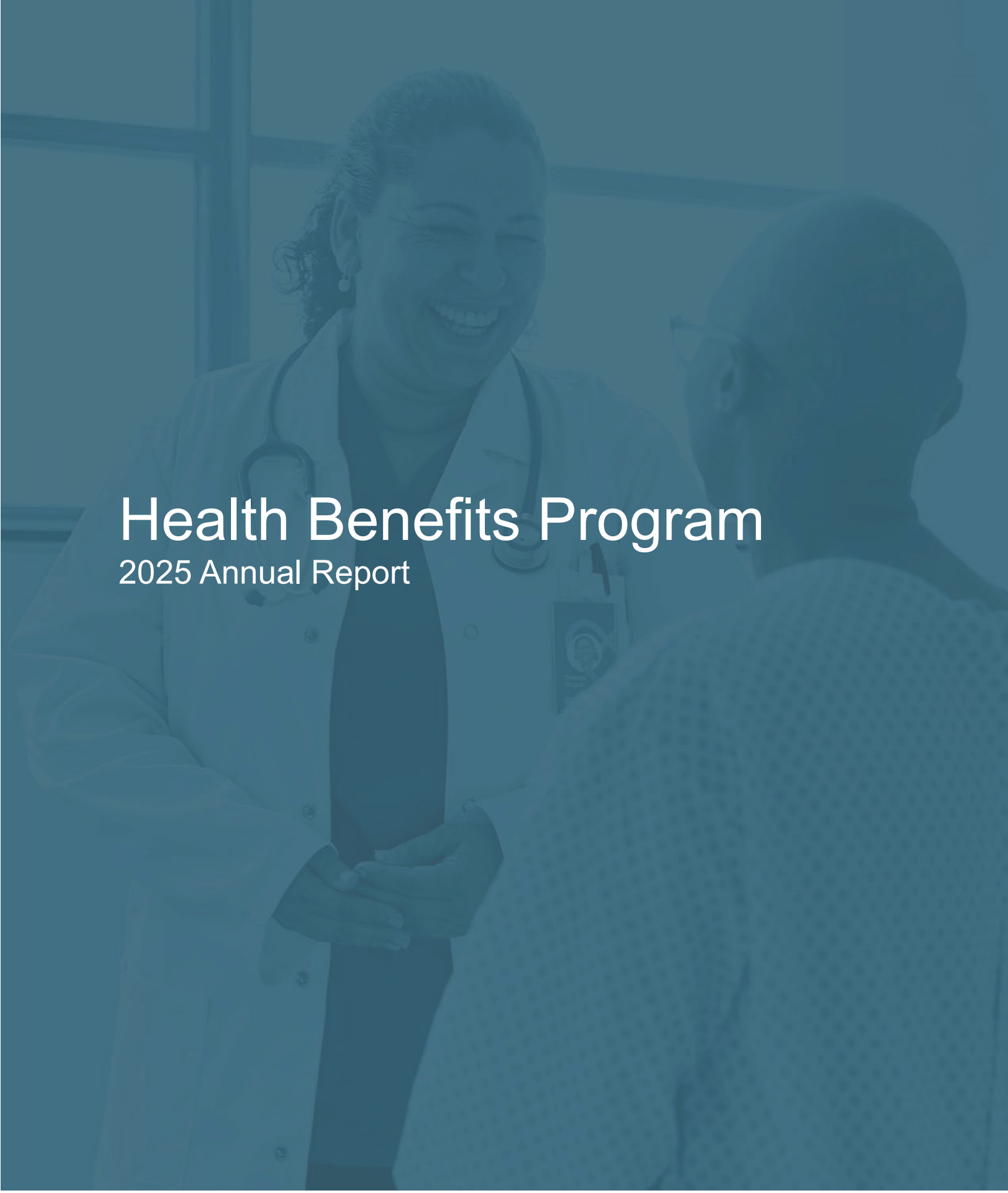


Health Benefits Program

2025 Annual Report

Published November 1, 2026

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, 2025. This report provides an overview of the Health Benefits Program, as required by California Government Code Section 22866.

CalPERS continued to enhance its health offerings in 2025 to meet the evolving needs of our more than 1.5 million members, focusing on improving access, affordability, and quality, while advancing long-term strategies to manage costs.

Overall health plan premiums experienced a rate change of 10.79% in 2025. Basic health maintenance organization (HMO) plans had an 8.72% overall increase, while Basic preferred provider organization (PPO) plans increased 9.82% overall. Premiums for our Medicare plans increased by 22.25%. More than 60,000 members, or 4.1% of our total members, switched to a new plan starting in 2025.

We implemented new five-year contracts with Blue Shield of California and Included Health to improve quality and reduce long-term medical costs for nearly 400,000 PPO members. The contracts introduced strong performance guarantees, putting $464 million at risk if the two partners fail to meet targets for controlling medical cost trends and for meeting quality standards in areas such as blood pressure control, diabetes care, immunizations, cancer screening, and pregnancy care. By aligning PPO and HMO contract incentives, health plans could face up to $1.3 billion in financial penalties over the course of the five-year agreements if they do not meet quality targets or contain medical cost trends, positioning CalPERS as a national model for cost and quality accountability.

Additionally, we expanded options for member access to high-quality plans and enhanced benefits. Service area expansions included the addition of lower-cost HMO options in six counties across the state, including rural areas where access to care remains a challenge. CalPERS added a doula benefit to advance health equity and decrease disparities in maternal and infant care, as well as enhanced coverage for travel and lodging when eligible medically necessary services such as abortions, gender affirming care, bariatric surgeries, organ and tissue transplants, and certain pediatric services aren't available close to home. Together, these new benefits help sustain our strategic goal to improve access to high-quality and equitable care.

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 member survey.

CalPERS is committed to providing affordable, accessible, equitable, and high-quality healthcare, reflecting our dedication to delivering benefits that meet the 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 2025, we spent $13.9 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 and Health Benefits Committee is one of six committees that report to the board, and it 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 throughout their lives.

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 and Benefits Branch (HPBB) aims to achieve exceptional healthcare through the following objectives:

- Ensure our members receive high-quality healthcare
- 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

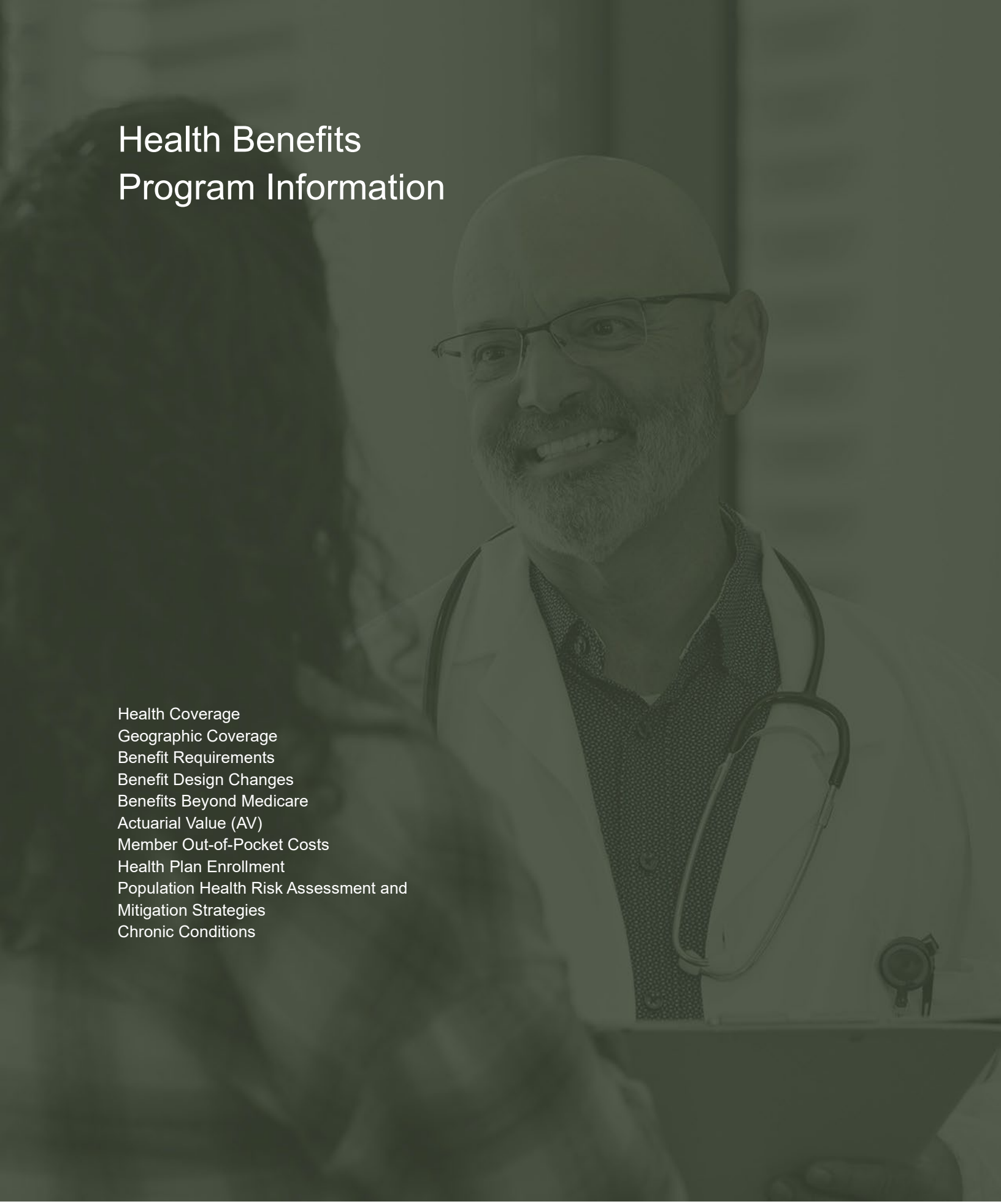
Figure 1 shows our health-related business plan initiatives for the 2025–26 Business Plan.[1] Additional information on the strategic plan and business plans are available in **Strategic & Business Plans** at **www.calpers.ca.gov.**

[1] All fiscal year 2025-26 HPBB Business Plan Initiatives have a reporting status of on-target.

Figure 1: 2025-26 HPBB Business Plan Initiatives



Health Benefits Program Information



Health Coverage
Geographic Coverage
Benefit Requirements
Benefit Design Changes
Benefits Beyond Medicare
Actuarial Value (AV)
Member Out-of-Pocket Costs
Health Plan Enrollment
Population Health Risk Assessment and Mitigation Strategies
Chronic Conditions

Health Coverage

We provide a wide selection of high-quality health plan options for our members and their families. For the 2025 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.

In 2025, we transitioned our PERS Gold and PERS Platinum Basic and Supplement to Medicare plans to new health plan administrators. Blue Shield of California and Included Health, a population health management organization, are partnering to administer CalPERS' Basic PPO plans, with Included Health providing care navigation, care coordination, as well as virtual primary care, urgent care, and behavioral health services, and Blue Shield handling core health plan administration. Blue Shield of California is also administering the Supplement to Medicare PPO plans, including all administrative and customer service functions.

Look ahead:
Effective January 1, 2026, CVS Caremark (CVS) replaced OptumRx as the new pharmacy benefits manager (PBM). CVS is providing self-funded pharmacy benefits for many 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 outcomes of CalPERS members.

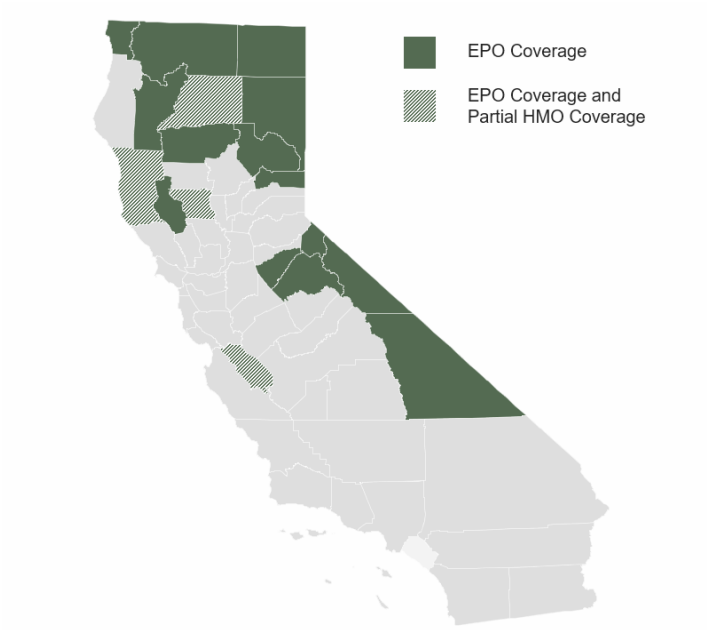
[2] We offer limited Basic and Medicare health plan options for members who live out-of-state.
[3] We do not negotiate premiums and are not responsible for the benefit administration of association plans.

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 difficulty 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 healthcare services than those living in urban and suburban areas.

Figure 2: 2025 CalPERS EPO Coverage by County



In recent years, we have expanded 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 2025, 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 toward our 2027 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 14 rural counties of Alpine, Calaveras, Del Norte, Inyo, Lake, Lassen, Modoc, Mono, Plumas, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne. Members in Colusa, Mendocino, and San Benito counties maintained access to EPO coverage and also have HMO coverage in partial areas of each county. Additionally, HMO coverage was added to partial areas of Shasta County, along with existing EPO coverage. We also expanded HMO health plan offerings into all, or portions of, Contra Costa, Imperial, Monterey, Napa, and Solano counties.

[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 healthcare 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 healthcare 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 healthcare 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 healthcare 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 for behavioral healthcare, 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 healthcare 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
- Doula services
- Travel for medically necessary care

Benefit Design Changes

Each year, we 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 2025, we adopted the following board-approved benefit design changes:

Doula Benefit

California Assembly Bill 904 requires health plans to provide doula care for non-medical care and support of pregnant and postpartum Basic plan members including health education, advocacy, and physical and emotional support before, during, and after pregnancy, miscarriage, stillbirth, and abortion. Doula benefits are also intended to improve health equity by decreasing known disparities in maternal and infant healthcare, especially for Black, Native American, and Pacific Islander communities.

Travel for Medically Necessary Care

Travel for medically necessary care standardizes coverage of travel and lodging for eligible medically necessary services that cannot be accessed locally for all Basic and Medicare members and aligns with our goal of ensuring access to high-quality, equitable care.

Coverage Without Cost Sharing Following Rape and Sexual Assault

California Assembly Bill 2843 requires health plans to cover emergency room services and follow-up healthcare treatment, with no cost-sharing, for Basic members who are treated following a rape or sexual assault for the first nine months after the member initiates treatment.

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 2025 was $10 million.

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 A, 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: 2025 Average Out-of-Pocket Annual Member Costs[5]

Plan Type	$/year
Basic HMO	$146
Basic EPO	$196
Basic PPO	$1,068
Medicare Advantage	$286
Medicare Supplement	$230
Overall Average	**$322**

Refer to Appendix A 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.**

[5] We base these figures on health claims data for the 2025 plan year. We do not collect data on non-covered services such as over-the counter medications or out-of-network care.

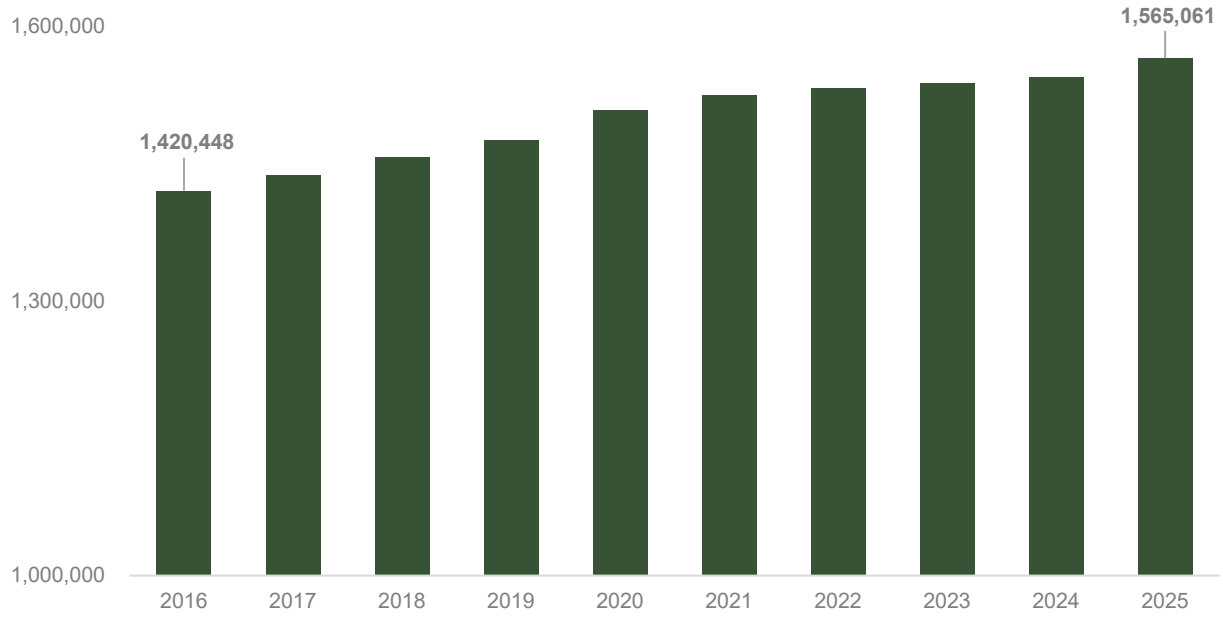
Health Plan Enrollment

We have seen our health plan enrollment grow over the past 10 years. Between 2016 and 2025, CalPERS' total enrollment has increased by 10.18%.[6]

Appendix B displays detailed enrollment data for plan years 2023–2025 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



[6] Enrollment data is as of January 1, 2025.

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 HMO and PPO 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 healthcare 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 healthcare services more than the average member, making their 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

To understand the health of our members, we examine data on chronic conditions, review population demographics, and analyze utilization and trend data. In 2025, 42% of our population had one or more of the top chronic conditions.[7,8]

2025 Common Chronic Conditions[7,8,9]

Table 2a: Basic Plan Members

Common Chronic Conditions	2024 Population	2024 Prevalence (%)	2025 Population	2025 Prevalence (%)
Hypertension	183,816	15.6%	187,065	15.7%
Asthma	125,008	10.6%	122,801	10.3%
Depression	116,607	9.9%	121,333	10.2%
Diabetes	102,466	8.7%	106,044	8.9%
Ischemic Heart Disease	20,047	1.7%	21,469	1.8%
Heart Failure/Cardiomyopathy	12,798	1.1%	13,612	1.1%
Chronic Obstructive Pulmonary Disease	9,633	0.8%	9,443	0.8%

Table 2b: Medicare Plan Members

Common Chronic Conditions	2024 Population	2024 Prevalence (%)	2025 Population	2025 Prevalence (%)
Hypertension	181,584	63.1%	189,328	64.4%
Diabetes	80,920	28.1%	85,320	29.0%
Ischemic Heart Disease	50,494	17.5%	55,010	18.7%
Depression	41,637	14.5%	44,632	15.2%
Asthma	37,834	13.1%	39,479	13.4%
Heart Failure/Cardiomyopathy	33,368	11.6%	37,885	12.9%
Chronic Obstructive Pulmonary Disease	25,881	9.0%	26,996	9.2%

7 We use the Health Care Decision Support System (HCDSS) similar diagnostic category method to measure prevalence of chronic conditions. This new methodology enables a more complete capture of prevalence data for the CalPERS population.

8 Data based on members living in California only and include 1,179,952 Basic members and 287,862 Medicare members for 2024 and 1,188,982 Basic members and 294,110 Medicare members in 2025.

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

Health Plan Information



Health Plan Expenditures and Premium Trends
Medical Trends
Premium Reconciliation
Clinical Quality
Medicare Star Ratings
Member Experience

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 healthcare costs. We perform analyses in accordance with generally accepted actuarial standards of practice. The process to establish the 2025 health plan premiums began in 2024 and includes data from 2023 and 2024.

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 2025, the total estimated premium expenditure was nearly $13.9 billion. Premiums increased by 10.77% overall for Basic and Medicare plans combined.[10] CalPERS' Basic HMO plans increased by an average of 8.72%. Basic PPO plans increased by an average of 9.82%, Medicare Advantage plans increased by an average of 12.58%, and Supplement to Original Medicare plans increased by an average of 30.59%.

[10] 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	2021	2022	2023	2024	2025
Basic HMOs	4.44%	4.69%	4.35%	10.50%	8.72%
Basic PPOs	8.54%	8.67%	15.76%	12.17%	9.82%
Total Basic Plans	**5.40%**	**5.65%**	**7.21%**	**10.95%**	**9.08%**
Medicare Advantage	(4.46%)	(6.37%)	(3.23%)	13.17%	12.58%
Medicare Supplement	(0.65%)	5.48%	9.83%	6.62%	30.59%
Total Medicare Plans	**(2.54%)**	**(0.36%)**	**3.69%**	**9.55%**	**22.25%**
Overall	**4.32%**	**4.86%**	**6.75%**	**10.77%**	**10.79%**

Table 4: Historic Annual Expenditures by Member Type[11] (in Billions)

Member Type	2021	2022	2023	2024	2025
Active	$7.24	$7.57	$8.05	$8.95	$9.85
Retired	$2.93	$3.02	$3.21	$3.49	$4.00
Total	**$10.17**	**$10.59**	**$11.25**	**$12.44**	**$13.85**

Table 5: Historic Annual Expenditures by Employer Type[11] (in Billions)

Employer Type	2021	2022	2023	2024	2025
State	$6.99	$6.05	$6.39	$7.08	$7.92
Contracting Agency	$3.18	$4.54	$4.86	$5.36	$5.94
Total	**$10.17**	**$10.59**	**$11.25**	**$12.44**	**$13.85***

*Total may not equal the sum of the Employer Type due to rounding.

Appendix C displays detailed premium expenditure data for plan years 2023–2025 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.**

[11] The numbers presented in tables 4 and 5 are estimated expenditures, not actuals. Since membership fluctuates throughout a calendar year, we use one 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 healthcare 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, measured by Per Member Per Month (PMPM), increased 4.0% overall in calendar year 2025 from 2024. The 2025 trend increased in each individual category with the exception of inpatient, office visits, mental health/substance use, and medical Rx. The categories that experienced the largest increases were the "all other" category (17.6%), emergency room (14.0%), and preventive care (13.5%).

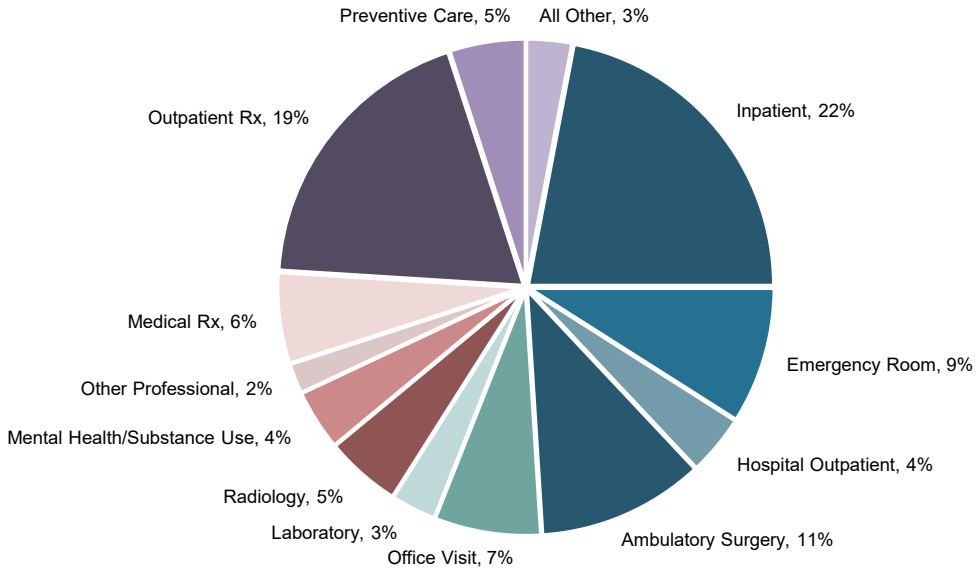
Figure 4 below shows the composition of total allowed PMPM spend by percentage of each service category in 2025.

Table 6: 2024–2025 Percentage Change Trend in Allowed PMPM, Within Each Service Category[12,13]

Service Category	2024–2025
All Other[14]	17.6%
Ambulatory Surgery	3.7%
Emergency Room	14.0%
Hospital Outpatient	0.2%
Inpatient	-1.8%
Laboratory	5.8%
Medical Rx[15]	-1.1%
Mental Health/Substance Use	-0.5%
Office Visit	-5.1%
Other Professional	6.9%
Outpatient Rx[16]	7.6%
Preventive Care	13.5%
Radiology	9.6%

Data as of June 30, 2026

Figure 4: Percentage of PMPM Spend by Service Category



Data as of June 30, 2026

[12] Allowed cost divided by the sum of members months in period, adjusted for population size.
[13] Contractual "allowed amounts" from payment to providers inclusive of member out-of-pocket obligations such as coinsurance, copays, deductibles, etc.
[14] All Other category represents a small portion of the total cost (3% in 2025), so even small fluctuations can have a noticeable impact on the percentage change in trend.
[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 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 2025. We extracted the health premium data from myCalPERS as of May 18, 2026.

Table 7: Health Premium Management Report for Calendar Year 2025
(Dollars in Thousands)

Health Plan Carriers	Health Premium Amount
Anthem Blue Cross	$474,251
Association Plans (CAHP, CCPOA, and PORAC)	$772,369
Blue Shield of California	$5,395,566
Health Net of California	$81,496
Kaiser Permanente	$5,756,949
Sharp Health Plan	$121,644
UnitedHealthcare	$1,060,999
Western Health Advantage	$206,583
Total	**$13,869,856***

*Total may not equal the sum of the Health Plan Carriers due to rounding.

Clinical Quality

We require our health plans to annually report on national, evidence-based clinical performance measures to evaluate and improve the quality of care that health plans provide to our members. Our health plan contracts include quality performance measures intended to tie substantial financial incentives to improving the quality of healthcare and reducing health disparities for our members. Specifically, the Quality Alignment Measure Set (QAMS) focus on improving care for clinically important conditions for which there are major opportunities for improvement. Inaugural QAMS results by health plan for Measurement Year 2024 are included in Appendix D. QAMS results will also be posted publicly each year in advance of Open Enrollment, to improve transparency and to better inform member health plan choice.

We also require our health plans to provide data on a broader set of 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 a Star Rating to summarize each Medicare Advantage plan's overall performance. Medicare Star Ratings are unavailable for our Supplement to Original Medicare plans because they are neither Medicare Advantage plans nor Part D plans.

CMS continues to implement enhancements to the Medicare Advantage and Part D Star Ratings program to promote continuous quality improvement. Minor methodological changes were made for 2025, such as increasing the emphasis on weighting of measures for clinical outcomes. Numerous factors impact health plan Star Ratings results, including annual adjustments made by CMS to the Star Ratings methodology as well as the performance thresholds, fluctuations in Medicare Advantage health plan enrollment, and individual health plan performance. CalPERS monitors Star Ratings results and requires its Medicare Advantage plans to maintain a Star Rating of 3 or above. Plans that fall below a 3-Star Rating are required to participate in a corrective action plan which includes regular monitoring by CalPERS.

Table 8: Overall Medicare Star Ratings

Medicare Advantage Plan	2024 Overall Medicare Star Rating	2025 Overall Medicare Star Rating	2026 Overall Medicare Star Rating*
Anthem Medicare Preferred PPO	4	4	4
Blue Shield Medicare PPO	3.5	2.5	3.5
California Correctional Peace Officers Association**	3.5	2.5	3.5
Kaiser Permanente Senior Advantage	4	4.5	4.5
Kaiser Permanente Senior Advantage Out-of-State	4	4.5	4.5
Kaiser Permanente Senior Advantage Summit	4	4.5	4.5
Sharp Direct Advantage HMO	4.5	4	3.5
UnitedHealthcare Medicare Advantage	4.5	4	4.5
UnitedHealthcare Medicare Advantage Edge	4.5	4	4.5

*Each year's Star Rating is released the year prior, based on data from two years prior, e.g., the 2026 overall ratings were released in 2025 and based on 2024 data.

** Administered by Blue Shield of California

[17] How to compare plans using the Medicare Star Rating System. (2025) https://www.medicareinteractive.org/understanding-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 is the highest possible rating. Please note that health plans with less than 2,000 enrollees were not surveyed.

Figure 5a: Basic Health Plan Experience Ratings

Basic Plan Ratings *(score out of 10)*	
Anthem Blue Cross Select HMO	7.84
Anthem Blue Cross Traditional HMO	7.91
Blue Shield of California Access+ HMO	7.65
Blue Shield of California Trio HMO	7.65
Health Net Salud y Más HMO	7.79
Kaiser Permanente HMO	7.99
PERS Gold PPO	6.33
PERS Platinum PPO	7.55
Sharp Performance Plus HMO	8.63
UnitedHealthcare SignatureValue Alliance HMO	7.60
UnitedHealthcare SignatureValue Harmony HMO	7.21
Western Health Advantage HMO	7.98
Average Basic Plan Rating	**7.67**

Health Plan Experience Ratings

Figures 5a–b shows the average and overall 2025 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 5b: Medicare Health Plan Experience Ratings

Medicare Plan Ratings *(score out of 10)*	
Anthem Medicare Preferred (PPO)	8.63
Blue Shield Medicare (PPO)	8.63
Kaiser Permanente Senior Advantage	8.82
Kaiser Permanente Senior Advantage Summit	8.87
PERS Gold Medicare Supplement	8.58
PERS Platinum Medicare Supplement	8.96
UnitedHealthcare Group Medicare Advantage (PPO)	8.81
Average Basic Plan Rating	**8.86**

Financial Information

Federal Subsidies
Administrative Expenditures
Reserves
Investment Strategies

Federal Subsidies

Federal subsidies or contributions have a positive impact on the overall affordability of healthcare 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 healthcare include:

- Direct subsidy
- Catastrophic reinsurance payments subsidy
- Manufacturer Discount Program
- Low Income Cost-Sharing Subsidy
- Low Income Premium Subsidy
- Premium Stabilization Demonstration Funds

In 2025, CalPERS collected approximately $988.7 million in federal subsidies.

Direct subsidy represents 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 Manufacturer Discount Program represents 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). Premium Stabilization Demonstration Funds were introduced by CMS for 2025 to lower Part D premiums. The program was introduced to help prevent large increases in Medicare prescription drug plan premiums as major changes from the Inflation Reduction Act took effect. These are additional federal subsidy payments provided to participating Medicare Part D prescription drug plans. The funds are intended to stabilize premiums for beneficiaries and reduce financial risk for insurers. 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 2025 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 2025–26, we paid $83 million to support our Health Benefits Program. Of our total 2,843 authorized positions 409.1 directly and indirectly support the Health Benefits Program (see Table 9). Direct support positions include those in the Health Policy and Benefits Branch, the Actuarial Office, and Customer Services and 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 and Technology Branch.

Table 9: Staff Levels

Staff Levels	Authorized Positions
Direct Support Positions	244.3
Enterprise Support Operations Positions	164.8
Total Staffing Levels*	**409.1**

Personal services expenditures total $58.4 million in fiscal year 2025-26 (see Table 10).

Table 10: Personal Services

Personal Services	Dollars in Thousands
Salary and Wages	$37,668
Staff Benefits	20,710
Total Personal Services	**$58,378**

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 and equipment expenses in fiscal year 2025-26 total $24.6 million (see Table 11).

Table 11: Operating Expenses & Equipment

Operating Expenses & Equipment	Dollars in Thousands
Consultant and Professional Services — Internal	$120
Consultant and Professional Services — External	9,754
General Operating Expenses	9,899
Statewide Administrative Cost (Pro-Rata)	4,829
Total Operating Expenses and Equipment	**$24,602**

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

Funding Sources	Dollars in Thousands
Public Employees' CRF	$35,569
Public Employees' HCF	47,411
Total Funding	**$82,980**

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 a major health event; and 3) Other administrative reserves, to cover the wind-down cost should a plan suddenly terminate.

As of December 31, 2025, the actuarial reserve level for the self-funded PPO plans was $809 million. However, the total assets level was $654 million, resulting in a fund balance to actuarial reserve ratio of 81%, which is $155 million lower than the actuarial reserve level.[18] Since plan assets are below 90% of the actuarial reserve amount, the board approved a surcharge for the 2026 plan year premiums.

For the self-funded pharmacy portion of CalPERS' HMO plans, the actuarial reserve level was $10 million and total assets were $54 million as of December 31, 2025.

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 2026.

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 healthcare 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 2025 actuarial reserve level reflects claims processed as of December 31, 2025.

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 PMIA will be managed to ensure the safety of the portfolio by investing in high credit quality securities and maintaining a mix of securities with various terms that in aggregate provides reasonable protection that no single investment, or class of investments will have a disproportionate impact on the total portfolio.
- The PMIA will be managed to ensure that scheduled and unscheduled cash needs can be met.
- The PMIA 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
21–22	SMIF	$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%
25–26		1,021,371,193	4.04%

* 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 **https://www.treasurer.ca.gov/pmia-investment.**

Public Employees' Health Care Fund

The Public Employees' HCF is invested at the State Treasurer's Office in the SMIF and for FY 2025-26, is invested in the State Street Investment Management (SSIM) Short Term Investment Fund (STIF). In June 2024, the Board approved changing the HFC allocation from SSIM U.S Aggregate Bond Index Fund (SSIM Bond Fund) to SSIM STIF (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 Bond Fund, the SSIM STIF, and the SMIF* (Net of Fees)

Fiscal Year End	Allocation	Invested Assets	Annual Return
21–22	SSIM Bond Fund	$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%
25–26		80,286,957	4.05%
21–22	SMIF	$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%
25–26		1,695,939,563	4.04%

* 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, 2026, is 1.41%, past performance is not a guarantee of future results.

Appendices

A Average Member Out of Pocket Costs And AV Metal Tier by Health Plan
B Historic Enrollment
C Historic Expenditures
D 2024 Quality Alignment Measure Set Results

Appendix A — 2025 Average Member Out-of-Pocket Costs[19] and AV Metal Tier by Health Plan

Basic HMO Plans	2025	AV Metal Tier
Anthem Blue Cross Select	$210	Platinum
Anthem Blue Cross Traditional	252	Platinum
Blue Shield Access+	208	Platinum
Blue Shield Trio	150	Platinum
Health Net Salud y Más	102	Platinum
Kaiser Permanente	116	Platinum
Sharp Performance Plus	170	Platinum
UnitedHealthcare SignatureValue Alliance	183	Platinum
UnitedHealthcare SignatureValue Harmony	137	Platinum
Western Health Advantage	189	Platinum
Average Member Out-of-Pocket for Basic HMO Plans	**$146**	**—**

Basic EPO Plans	2025	AV Metal Tier
Blue Shield EPO	196	Platinum
Average Member Out-of-Pocket for Basic EPO Plans	**$196**	**—**

Basic PPO Plans	2025	AV Metal Tier
PERS Gold	$1,041	Gold
PERS Platinum	1,105	Platinum
Average Member Out-of-Pocket for Basic PPO Plans	**$1,068**	**—**

[19] Average annual costs rounded to nearest dollar.

Appendix A — 2025 Average Member Out-of-Pocket Costs[19] and AV Metal Tier by Health Plan[20], cont.

Medicare Advantage Plans	2025	AV Metal Tier
Anthem Medicare Preferred PPO	$414	—
Blue Shield Medicare PPO	212	—
Kaiser Permanente Senior Advantage	271	—
Kaiser Permanente Senior Advantage Summit	209	—
Sharp Direct Advantage HMO	160	—
UnitedHealthcare Group Medicare Advantage PPO	340	—
Average Member Out-of-Pocket for Medicare Advantage Plans	**$286**	**—**

Supplement to Original Medicare Plans	2025	AV Metal Tier
PERS Gold	$188	—
PERS Platinum	232	—
Average Out-of-Pocket for Supplement to Original Medicare Plans	**$230**	**—**

[19] Average annual costs rounded to nearest dollar.
[20] A"—" indicates that AV Metal Tiers are not provided for Medicare plans.

Appendix B — Historic Enrollment[21]

	2023	2024	2025
Basic HMO Plans			
Anthem Blue Cross Select	38,652	31,932	29,325
Anthem Blue Cross Traditional	10,887	11,612	11,295
Blue Shield Access+	92,956	121,390	132,661
Blue Shield Trio	29,589	43,702	47,710
Health Net Salud y Más	12,011	12,500	11,600
Health Net SmartCare	8,842	—	—
Kaiser Permanente	549,876	528,054	522,870
Kaiser Out-of-State	1,031	1,020	919
Sharp Performance Plus	14,477	14,545	14,654
UnitedHealthcare SignatureValue Alliance	72,405	75,955	80,779
UnitedHealthcare SignatureValue Harmony	4,285	7,060	10,484
Western Health Advantage	15,848	21,349	23,801
Basic EPO Plans			
Anthem Blue Cross Del Norte County	61	51	—
Blue Shield of California	1,454	2,183	2,917
Basic PPO Plans			
PERS Gold	134,242	134,288	138,029
PERS Platinum	130,885	112,313	102,423
Basic Association Plans			
California Association of Highway Patrolmen	26,329	26,649	27,028
California Correctional Peace Officers Association North	6,033	5,177	4,761
California Correctional Peace Officers Association South	29,538	28,723	27,885
Peace Officers Research Association of California	23,288	24,815	26,972
Basic Total	**1,202,689**	**1,203,318**	**1,216,113**

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

Appendix B — Historic Enrollment, cont.[21]

	2023	2024	2025
Medicare Advantage Plans			
Anthem Medicare Preferred PPO	6,136	6,547	7,068
Blue Shield Medicare PPO	2,870	5,284	9,500
Kaiser Permanente Senior Advantage	108,068	106,678	106,933
Kaiser Permanente Senior Advantage Out-of-State	2,759	2,646	2,630
Kaiser Permanente Senior Advantage Summit	5,055	8,228	10,079
Kaiser Permanente Out-of-State Senior Advantage Summit	—	175	300
Sharp Direct Advantage HMO	317	453	600
UnitedHealthcare Medicare Advantage	44,013	42,951	47,466
UnitedHealthcare Medicare Advantage Edge	3,603	5,126	—
Western Health Advantage MyCare Select	270	488	—
Supplement to Original Medicare Plans			
PERS Gold	3,954	4,526	5,390
PERS Platinum	148,226	147,709	148,350
Medicare Association Plans			
California Association of Highway Patrolmen	4,630	4,728	4,802
California Correctional Peace Officers Association North	814	882	966
California Correctional Peace Officers Association South	1,073	1,192	1,361
Peace Officers Research Association of California	3,067	3,260	3,503
Medicare Total	**334,855**	**340,873**	**348,948**
Grand Total	**1,537,544**	**1,544,191**	**1,565,061**

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

Appendix B — Historic Enrollment, cont.

Program	2023	2024	2025
State	891,807	900,600	915,383
Contracting Agency	645,737	643,591	649,678
Total	**1,537,544**	**1,544,191**	**1,565,061**

Employment Status	2023	2024	2025
Active	1,019,237	1,024,138	1,040,563
Retired	518,307	520,053	524,498
Total	**1,537,544**	**1,544,191**	**1,565,061**

Subscriber and Dependent Tier	2023	2024	2025
Single	367,038	375,770	384,183
2-Party	426,062	429,026	435,132
Family	744,444	739,395	745,746
Total	**1,537,544**	**1,544,191**	**1,565,061**

Appendix C — Historic Expenditures[22]

Estimated Expenditures (Dollars in Thousands)

	2023	2024	2025
Basic HMO Plans			
Anthem Blue Cross Select	$322,724	$284,163	$286,416
Anthem Blue Cross Traditional	121,135	139,965	145,620
Blue Shield Access+	758,613	1,039,901	1,236,295
Blue Shield Trio	211,920	333,130	397,123
Health Net Salud y Más	70,022	76,046	81,375
Health Net SmartCare	83,044	—	—
Kaiser Permanente	4,467,925	4,872,509	5,232,524
Kaiser Out-of-State	13,061	14,534	14,374
Sharp Performance Plus	103,248	113,373	119,310
UnitedHealthcare SignatureValue Alliance	562,932	627,757	727,387
UnitedHealthcare SignatureValue Harmony	29,084	51,131	82,803
Western Health Advantage	114,914	164,102	205,379
Basic EPO Plans			
Anthem Blue Cross Del Norte County	$601	$606	—
Blue Shield of California	12,681	19,902	28,256
Basic PPO Plans			
PERS Gold	$960,896	$1,086,313	$1,226,811
PERS Platinum	1,396,702	1,367,294	1,370,968
Basic Association Plans			
California Association of Highway Patrolmen	$161,698	$178,661	$201,605
California Correctional Peace Officers Association North	50,057	45,131	44,883
California Correctional Peace Officers Association South	195,041	203,282	211,934
Peace Officers Research Association of California	168,832	203,799	229,222
Basic Total	**$9,805,129**	**$10,821,599**	**$11,842,285**

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

Appendix C — Historic Expenditures, cont.[22]

	2023	2024	2025
Medicare Advantage Plans			
Anthem Medicare Preferred PPO	$31,133	$32,371	$41,721
Blue Shield Medicare PPO	14,114	26,972	53,256
Kaiser Permanente Senior Advantage	368,856	416,656	441,202
Kaiser Permanente Senior Advantage Out-of-State	9,158	10,046	10,574
Kaiser Permanente Senior Advantage Summit	21,283	39,247	50,492
Kaiser Permanente Senior Advantage Summit Out-of-State	—	871	1,495
Sharp Direct Advantage HMO	1,025	1,478	2,037
UnitedHealthcare Medicare Advantage	158,343	175,848	251,897
UnitedHealthcare Medicare Advantage Edge	15,946	22,958	—
Western Health Advantage MyCare Select	1,184	1,670	—
Supplement to Original Medicare Plans			
PERS Gold	$19,171	$22,596	$36,274
PERS Platinum	748,592	794,688	1,042,665
Medicare Association Plans			
California Association of Highway Patrolmen	$27,343	$33,782	$34,667
California Correctional Peace Officers Association North	3,980	6,099	7,102
California Correctional Peace Officers Association South	7,049	8,399	10,098
Peace Officers Research Association of California	22,377	23,935	27,952
Medicare Total	**$1,449,554**	**$1,617,616,**	**$2,011,432**
Grand Total	**$11,254,683**	**$12,439,215**	**$13,853,716**

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

Appendix C — Historic Expenditures, cont.

Program	2023	2024	2025
State	$6,393,375	$7,083,700	$7,916,748
Contracting Agency	4,861,309	5,355,515	5,936,968
Total	**$11,254,684***	**$12,439,215**	**$13,853,716**

Employment Status	2023	2024	2025
Active	$8,047,626	$8,947,690	$9,853,120
Retired	3,207,057	3,491,525	4,000,596
Total	**$11,254,683**	**$12,439,215**	**$13,853,716**

Subscriber and Dependent Tier	2023	2024	2025
Single	$2,926,861	$3,306,527	$3,761,221
2-Party	3,346,285	3,690,278	4,142,293
Family	4,981,537	5,442,410	5,950,202
Total	**$11,254,683**	**$12,439,215**	**$13,853,716**

*Total may not equal due to rounding.

Appendix D — 2024[23] Quality Alignment Measure Set Results (QAMS)[24]

	Childhood Immunizations	Colorectal Cancer Screening	Controlling High Blood Pressure	Comprehensive Diabetes Care	Postpartum Care	Prenatal Care
Anthem Blue Cross Select	42.15%	61.50%	62.66%	30.69%	64.57%	64.57%
Anthem Blue Cross Traditional	41.82%	67.45%	48.02%	30.29%	67.37%	56.84%
Blue Shield Access+	45.26%	67.14%	76.40%	18.98%	85.07 %	80.60%
Blue Shield Trio	42.56%	61.25%	74.70%	21.17%	79.03%	87.10%
Health Net Salud y Mas	28.21%	49.21%	62.23%	27.63%	88.06%	85.07%
Kaiser Permanente	61.38%	76.58%	82.11%	17.75%	95.29%	96.66%
UnitedHealthcare SignatureValue Alliance	—	—	—	—	—	—
UnitedHealthcare SignatureValue Harmony	—	—	—	—	—	—
Sharp Performance Plus	61.54%	63.15%	82.22%	19.30%	84.62%	96.15%
Western Health Advantage	43.08%	73.81%	74.58%	16.39%	92.31%	94.87%

= Below the NCQA 25th percentile (full financial penalty owed)
= At or above the NCQA 66th percentile (no financial penalty owed)
= Between the NCQA 25th and 66th percentiles (partial financial penalty owed)

[23] Measurement Year 2024 is data from 2024 reported out in 2025.
[24] A "—" indicates CalPERS unable to verify results.



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