out-of-Pocket Costs by Health Plan).

[16] Deductibles for PERS Gold Basic plan members were $1,000 for individuals and $2,000 for a family. Incentives were available to reduce individual deductible (max. $500) or family deductible (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 2022, we collected over $700,000 in Employer Group Waiver Plans (EGWP) low income cost sharing federal government subsidy revenue. Conversely, CalPERS received less direct revenues for its Medicare plans due to changes to the Center for Medicaid and Medicare Services (CMS) payment rates and updated risk adjustment model, as well as due to our membership's improved risk factor. Therefore, a federal direct subsidy recapture of $8.3 million resulted in an overall net loss of $7.6 million in federal government subsidies.

Direct subsidies are fixed amounts that the 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 Gold and PERS Platinum Supplemental plans to Original Medicare 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 2022–23, we expended $78.5 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 our total 2,843 authorized positions, 431.2 directly and indirectly supported the Health Benefits Program in fiscal year 2022–23 (see Table 6). Direct support positions include those in the Health Policy & Benefits Branch, the Actuarial 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 Legal Office, Financial Office, and the Operations & Technology Branch. Personal services expenditures totaled $54.9 million in fiscal year 2022–23 (see Table 7).

Table 6: Staff Levels

Direct Support Positions	248.8
Enterprise Support Operations Positions	182.4
Total Staffing Levels	431.2

Table 7: Personal Services
(Dollars in Thousands)

Salary and Wages	$35,763
Staff Benefits	19,174
Total Personal Services	$54,937

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 2022–23 totaled $23.6 million (see Table 8).

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

Consultant and Professional Services – Internal	$138
Consultant and Professional Services – External	8,540
General Operating Expenses	9,960
Statewide Administrative Cost (Pro-Rata)	4,971
Total Operating Expenses & Equipment	$23,609

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

Table 9: Funding Sources
(Dollars in Thousands)

Public Employees' CRF	$31,527
Public Employees' HCF	47,019
Total Funding	$78,546

Reserves

Reserve Levels/Adequacy

Actuarial reserve levels are the actuarially prudent threshold for assets to account for worst-case scenarios, e.g., 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. As of December 31, 2022, the actuarial reserve level for the self-funded PPO plans was $656.8 million,[17] and the total assets level was $220.8 million, which created a $436.0 million reserve deficit, or a funded status of 34% of the actuarial reserves. Since plan assets have fallen below 90% of the actuarial reserve amount, the board approved an additional surcharge for the 2023 plan year premiums and future years' premiums. Although the assets do not meet the actuarial reserve levels, we expect to have sufficient funds to cover claims.

For the self-funded pharmacy portion of CalPERS' HMO plans, total assets were $25.1 million as of December 31, 2022.

CalPERS used the total assets levels account for encumbered dollars for buydowns to lower premiums for the 2022 plan year.

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 incurred claims.

Policies to Reduce Surplus Reserves/Rebuild Inadequate Reserves

We implemented our HCF reserve policy in September 2018. The main purpose of the 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 RBC requirement for the PPO plans is designed to provide adequate protection against adverse claims experience, thereby making reinsurance unnecessary once assets are replenished to actuarial reserve levels.

For the flex-funded HMO plans, reinsurance is not needed due to the nature of the flex-funding arrangement. A flat per-member administrative fee is negotiated in the contracts 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 use those savings to reduce premiums in subsequent years.

[17] The 2022 actuarial reserve level reflects claims processed as of March 31, 2023.

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
18/19	Surplus Money Investment Fund (SMIF)	$644,041,241	2.27%
19/20		728,825,669	1.95%
20/21		728,469,734	0.50%
21/22		756,131,527	0.37%
22/23		720,365,295	2.19%

* See Appendix F 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 in **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
18/19	State Street Global Advisors (SSGA) U.S. Aggregate Bond Index Fund	$478,180,431	7.87%
19/20		520,391,768	8.82%
20/21		518,420,597	(0.39%)
21/22		327,522,392	(10.32%)
22/23		205,091,033	(0.98%)
18/19	Surplus Money Investment Fund (SMIF)	$371,458,597	2.27%
19/20		277,031,123	1.95%
20/21		151,173,735	0.50%
21/22		116,746,966	0.37%
22/23		194,188,046	2.19%

* See Appendix F 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, 2023, is 1.52%, past performance is not a guarantee of future results.

The SMIF does not follow a benchmark. However, comparison of PMIA yields to the Federal Funds Rate and the S&P Government Investment Pool index are provided by the Office of the State Treasurer. For further information on the PMIA, visit **www.treasurer.ca.gov/pmia-laif/pmia/index.asp**.

Appendices

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Appendix A – Implementing Statute

Government Code Section 22866

22866. (a) The board shall report to the Legislature and the Director of Finance on or before November 1, 2016, and annually thereafter, regarding the health benefits program. The report shall include, but not be limited to the following:

(1) General overview of the health benefits program, including, but not limited to, the following:

(A) Description of health plans and benefits provided, including essential and nonessential benefits as required by state and federal law, member expected out-of-pocket expenses, and actuarial value by metal tier as defined by the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(B) Geographic coverage.

(C) Historic enrollment information by basic and Medicare plans, by state and contract agencies, by active and retired membership, and by subscriber and dependent tier.

(D) Historic expenditures by basic and Medicare plans, by state and contract agencies, by active and retired membership, and by subscriber and dependent tier.

(2) Reconciliation of premium increases or decreases from the prior plan year, and the reasons for those changes.

(A) Description of benefit design and benefit changes, including prescription drug coverage, by plan. The description shall detail whether benefit changes were required by statutory mandate, federal law, or an exercise of the board's discretion, the costs or savings of the benefit change, and the impact of how the changes fit into a broader strategy.

(B) Discussion of risk.

(C) Description of medical trend changes in aggregate service categories for each plan. The aggregate service categories used shall include the standard categories of information collected by the board, consisting of the following: inpatient, emergency room, ambulatory surgery, office, ambulatory radiology, ambulatory lab, mental health and substance abuse, other professional, prescriptions, and all other service categories.

(D) Reconciliation of past year premiums against actual enrollments, revenues, and accounts receivables.

(3) Overall member health as reflected by data on chronic conditions.

(4) The impact of federal subsidies or contributions to the health care of members, including Medicare Part A, Part B, Part C, or Part D, low-income subsidies, or other federal program.

(5) The cost of benefits beyond Medicare contained in the board's Medicare supplemental plans.

(6) A description of plan quality performance and member satisfaction, including, but not limited to, the following:

(A) The Healthcare Effectiveness Data and Information Set, referred to as HEDIS.

(B) The Medicare star rating for Medicare supplemental plans.

(C) The degree of satisfaction of members and annuitants with the health benefit plans and with the quality of the care provided, to the extent the board surveys participants.

(D) The level of accessibility to preferred providers for rural members who do not have access to health maintenance organizations.

(E) Other applicable quality measurements collected by the board as part of the board's health plan contracts.

(7) A description of risk assessment and risk mitigation policy related to the board's self-funded and partially self-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.

Appendix B – Historic Enrollment

Enrollment as of January 1 of Each Reported Year[18]

	2020	2021	2022
Basic HMO Plans			
Anthem Blue Cross Select	43,478	48,692	48,068
Anthem Blue Cross Traditional	14,165	12,848	11,356
Blue Shield Access+	93,869	81,127	79,153
Blue Shield Trio	8,336	12,590	17,249
Health Net - Salud y Más	10,790	11,819	12,774
Health Net - SmartCare	18,213	14,918	10,856
Kaiser Permanente	548,287	555,002	555,698
Kaiser Out-of-State	849	950	1,051
Sharp Health Plan	14,024	14,583	14,790
UnitedHealthcare Signature Value Alliance	85,684	82,927	76,469
UnitedHealthcare Signature Value Harmony	—	—	2,679
Western Health Advantage	11,038	11,347	13,338
Basic EPO and PPO Plans			
Anthem Blue Cross Del Norte EPO	81	81	65
Blue Shield EPO	966	880	895
PERSCare	28,275	25,689	—
PERS Choice	146,790	142,946	—
PERS Gold	—	—	123,631
PERS Platinum	—	—	152,776
PERS Select	91,972	107,287	—
Basic Association Plans			
California Association of Highway Patrolmen	28,049	27,304	26,701
California Correctional Peace Officers Association North	8,324	7,675	7,189
California Correctional Peace Officers Association South	31,547	30,662	30,095
Peace Officers Research Association of California	21,236	21,363	21,883
Basic Total	1,205,973	1,210,690	1,206,716

[18] 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.

	2020	2021	2022
Medicare Advantage Plans			
Anthem Medicare Preferred PPO	2,901	4,177	5,412
Blue Shield Medicare PPO	—	—	591
Kaiser Permanente Senior Advantage	103,846	107,545	110,857
Kaiser Permanente Senior Advantage Out-of-State	2,338	2,454	2,620
Sharp Direct Advantage	—	24	170
UnitedHealthcare Medicare Advantage	43,094	44,920	44,661
UnitedHealthcare Medicare Advantage Edge	—	—	2,061
Western Health Advantage MyCare Select	—	—	57
Supplement to Original Medicare Plans			
PERSCare	64,237	65,898	—
PERS Choice	75,126	77,911	—
PERS Gold	—	—	3,316
PERS Platinum	—	—	147,111
PERS Select	2,421	2,913	—
Medicare Association Plans			
California Association of Highway Patrolmen	4,469	4,516	4,587
California Correctional Peace Officers Association North	636	687	744
California Correctional Peace Officers Association South	797	886	992
Peace Officers Research Association of California	2,573	2,722	2,854
Medicare Total	302,438	314,653	326,033
Grand Total	**1,508,411**	**1,525,343**	**1,532,749**

	2020	2021	2022
Program			
State	884,106	887,580	889,577
Contracting Agency	624,305	637,763	643,172
Total	1,508,411	1,525,343	1,532,749

Employment Status			
Active	1,022,926	1,025,477	1,021,213
Retired	485,485	499,866	511,536
Total	1,508,411	1,525,343	1,532,749

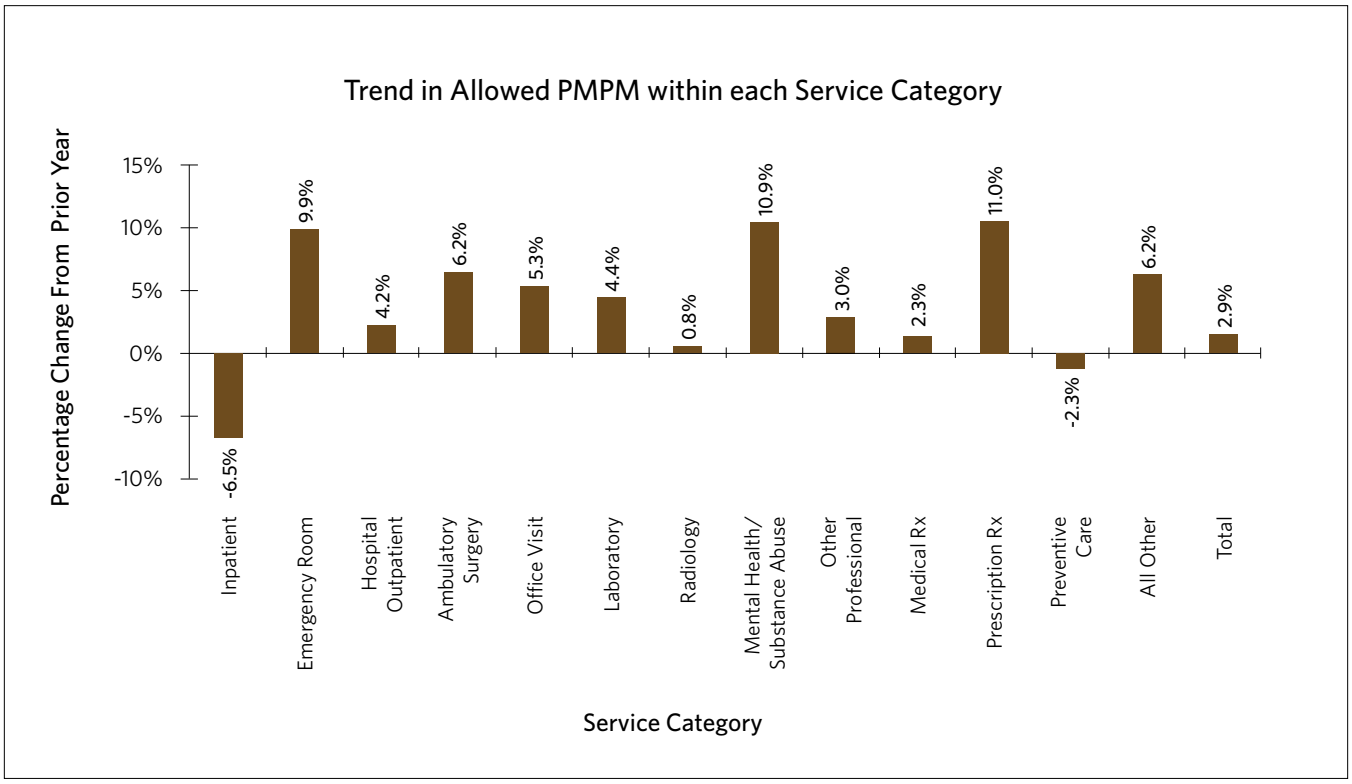
Subscriber and Dependent Tier			
Single	336,699	346,222	356,348
2-Party	416,460	421,724	423,554
Family	755,252	757,397	752,847
Total	1,508,411	1,525,343	1,532,749

Appendix C – Medical Trends

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

The trend in allowed PMPM [19] cost [20] is examined across 13 service categories,[21] revealing the key drivers of medical trend changes in 2022, compared to 2021.

The chart below shows the trend for each individual service category. Most categories experienced an increase. The categories that experienced the largest increases were the prescription drug and mental health/substance abuse categories. The only service categories to experience a decrease were inpatient and preventive care.



Data as of June 22, 2023

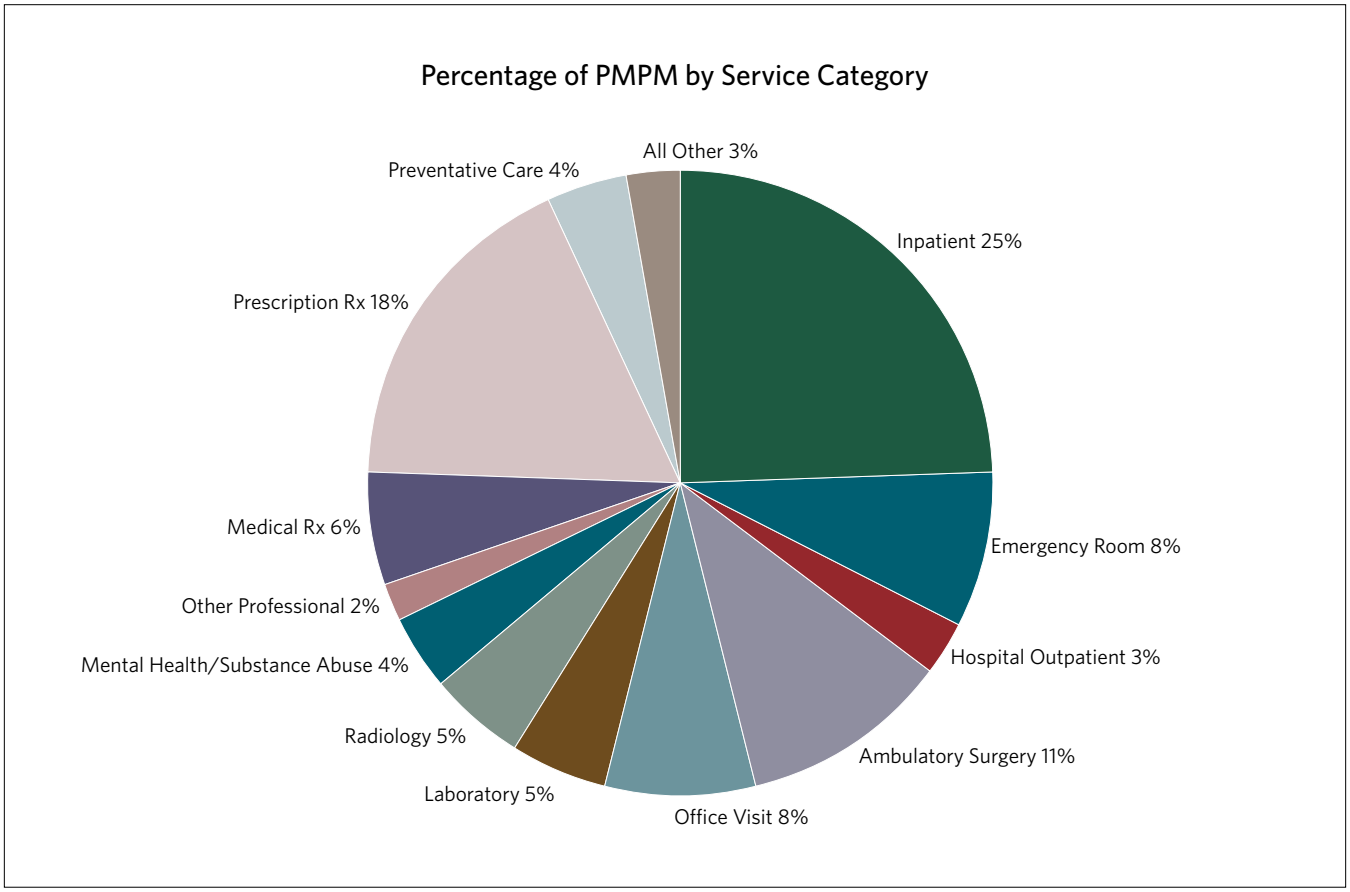
[19] Allowed cost divided by the sum of member months in period, adjusted for population size.

[20] 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).

[21] 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 category [22] in 2022. The three major drivers that account for 54% of the total allowed PMPM are inpatient (25%), prescription drug (18%), and ambulatory surgery (11%).[23]



Data as of June 22, 2023

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

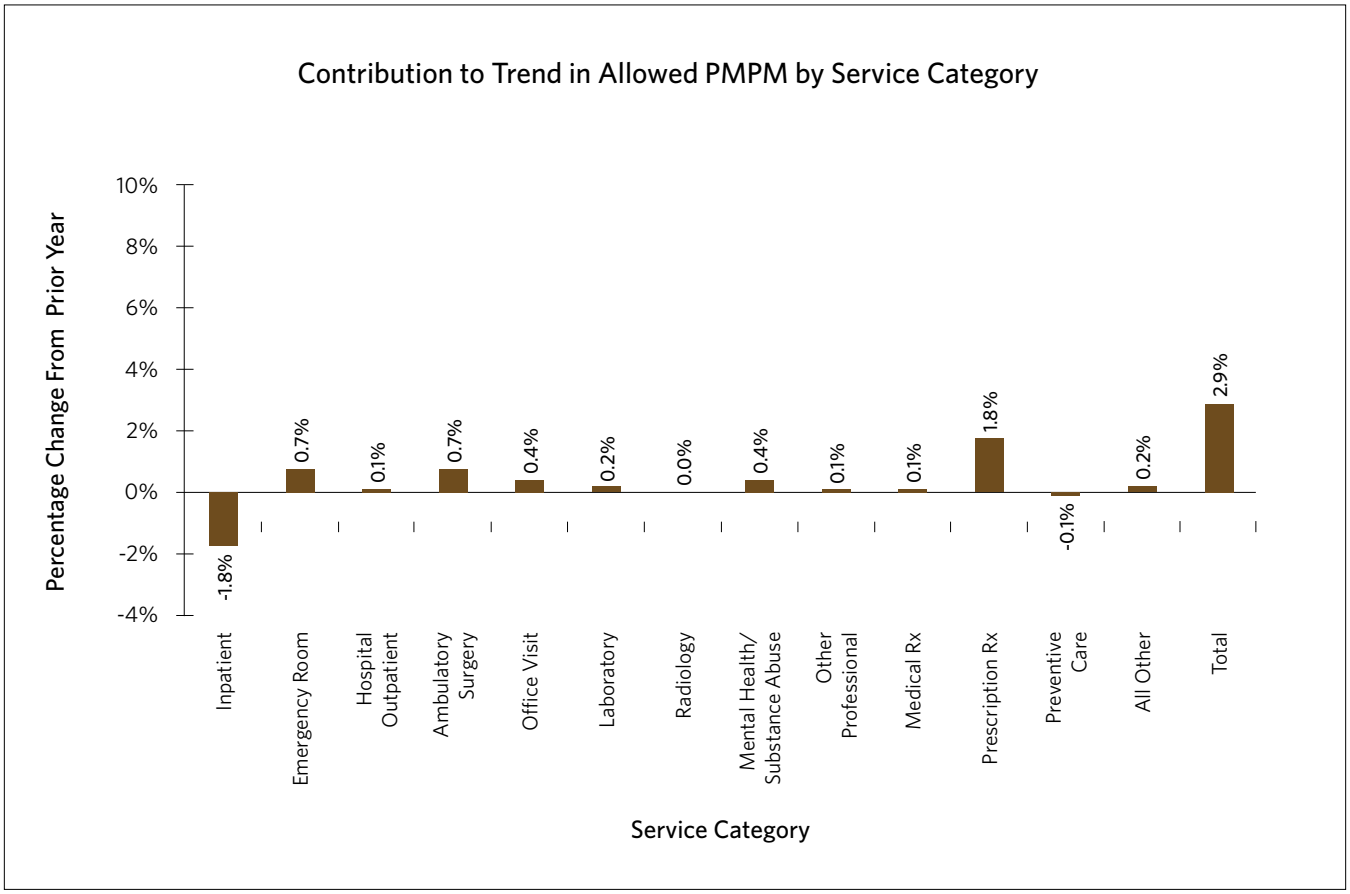
[23] The sum of the Percentage of PMPM by Service Category is greater than 100% due to rounding.

Appendix C – Medical Trends, cont.

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

In calendar year 2022, the total allowed PMPM increased 2.9% across all service categories.[24]

The chart below shows the major drivers that contributed to trend in the allowed PMPM for calendar year 2022. Prescription drugs accounted for 1.8% and emergency room and ambulatory surgery were each 0.7%. Inpatient decreased 1.8% and preventive care decreased 0.1%.[25]



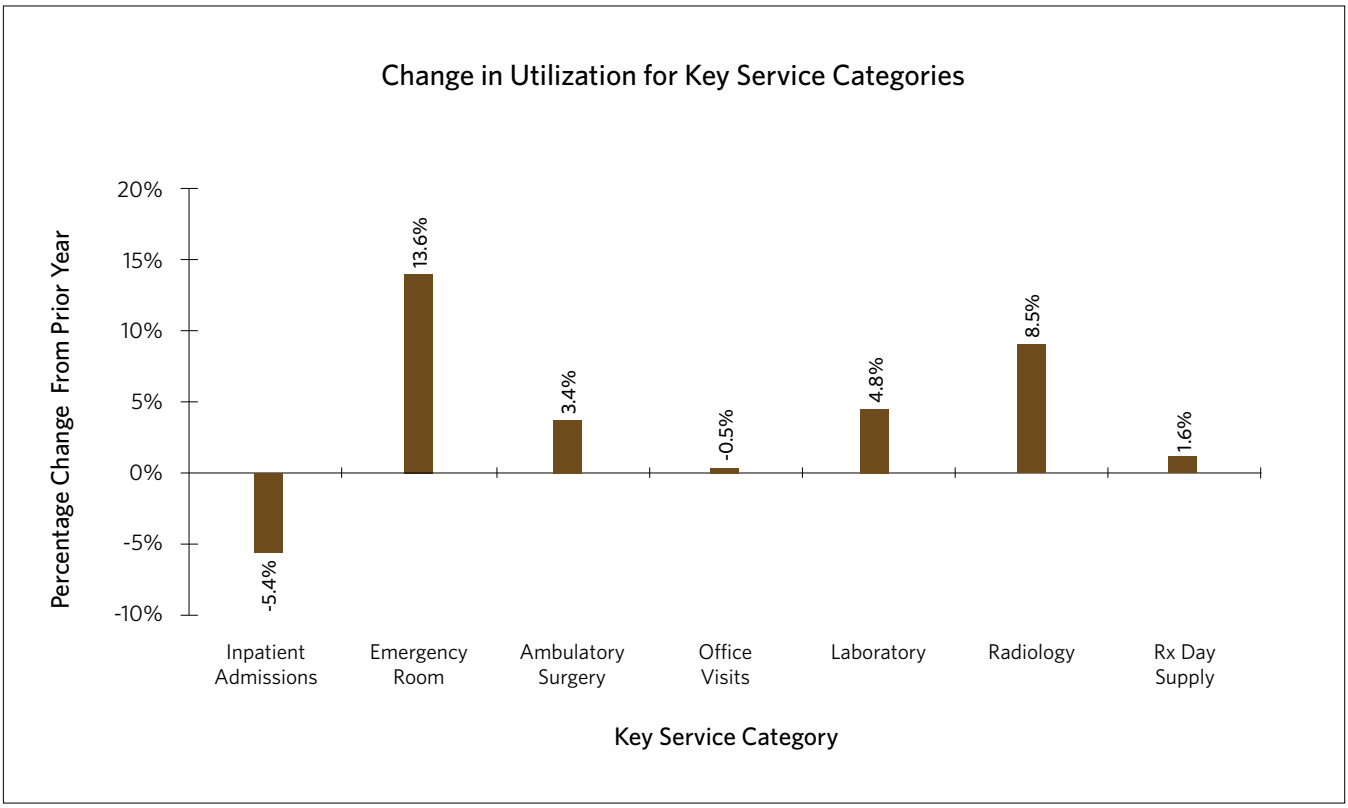
Data as of June 22, 2023

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

[25] Total may not equal the sum of the Contribution Trend in Allowed PMPM by service category due to rounding.

Change in Utilization by Key Service Categories

Among the largest service categories,[26] allowed PMPM is driven by change in utilization per unit. In 2022, an increase in utilization occurred in all key service categories except inpatient admissions and office visits. The largest increase occurred in emergency room visits (13.6%).



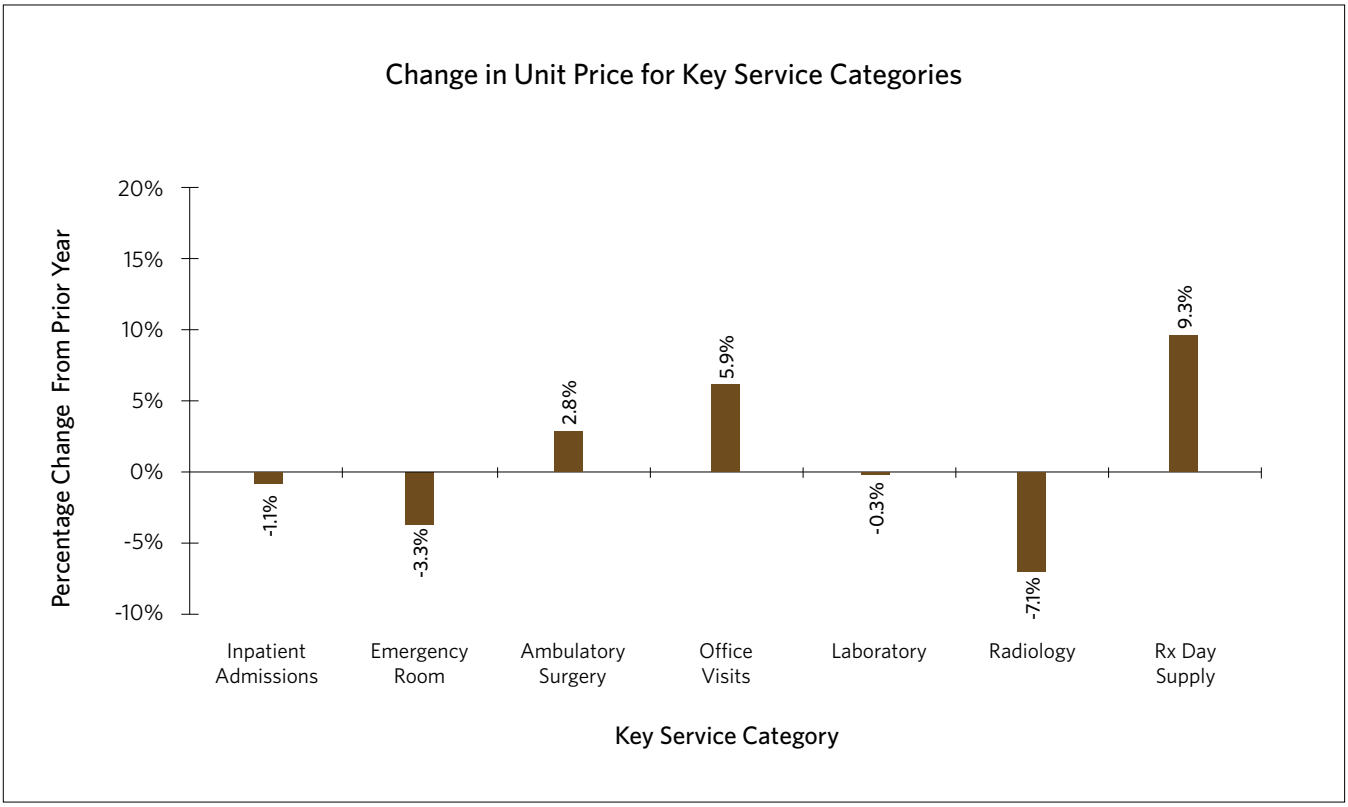
Data as of June 22, 2023

[26] The Rx Day Supply category does not include rebates.

Appendix C – Medical Trends, cont.

Change in Unit Price by Key Service Categories

Among the largest service categories,[27] allowed PMPM is driven by change in price per unit. In 2022, an increase in unit price occurred in three service categories: ambulatory surgery (2.8%), office visits (5.9%) and prescription days' supply (9.3%).



Data as of June 22, 2023

[27] The Rx Day Supply service category does not include rebates.

Appendix D – Part 1 of 2 Basic Health Plan HEDIS Measures

Measure	Anthem HMO	Anthem PPO	BSC	Kaiser
Prevention and Screening				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents — BMI percentile (Total)*	68.3%	65.6%	66.1%	95.1%
Childhood Immunization Status — Combination 10*	54.0%	49.4%	52.6%	66.9%
Immunizations for Adolescents — Combination 2*	36.5%	25.2%	34.8%	58.1%
Breast Cancer Screening — Total	77.0%	72.1%	76.6%	82.5%
Cervical Cancer Screening*	74.4%	74.8%	77.1%	81.6%
Colorectal Cancer Screening*	50.6%	58.4%	56.9%	67.9%
Chlamydia Screening in Women — Total	51.2%	44.9%	50.5%	60.4%
Respiratory Conditions				
Appropriate Testing for Pharyngitis (Total)	49.4%	61.0%	46.7%	46.5%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis/Bronchiolitis (Total)	44.2%	47.7%	41.7%	81.3%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	27.7%	32.9%	30.4%	33.5%
Pharmacotherapy Management of COPD Exacerbation — Systemic Corticosteroid	73.1%	67.6%	67.3%	86.6%
Pharmacotherapy Management of COPD Exacerbation — Bronchodilator	84.6%	76.1%	85.0%	94.6%
Cardiovascular Conditions				
Controlling High Blood Pressure	63.8%	48.9%	65.8%	75.0%
Persistence of Beta-Blocker Treatment after a Heart Attack	79.0%	79.4%	85.7%	86.9%
Diabetes				
Comprehensive Diabetes Care — HbA1c Control (<8%)*	60.3%	58.6%	63.3%	59.8%
Comprehensive Diabetes Care — Eye Exams*	54.5%	41.4%	55.8%	75.8%
Overuse/Appropriateness				
Use of Imaging Studies for Low Back Pain	76.2%	78.5%	84.4%	87.2%
Use of Opioids at High Dosage	3.7%	4.3%	3.0%	1.5%

* "Hybrid measure" for which HMOs gather information from patients' medical records for HEDIS measures; however, some HMOs report only administrative data, as allowed by NCQA.

Measure	Anthem HMO	Anthem PPO	BSC	Kaiser
Behavioral Health				
Antidepressant Medication Management — Effective Acute Phase Treatment	71.3%	77.0%	67.0%	83.0%
Antidepressant Medication Management — Effective Continuation Phase Treatment	54.7%	61.4%	52.4%	58.0%
Follow Up Care for Children Prescribed ADHD Medication — Initiation Phase	38.8%	41.2%	47.5%	76.8%
Follow Up Care for Children Prescribed ADHD Medication — Continuation & Maintenance Phase	41.3%	43.3%	52.4%	78.4%
Follow Up after Hospitalization for Mental Illness — 7-days	45.5%	47.4%	43.1%	78.6%
Follow Up after Hospitalization for Mental Illness — 30-days	68.3%	70.7%	68.8%	89.0%
Access/Availability of Care				
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of SUD Treatment (Total)	35.3%	38.7%	46.2%	51.1%
Initiation and Engagement of Substance Use Disorder Treatment - Engagement of SUD Treatment (Total)	13.7%	16.6%	14.7%	26.2%
Prenatal and Postpartum Care — Timeliness of Prenatal Care*	86.7%	86.3%	80.2%	94.4%
Prenatal and Postpartum Care — Postpartum Care*	84.7%	81.3%	74.0%	92.3%

* "Hybrid measure" for which HMOs gather information from patients' medical records for HEDIS measures; however, some HMOs report only administrative data, as allowed by NCQA.

Notes:

- The measures presented are from HEDIS® 2022 Volume 2: Technical Specifications for Health Plans.
- Due to space limitations, measures focusing on specific age groups (e.g., "16-20 Years" vs "2-24 Years" for "Chlamydia Screening in Women"), as well as measures unavailable for all HMO and PPO plans, are excluded from this table.
- Plan Abbreviations and Acronyms: Anthem = Anthem Blue Cross, BSC = Blue Shield of California, and UHC = United Healthcare.
- In the immunization measures, "Combination 10" and "Combination 2" refer to different sets of recommended vaccines; see NCQA website for details.
- Acronyms used in measures: BMI = Body Mass Index ; COPD = Chronic Obstructive Pulmonary Disease; HbA1c = Hemoglobin A1c; and ADHD = Attention Deficit Hyperactivity Disorder

Appendix D – Part 2 of 2 Basic Health Plan HEDIS Measures

Measure	Health Net	Sharp	UHC	WHA
Prevention and Screening				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents — BMI percentile (Total)*	73.2%	83.1%	72.2%	75.2%
Childhood Immunization Status — Combination 10*	62.5%	59.4%	53.6%	58.3%
Immunizations for Adolescents — Combination 2*	41.9%	35.2%	38.7%	37.0%
Breast Cancer Screening — Total	77.1%	83.3%	77.9%	79.1%
Cervical Cancer Screening*	76.4%	82.1%	82.6%	79.2%
Colorectal Cancer Screening*	58.2%	62.8%	54.7%	61.3%
Chlamydia Screening in Women — Total	51.3%	60.3%	58.1%	61.1%
Respiratory Conditions				
Appropriate Testing for Pharyngitis (Total)	47.9%	72.7%	47.9%	67.8%
Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis (Total)	45.0%	61.1%	46.7%	55.1%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	35.4%	36.1%	26.7%	22.7%
Pharmacotherapy Management of COPD Exacerbation — Systemic Corticosteroid	79.7%	71.4%	58.8%	60.9%
Pharmacotherapy Management of COPD Exacerbation — Bronchodilator	84.8%	92.9%	91.2%	69.6%
Cardiovascular Conditions				
Controlling High Blood Pressure	62.5%	75.0%	63.3%	69.5%
Persistence of Beta-Blocker Treatment after a Heart Attack	79.4%	90.5%	86.8%	78.1%
Diabetes				
Comprehensive Diabetes Care — HbA1c Control (<8%)*	65.0%	69.7%	68.8%	63.3%
Comprehensive Diabetes Care — Eye Exams*	60.6%	78.7%	51.7%	62.0%
Overuse/Appropriateness				
Use of Imaging Studies for Low Back Pain	77.3%	77.5%	78.9%	78.3%
Use of Opioids at High Dosage	4.0%	2.6%	2.4%	4.0%

* "Hybrid measure" for which HMOs gather information from patients' medical records for HEDIS measures; however, some HMOs report only administrative data, as allowed by NCQA.

Measure	Health Net	Sharp	UHC	WHA
Behavioral Health				
Antidepressant Medication Management — Effective Acute Phase Treatment	71.2%	80.5%	66.3%	71.0%
Antidepressant Medication Management — Effective Continuation Phase Treatment	56.8%	64.7%	49.6%	56.0%
Follow Up Care for Children Prescribed ADHD Medication — Initiation Phase	40.9%	32.6%	31.5%	48.0%
Follow Up Care for Children Prescribed ADHD Medication — Continuation & Maintenance Phase	47.9%	34.3%	48.9%	48.0%
Follow Up after Hospitalization for Mental Illness — 7-days	48.0%	59.9%	43.9%	35.0%
Follow Up after Hospitalization for Mental Illness — 30-days	69.2%	82.2%	61.6%	59.4%
Access/Availability of Care				
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of SUD Treatment (Total)	28.6%	33.8%	32.3%	24.6%
Initiation and Engagement of Substance Use Disorder Treatment - Engagement of SUD Treatment (Total)	11.1%	12.2%	12.4%	5.4%
Prenatal and Postpartum Care — Timeliness of Prenatal Care*	93.2%	91.7%	86.0%	83.3%
Prenatal and Postpartum Care — Postpartum Care*	90.4%	89.2%	82.1%	88.3%

* "Hybrid measure" for which HMOs gather information from patients' medical records for HEDIS measures; however, some HMOs report only administrative data, as allowed by NCQA.

Notes:

- The measures presented are from HEDIS® 2022 Volume 2: Technical Specifications for Health Plans.
- Due to space limitations, measures focusing on specific age groups (e.g., "16-20 Years" vs "21-24 Years" for "Chlamydia Screening in Women"), as well as measures unavailable for all HMO and PPO plans, are excluded from this table.
- Plan Abbreviations and Acronyms: WHA = Western Health Advantage.
- In the immunization measures, "Combination 10" and "Combination 2" refer to different sets of recommended vaccines; see NCQA website for details.
- Acronyms used in measures: BMI = Body Mass Index ; COPD = Chronic Obstructive Pulmonary Disease; HbA1c = Hemoglobin A1c; and ADHD = Attention Deficit Hyperactivity Disorder.

Appendix E – Historic Expenditures

Estimated Expenditures (dollars in thousands) [28]

	2020	2021	2022
Basic HMO Plans			
Anthem Blue Cross Select	$310,929	$362,294	$374,876
Anthem Blue Cross Traditional	155,277	152,627	132,124
Blue Shield Access+	812,836	712,950	675,377
Blue Shield Trio	52,564	86,238	125,499
Health Net Salud y Más	40,158	47,018	56,960
Health Net SmartCare	149,058	129,376	100,188
Kaiser Permanente	3,794,672	4,027,970	4,233,197
Kaiser Out-of-State	9,265	11,406	13,014
Sharp Health Plan	78,843	85,927	96,055
UnitedHealthcare SignatureValue Alliance	571,301	578,984	571,307
UnitedHealthcare SignatureValue Harmony	—	—	18,799
Western Health Advantage	75,523	81,030	94,098
Basic EPO and PPO Plans			
Anthem Del Norte EPO	$572	$605	$589
Blue Shield EPO	9,272	8,470	8,382
PERSCare	291,458	175,944	—
PERS Choice	1,136,287	1,187,352	—
PERS Gold	—	—	753,696
PERS Platinum	—	—	1,414,699
PERS Select	415,729	531,714	—
Basic Association Plans			
California Association of Highway Patrolmen	160,639	165,111	162,386
California Correctional Peace Officers Association North	59,029	56,028	55,318
California Correctional Peace Officers Association South	179,051	181,111	187,731
Peace Officers Research Association of California	150,120	146,468	154,122
Basic Total	$8,452,584	$8,844,176*	$9,228,417

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

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

Appendix E – Historic Expenditures, cont.

	2020	2021	2022
Medicare Advantage Plans			
Anthem Medicare Preferred PPO	$13,508	$21,138	$24,494
Blue Shield Medicare PPO	—	—	5,568
Kaiser Permanente Senior Advantage	422,944	433,964	406,390
Kaiser Permanente Senior Advantage Out-of-State	9,523	9,512	9,437
Sharp Direct Advantage HMO	—	199	681
UnitedHealthcare Medicare Advantage	169,105	169,962	157,552
UnitedHealthcare Medicare Advantage Edge	—	—	9,625
Western Health Advantage MyCare Select	—	—	446
Supplement to Original Medicare Plans			
PERSCare	10,209	12,813	—
PERS Choice	316,740	330,671	—
PERS Gold	—	—	15,860
PERS Platinum	—	—	676,992
PERS Select	296,587	301,378	—
Medicare Association Plans			
California Association of Highway Patrolmen	24,110	26,666	27,178
California Correctional Peace Officers Association North	3,720	4,059	4,836
California Correctional Peace Officers Association South	4,661	5,453	6,323
Peace Officers Research Association of California	15,798	20,537	16,265
Medicare Total	$1,286,905	$1,326,842*	$1,361,647
Grand Total	$9,739,488	$10,171,019**	$10,590,064

Appendix E – Historic Expenditures, cont.

	2020	2021	2022
Program			
State	$5,627,611	$6,991,945	$6,047,556
Contracting Agency	$4,111,877	3,179,680	4,542,978
Total	$9,739,488	$10,171,625	$10,590,534
Employment Status			
Active	$6,951,284	$7,238,112	$7,572,505
Retired	2,788,204	2,932,907	3,018,029
Total	$9,739,488	$10,171,625*	$10,590,534
Subscriber and Dependent Tier			
Single	$2,359,470	$2,575,767	$4,736,449
2-Party	2,996,081	3,063,420	2,706,733
Family	4,383,937	4,531,831	3,147,352
Total	$9,739,488	$10,171,018**	$10,590,534

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

**Grand total may not equal sum of Basic and Medicare totals due to rounding.

Appendix F – 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
3/31/2012	0.374%	12/31/2017	1.128% (a)(b)
6/30/2012	0.361%	3/31/2018	1.288% (a)(b)
9/30/2012	0.349%	6/30/2018	1.529% (a)
12/31/2012	0.316%	9/30/2018	1.731% (a)
3/31/2013	0.275%	12/31/2018	1.921% (a)
6/30/2013	0.246%	3/31/2019	2.088% (a)
9/30/2013	0.249%	6/30/2019	2.148% (a)
12/31/2013	0.248%	9/30/2019	2.042% (a)(c)
3/31/2014	0.222%	12/31/2019	1.856% (a)(c)
6/30/2014	0.228%	3/31/2020	1.650% (a)(c)
9/30/2014	0.234%	6/30/2020	1.236% (a)(c)
12/31/2014	0.249%	9/30/2020	0.698% (a)(c)
3/31/2015	0.254%	12/31/2020	0.498% (a)(c)
6/30/2015	0.283%	3/31/2021	0.349% (a)(c)
9/30/2015	0.316%	6/30/2021	0.277% (a)(c)
12/31/2015	0.364%	9/30/2021	0.198%(a)(c)(d)
3/31/2016	0.460%	12/31/2021	0.189%(a)(c)(d)
6/30/2016	0.543%	3/31/2022	0.269%(a)(c)(d)
9/30/2016	0.599%	6/30/2022	0.654%(a)(c)(d)
12/31/2016	0.672%	9/30/2022	1.220% (a)(c)(d)
3/31/2017	0.769%	12/31/2022	1.881% (a)(c)(d)
6/30/2017	0.922%	3/31/2023	2.511% (a)(c)(d)
9/30/2017	1.069%	6/30/2023	2.911% (a)(c)(d)

(a) Does not include interest earned on the Supplemental Pension Payment pursuant to Government Code 20825 (c)(1).
(b) Revised June 8, 2018
(c) Does not include interest earned on the Wildfire Fund loan pursuant to Public Utility Code 3288 (a).
(d) Does not include interest earned on the State and Local Government Securities.

Appendix G – Average Member Out-of-Pocket Costs by Health Plan*

Basic EPO and HMO Plans	2022
Anthem Blue Cross Del Norte County EPO	$213
Anthem Blue Cross Select HMO	161
Anthem Blue Cross Traditional HMO	214
Blue Shield Access+ EPO	193
Blue Shield Access+ HMO	182
Blue Shield Trio HMO	138
Health Net Salud y Más	89
Health Net SmartCare	202
Kaiser Permanente	92
Sharp Health Plan	137
UnitedHealthcare SignatureValue Alliance	160
UnitedHealthcare SignatureValue Harmony	127
Western Health Advantage HMO	179
Average Member Out-of-Pocket for Basic EPO and HMO Plans	$117

Basic PPO Plans	
PERS Gold	$792
PERS Platinum	990
Average Member Out-of-Pocket for Basic PPO Plans	$895

Medicare Advantage Plans	
Anthem Medicare Preferred PPO	$424
Blue Shield Medicare PPO	194
Kaiser Permanente Senior Advantage	259
Sharp Direct Advantage HMO	166
UnitedHealthcare Group Medicare Advantage PPO	365
UnitedHealthcare Group Medicare Advantage Edge PPO	226
Western Health Advantage MyCare Select HMO	239
Average Member Out-of-Pocket for Medicare Advantage Plans	$288

Supplement to Original Medicare Plans	
PERS Gold	$266
PERS Platinum	285
Average Out-of-Pocket for Supplement to Original Medicare Plans	$285

*Average annual costs rounded to nearest dollar

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Ⓓ November 2023