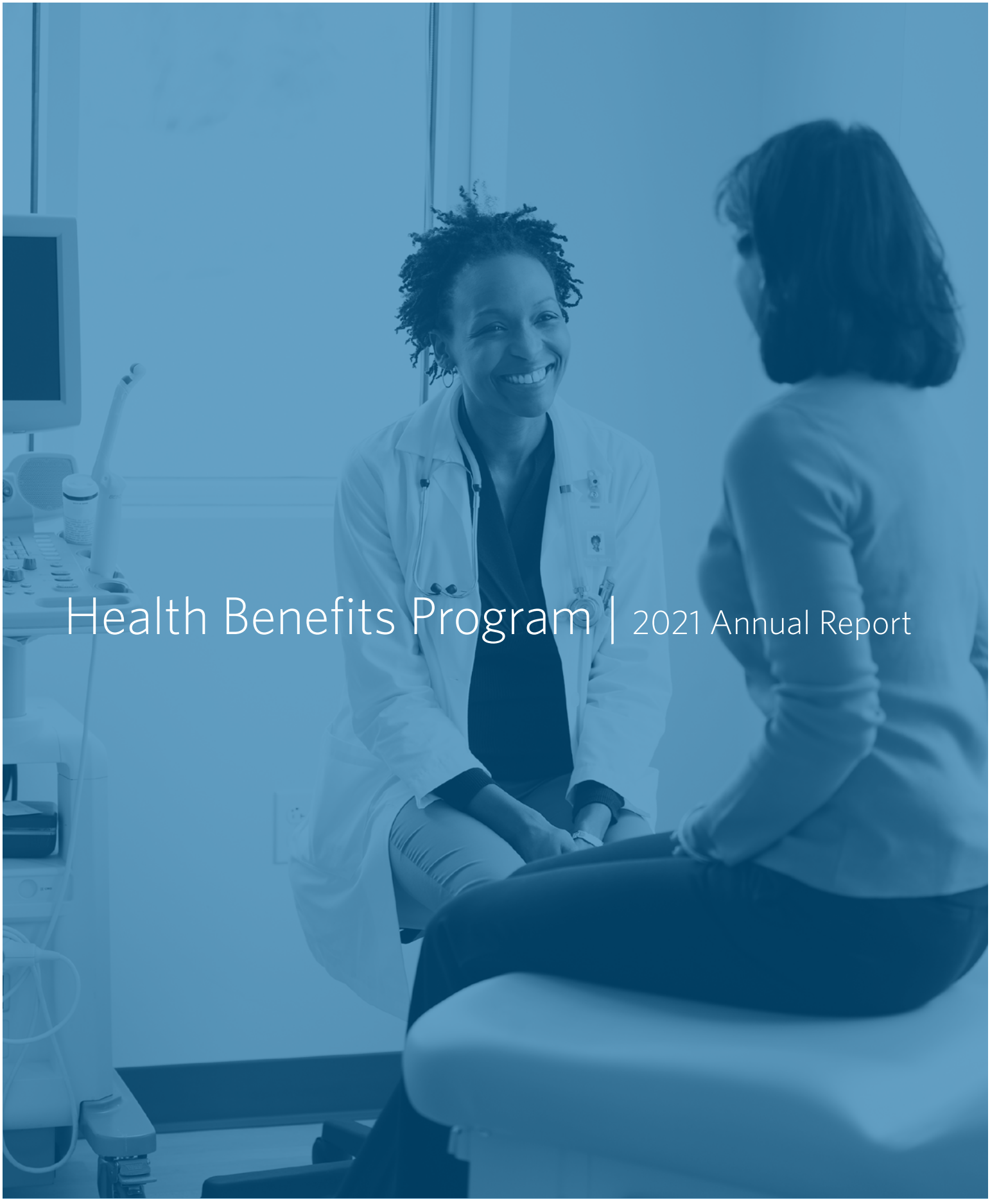

Health Benefits Program | 2021 Annual Report

Published November 1, 2022

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, 2021. This report provides an overview of the Health Benefits Program, as required by California Government Code Section 22866 (see Appendix A).

In 2021, we faced the second year of the pandemic and its ongoing impacts on the health care system. Throughout the year we informed our members about COVID-19 vaccine availability and boosters and engaged with our plans to ensure our members received high-quality care in the settings they needed and received their prescriptions timely and safely.

Overall health plan premiums increased 4.32%. The overall impact of COVID-19 on the 2021 premiums was 0.57%. Basic health maintenance organization (HMO) health plans had a 4.44% overall increase, while Basic preferred provider organization (PPO) plans increased 8.54% overall. Premiums for Medicare HMO and PPO plans decreased overall by 4.46% and 0.65%, respectively. There was no COVID-19 premium impact to Medicare plans as Medicare covered these costs.

We added high-quality service area expansions and benefits to provide choice and improve members' health. Our board approved the addition of a new cost-effective narrow network managed care plan in three higher cost counties and expanded coverage and added supplemental benefits important to members in some of our Medicare Advantage plans.

We expanded our work on achieving health equity, aimed at ensuring care is equitable for all members, regardless of race, ethnicity, gender identity, or sexual orientation. We actively communicated with members to encourage them to complete their Health Demographic Profile in their myCalPERS account. In November 2021, our board approved health equity benefit language changes for reproductive health and fertility care to take effect in the 2023 plan year.

To improve customer service, we added new health enrollment self-service functionality in myCalPERS. State and new contracting agency active employees can now make changes to their health enrollment as well as submit supporting documentation online through their myCalPERS account.

In this year's annual report, you'll find information about our health plans, geographic coverage, benefit designs, actuarial value, financial information, and member satisfaction results from our annual health plan survey.

Marcie Frost
Chief Executive Officer

About CalPERS

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 2021, we spent over $10.2 billion to purchase health benefits for active and retired members and their families on behalf of the State of California (including the California State University) and nearly 1,200 public agencies and schools.

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

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

Beginning in the 1960s, we became the health benefits purchaser for state employees and participating public agencies and schools. We have a vested interest in the health of our members, not only during their tenure as employees, but also throughout retirement. This long-term relationship with active and retired members drives the comprehensive, quality health benefits we provide to help our members maintain their quality of life no matter what their age.

2017–22 Strategic Plan

The 2017–22 Strategic Plan is the roadmap that guides the enterprise to meet the investment, retirement, and health benefit needs of our members and their families. It is the result of a collaborative process between our board and executive team that steers us through June 30, 2022. 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

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

- Fund the System through an integrated view of pension assets and liabilities
- Mitigate the risk of significant investment loss
- Deliver target risk-adjusted investment returns
- Educate employers, members, and stakeholders on system risks and mitigation strategies
- Integrate environmental, social, and governance considerations into investment decision making

High-Quality Affordable Health Care: Improve health care quality, access & affordability

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

Reduce Complexity: Reduce complexity across the enterprise

- Simplify programs to improve service and/or reduce cost
- Streamline operations to gain efficiencies, improve productivity, and reduce costs

Risk Management: Cultivate a risk-intelligent organization

- Enhance compliance and risk functions throughout the enterprise
- Continue to evolve cyber security program

Talent Management: Promote a high-performing and diverse workforce

- Recruit and empower a broad range of talents to meet organization priorities
- Cultivate leadership competencies and develop succession plans across the enterprise

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

Note: The CalPERS 2017–22 Strategic Plan is a dynamic document that must maintain its relevance to guide us over a period of five years. As such, the newly issued version reflects new information since it went into effect July 1, 2017. It may continue to change over time to reflect the needs of the enterprise and our members.

Strategic Direction and Policy Initiatives

The CalPERS 2017–22 Strategic Plan[1] has a stated goal to improve health care quality, access, and affordability along with the following objectives:

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

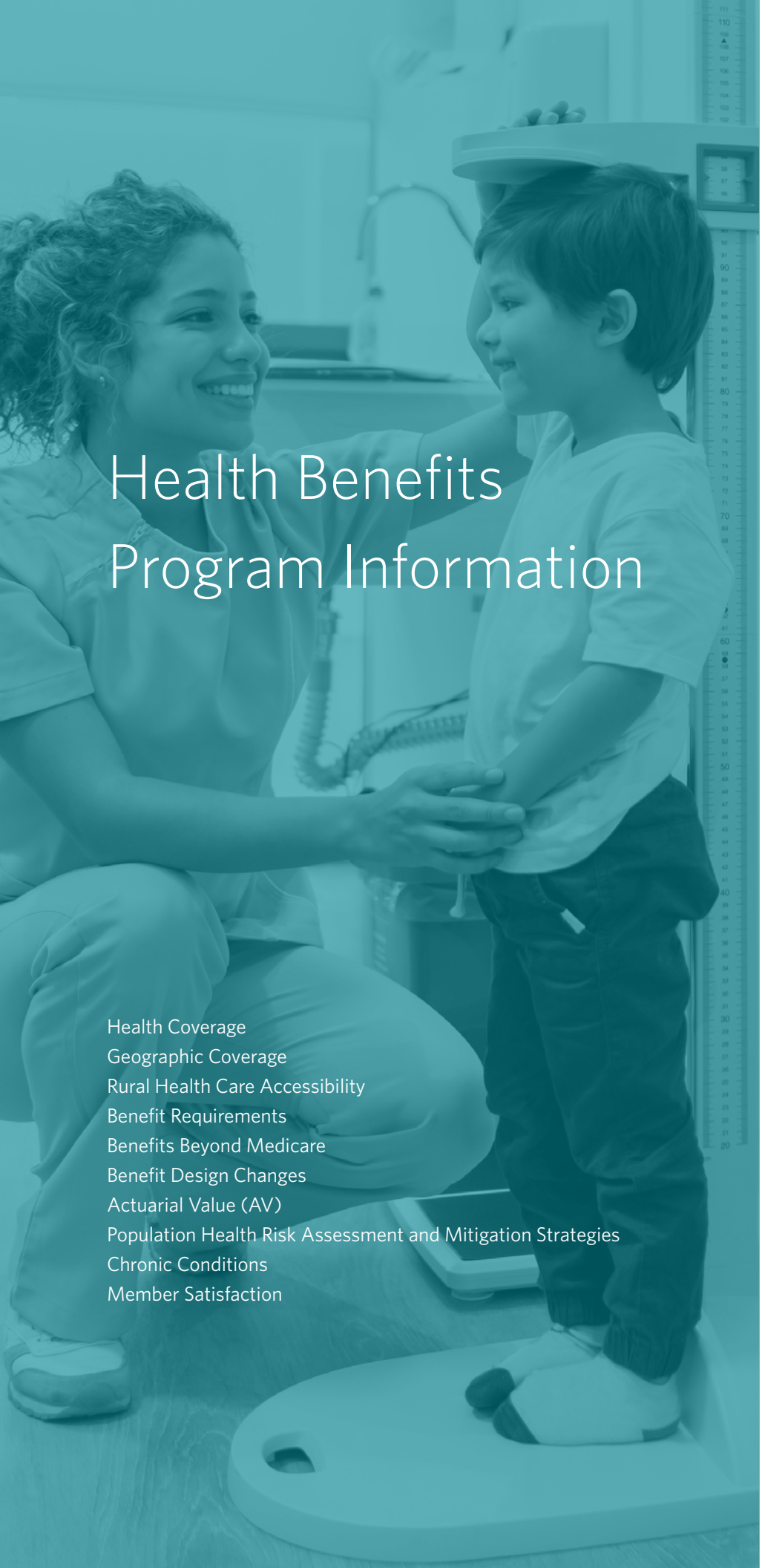
Table 1 shows the status of health-related Business Plan initiatives[2, 3] and describes changes in strategic direction and major policy initiatives for the 2021 health plan year. It includes content from the CalPERS 2017–22 Strategic Plan, CalPERS Business Plans, and relevant CalPERS quarterly reports. These plans and reports are inter-related, complement each other, and focus on cost, quality, and accessibility. Additional information on the strategic plan and business plan are available in **Strategic & Business Plans** at **www.calpers.ca.gov**.

[1] *CalPERS 2017–22 Strategic Plan. https://www.calpers.ca.gov/docs/forms-publications/2017-22-strategic-plan.pdf*
[2] *CalPERS 2020–21 Business Plan. https://www.calpers.ca.gov/docs/forms-publications/2020-21-business-plan.pdf*
[3] *CalPERS 2021–22 Business Plan. https://www.calpers.ca.gov/docs/forms-publications/2021-22-business-plan.pdf*

Table 1: 2021 Health Program Business Plan Initiatives

Initiative Title	Description	Status
Risk Mitigation	Develop and implement a new health risk mitigation strategy and determine health plan premium disparities in preparation for the 2022 rate-setting process.	Complete[4]
Update Health Plan Contract Measures	Establish improved performance measures in our health plan contracts.	Ongoing
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.	Ongoing
Health Data Quality Management	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 Access and Quality	Assess the feasibility of health plan contractual opportunities, identify partnerships, and develop recommendations to improve behavioral health treatment for CalPERS health care members.	Ongoing
Health Equity	Develop and implement a health equity strategy that will aim to improve the overall clinical quality for CalPERS health care members.	Ongoing
Telehealth Access	Study the utilization and quality of telehealth to improve access and quality of care provided to CalPERS health care members.	Ongoing
Increase Competition	In regions of the state that have low competition among health care providers, CalPERS aims to increase competition using a variety of strategies.	Ongoing
Pharmaceutical Strategies	Using expert clinical input from nationally-recognized organizations and CalPERS utilization data, develop formulary management strategies that balance member choice, quality, safety, affordability and prescription drug access.	Ongoing

[4] *Risk Mitigation for Basic HMO Plans. https://www.calpers.ca.gov/page/active-members/health-benefits/plans-and-rates/how-calpers-sets-health-premiums/risk-mitigation-basic-plans*



Health Benefits Program Information

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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 2021 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 plans and Medicare Supplement plans:

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

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

- PERSCare
- PERS Choice
- PERS Select

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 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 plan:

- Anthem Medicare Preferred (PPO)

Basic and Supplement to Original Medicare health plans:

- PERSCare
- PERS Choice
- PERS Select

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 discover health plans and monthly premium based on their eligibility ZIP code.

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 are often shortages of doctors, specialists, and hospitals, and members may need to travel further to seek health care services than those living in urban and metropolitan areas.

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

Our PERSCare, PERS Choice, and PERS Select Basic PPO health plans provide statewide coverage through Anthem Blue Cross' Prudent Buyer Plan Network.

We use enrollment data from myCalPERS, our "system of record" for all CalPERS Health Benefits Program enrollment information. In 2021, there were more than 32,000 CalPERS members enrolled in a Basic PPO plan who lived in a rural county without access to an HMO plan. 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 these counties, the Anthem Blue Cross network included over 340 primary care physicians, 34 OB/GYNs, and approximately 440 medical specialists for a total of over 800 contracted physicians. In addition, Anthem Blue Cross contracted with over 80 professional specialists in these 15 counties.

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 seeking services and expand access to care. Our PPO plans utilize telehealth to provide 24/7 online access to board-certified providers 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. During the COVID-19 pandemic, telehealth services expanded and continue to be a convenient way for members to access 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 including consultation and referral
- Hospital inpatient services and ambulatory care services
- Diagnostic laboratory
- Diagnostic and therapeutic radiologic services
- Home health services
- Preventive health services
- Emergency health care services including ambulance and ambulance transport services, out-of-area coverage, and ambulance transport services provided through the 911 emergency response system
- Hospice care

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

Federal Law

Our HMO and PPO Basic plans meet 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 and PPO Basic health plans provide benefits in all required EHB categories except for pediatric dental and vision care.[5]

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

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

- Acupuncture
- Blood and blood products
- Durable medical equipment
- Family planning services
- Health education
- Organ and bone marrow transplants
- Reconstructive surgery (non-cosmetic)
- Skilled nursing care

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

Other Benefits

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

- Biofeedback
- Chiropractic services
- Hearing aid services

Benefits Beyond Medicare

In 2021, we offered PERSCare, PERS Choice, and PERS Select 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 2021 was $74 million.

Benefit Design Changes

Each year we and our health plan carriers consider potential changes to the benefit design of our health plans. Changes to our benefit designs can be the result of federal legislation or regulation, state legislation or regulation, or direction by the board.

In 2020, we adopted the following benefit changes for the 2021 health plan year:

Telehealth

The Teladoc copayment amount for Blue Shield Access+ and Blue Shield Trio decreased to $0.

Post-Hospital Discharge Meal Delivery

Kaiser Permanente Senior Advantage – Up to 84 home delivered meals immediately following an inpatient hospitalization when referred by a clinical staff member.

UnitedHealthcare Group Medicare Advantage – Up to 84 home delivered meals immediately following an inpatient hospital discharge.

Post-Hospital Discharge Transportation

Kaiser Permantente Senior Advantage – Covers up to 24 one-way trips per year, 50-mile radius per trip, includes wheelchair van service, sedan, and gurney van service.

UnitedHealthcare Group Medicare Advantage – Unlimited rides to medically related visits up to 30-days immediately following hospital discharge.

Non-Skilled In Home Care

UnitedHealthcare Group Medicare Advantage – 16 hours per month, members receive assistance with daily activities such as housekeeping, meal preparation, and personal care.

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 2021 Basic health plans.

Table 2a: Metal Tiers for 2021 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	98%	Platinum
Western Health Advantage	98%	Platinum

Table 2b: Metal Tiers for 2021 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
PERSCare	92%	Platinum
PERS Choice	90%	Platinum
PERS Select	88%	Gold

Table 2c: Metal Tiers for 2021 Association Health Plans

Association Plans	Actuarial Value	Metal Tier
California Association of Highway Patrolmen	92%	Platinum
California Correctional Peace Officers Association	98%	Platinum
Peace Officers Research Association of California	93%	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. The portfolio can be considered a fragmented risk pool in which each health plan is rated individually, based on its own membership and experience. We use age, gender, geographic, and diagnosis data from up to the past 18 months to assess the risk of current health plan enrollees and to predict future expected cost and utilization trends. Our portfolio continuously faces challenges related to risk concentration and adverse selection.

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

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

In 2020, CalPERS worked with consulting actuaries to assess the health plan portfolio and determine the appropriate mix of plan type and plan offering to minimize risk concentration and adverse selection. 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. The approved portfolio rating approach will enable us to manage population health risk within the portfolio of Basic health plans, promote efficient care management, and mitigate 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 rates are negotiated by their respective associations.

In April 2021, we shared risk scores with the health plan carriers and stakeholders. For more information on our risk scores by health plan, visit our **Plans & Rates** page 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 2021, this evaluation showed that approximately 20% of the CalPERS California population had one or more of the seven common chronic conditions listed below:

- Hypertension
- Diabetes
- Depression
- Asthma
- Coronary artery disease
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure

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

Table 3 provides a breakdown of chronic condition prevalence statewide, based on information from our HCDSS for 2021. 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 2021.

Table 3: 2021 Chronic Conditions Prevalence Among CalPERS Members*

	California	
	Percentages based on 1,442,133 members	
Chronic Condition	Population	Prevalence (%)
Hypertension	113,371	7.9%
Diabetes	90,880	6.3%
Depression	67,847	4.7%
Asthma	36,664	2.5%
Coronary artery disease	26,706	1.9%
COPD	8,877	0.6%
Congestive heart failure	4,857	0.3%

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

Member Satisfaction

Each year, we conduct a survey to evaluate members' experience with their health plan during the previous 12-month period. The 2022 CalPERS Health Plan Member Survey, evaluating plan year 2021 experiences, was conducted January to March 2022. Members were asked to rate their health plan and overall health care satisfaction using the 10-point scale where 0 was the lowest and 10 was the highest possible rating.

Health Plan Satisfaction Ratings

Figures 1a-b show the average and overall 2021 health plan satisfaction 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 Satisfaction Ratings

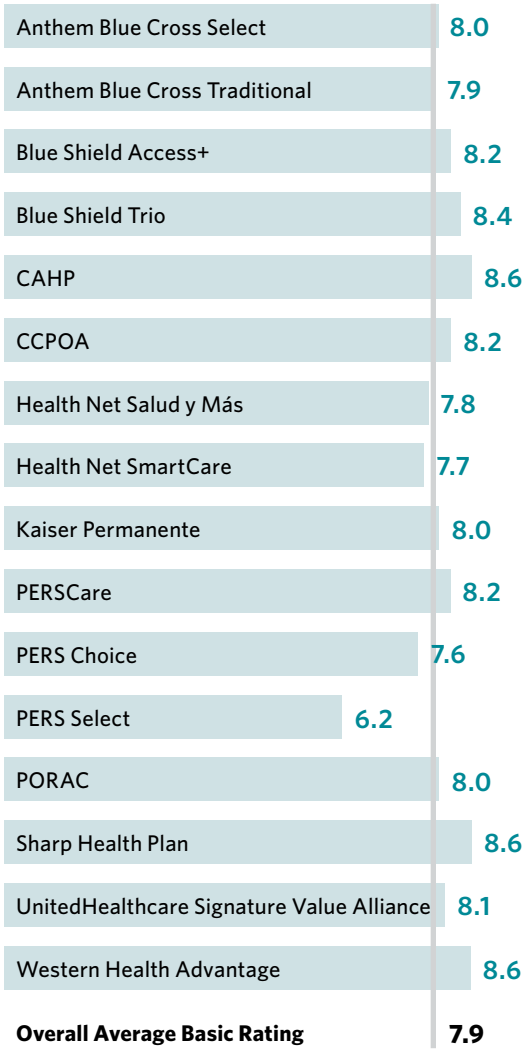
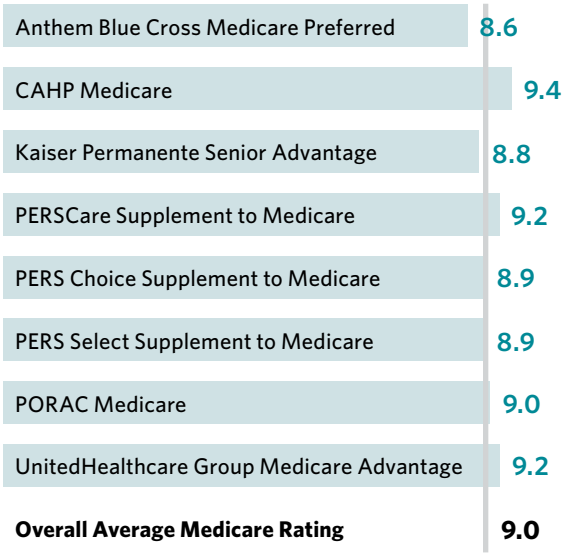


Figure 1b:
Medicare Health Plan Satisfaction Ratings



Health Care Satisfaction Ratings

Figures 2a-b show the average and overall 2021 health care satisfaction 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 Satisfaction Ratings

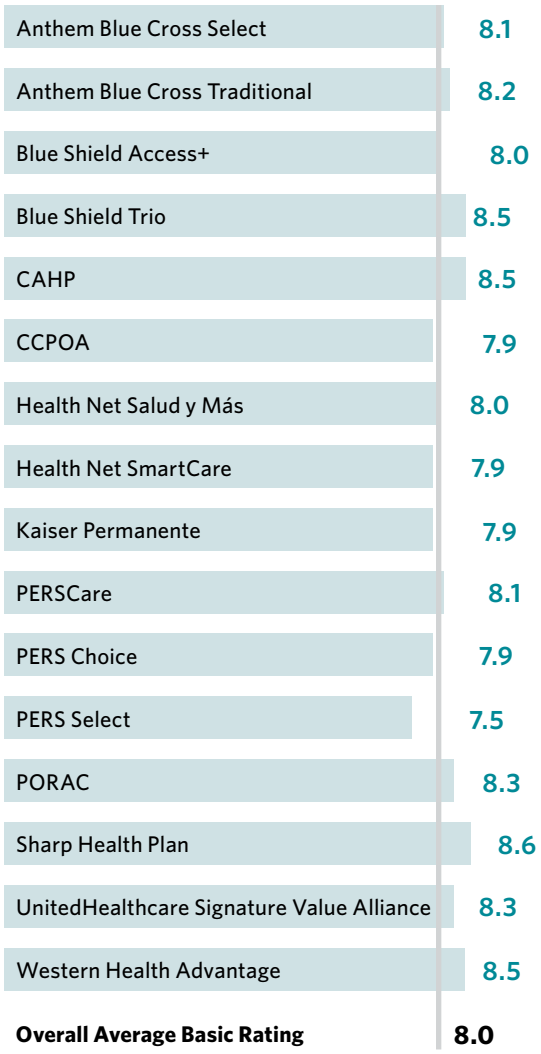
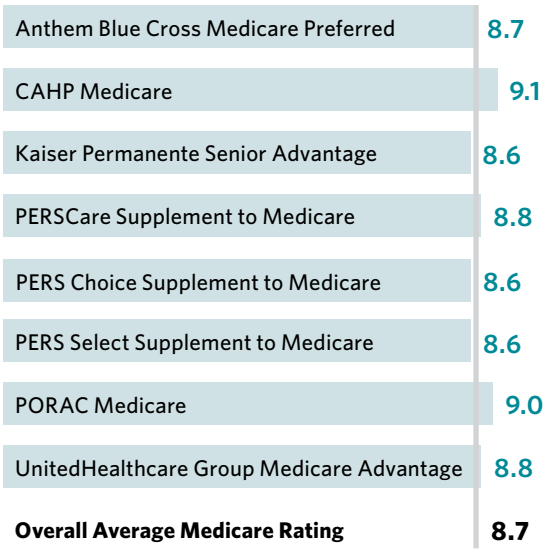
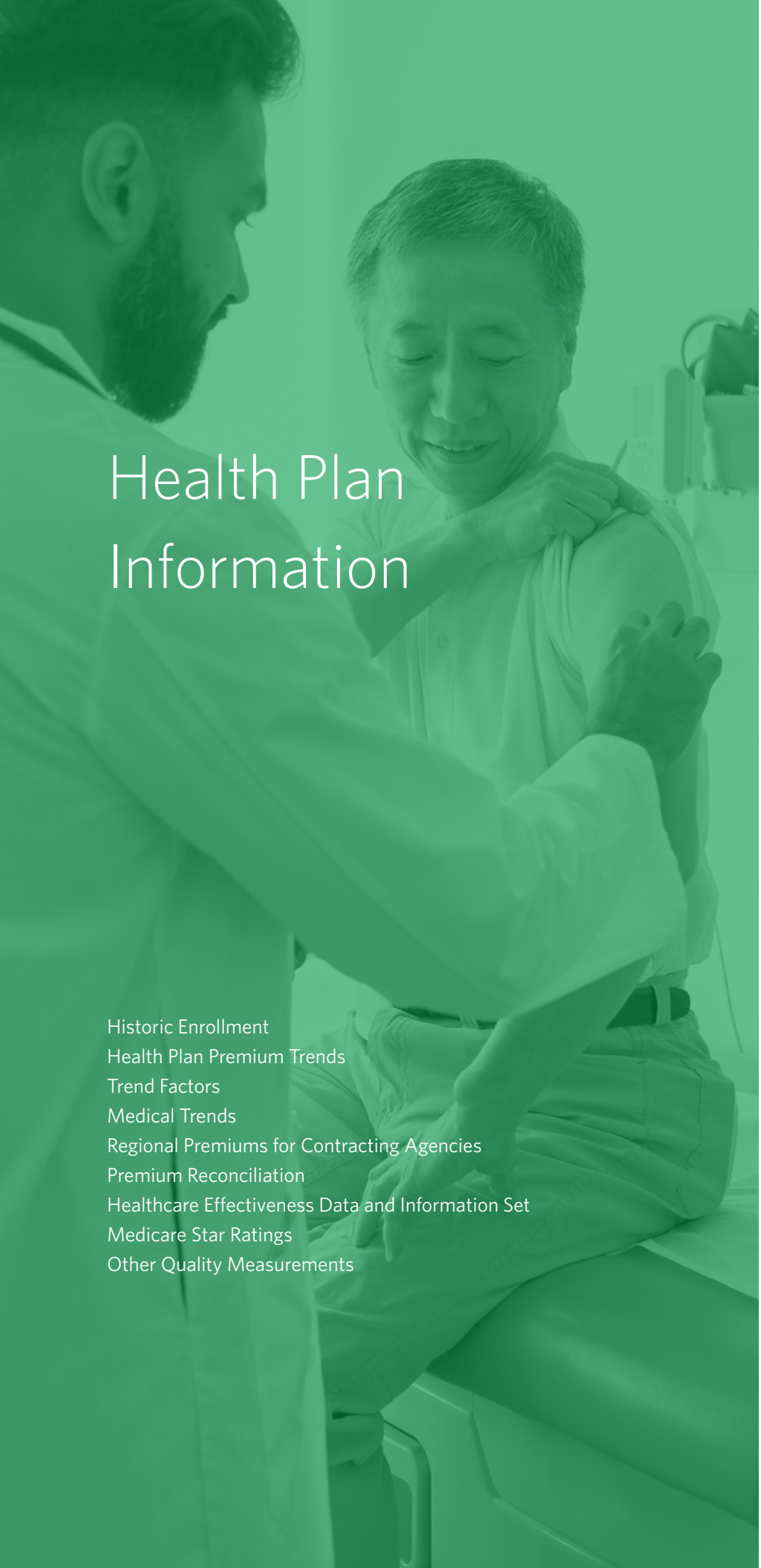


Figure 2b:
Medicare Health Care Satisfaction Ratings





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Historic Enrollment

We have seen our health plan enrollment grow over the past 10 years. Between 2012 and 2021, CalPERS' total enrollment has increased by 11.3%.

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 2019-2021. The CalPERS total enrollment count, derived from myCalPERS as of January 1, 2021, 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 2021 health plan premiums was started in 2020 and used data from 2019 and 2020.

Health care costs are rising due to a number of factors, including increases in hospital admissions, outpatient surgical procedures, and pharmacy costs. We continue to look for ways to keep costs low while upholding 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
- Population health risk
- Prevalence of chronic conditions
- Provider contract negotiation
- Medical cost inflation
- 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 COVID-19 pandemic impact on health care during 2020 and 2021, 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 (increases and decreases) in premiums result from a number of factors including higher medical and pharmaceutical costs, and benefit design changes.

For 2021, premiums increased by 4.32%[6] overall for Basic and Medicare plans combined. CalPERS' Basic HMO plans increased by an average of 4.44%, Basic PPO plans increased by an average of 8.54%, Medicare Advantage plans decreased by an average of 4.46%, and Medicare Supplement plans decreased by an average of 0.65%.

Medical Trends

The overall cost trend for our HMO, PPO, EPO, and association Basic health plans increased 16.6% in calendar year 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
- Preventative care
- All other

Analysis of trends allows a better understanding of the factors that impact health care premiums. Due to COVID-19, we anticipated a decrease in utilization in 2020 followed by a spike going into the second quarter of 2021. The 2021 trend in allowed Per Member Per Month (PMPM) increased overall and for each individual category with the exception of medical prescriptions. The utilization trend and unit price increased for all key service categories. See Appendix C for graphs displaying these medical trend changes.

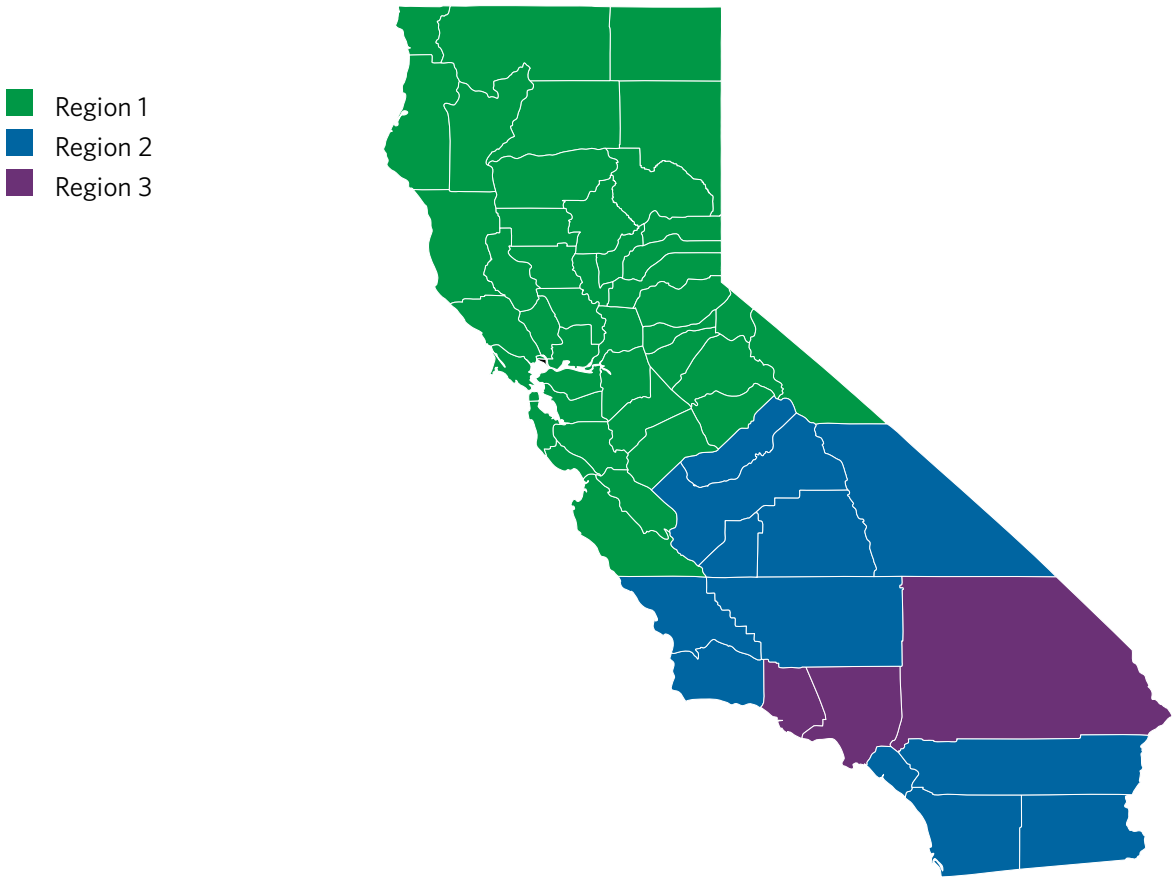
[6] Note that the average overall 4.32% increase in premiums for 2021 does not include association plans. The Basic and Medicare premium increases reflect average premium changes of only CalPERS' plans.

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. CalPERS excludes Medicare health plan premiums from regional pricing. CalPERS sets regional health plan premiums for a defined geographic area, and the differences between regional premiums reflect geographic differences in these factors.

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 2020 and 2021 are available in the July 14, 2020, Board of Administration Offsite agenda items in Board Meetings at **www.calpers.ca.gov**.

Figure 3: 2021 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 2021. The premium information was extracted from a point in time from myCalPERS as of June 15, 2022.

Table 4: Health Premium Management Report for Calendar Year 2021
(Dollars in Thousands)

Health Plan Carriers	Health Premium Amount*
Anthem Blue Cross	$3,191,163
Associations (CAHP, CCPOA, and PORAC)	605,186
Blue Shield of California	801,652
Health Net of California	174,148
Kaiser Foundation Health Plan	4,465,449
Sharp Health Plan	86,162
UnitedHealthcare	747,249
Western Health Advantage	81,266
Total	**$10,152,276**

* Premiums may not sum to total due to rounding.

Healthcare Effectiveness Data and Information Set

In the early 1990s, the National Committee for Quality Assurance (NCQA), a not-for-profit organization, began to manage the Healthcare Effectiveness Data and Information Set (HEDIS®). HEDIS® is a set of health plan performance measures designed to provide purchasers and consumers with the information they need for reliable comparison of health plan performance.[7] The current set of HEDIS® measures address "preventive services, chronic disease management, behavioral health care, appropriateness/overuse of services, and value."[8]

Employers, consultants, and consumers use HEDIS® data to help them choose the best health plan for their needs. HEDIS® measures are used by more than 90% of health plans in the United States to compare their plan performance and, more importantly, to make improvements in their quality of care and service.

Health plans collect and publicly report data used in the HEDIS® measurement process. To ensure that health plan data meets HEDIS® specifications, NCQA requires an independent auditor to examine each health plan's data and data analyses. NCQA then publishes HEDIS® data for health plan carriers annually on its website.[9] Other organizations such as Consumers Union and the California Office of the Patient Advocate disseminate HEDIS® data as well.

On an annual basis, large health plan carriers that contract with us are required to submit HEDIS® data to us. Data analysis and reporting during the contract year[10] is the same as the measurement year or calendar year when the services occurred.[11]

Appendices D and E display Basic HMO and Basic PPO health plans data for measurement year 2021.

Medicare Star Ratings

Medicare uses a Star Rating System to measure how well Medicare Advantage and Medicare Prescription Drug (Part D) plans perform.[12] Medicare scores how well plans did in several categories, including quality of care and customer service. Ratings range from 1 to 5 stars, with five being the highest and one being the lowest score. Medicare assigns plans an overall star rating to summarize the plan's performance as a whole. Plans also get separate star ratings in each individual category reviewed. Medicare star ratings are unavailable for our Supplement to Original Medicare plans because they are neither Medicare Advantage plans nor Part D plans.

7 HEDIS and Performance Measurement. (2021) https://www.ncqa.org/hedis/

8 HEDIS Measures and Technical Resources. (2021) https://www.ncqa.org/hedis/measures/

9 NCQA Health Insurance Plan Ratings 2022 https://www.ncqa.org/hedis/reports-and-research/ncqas-health-plan-ratings-2022/

10 The contract year in which data are analyzed and reported.

11 The contract year preceding the reporting year, during which the events measured actually occurred.

12 How to compare plans using the Medicare Star Rating System. (2022) https://www.medicareinteractive.org/get-answers/medicare-health-coverage-options/changing-medicare-coverage/how-to-compare-plans-using-the-medicare-star-rating-system

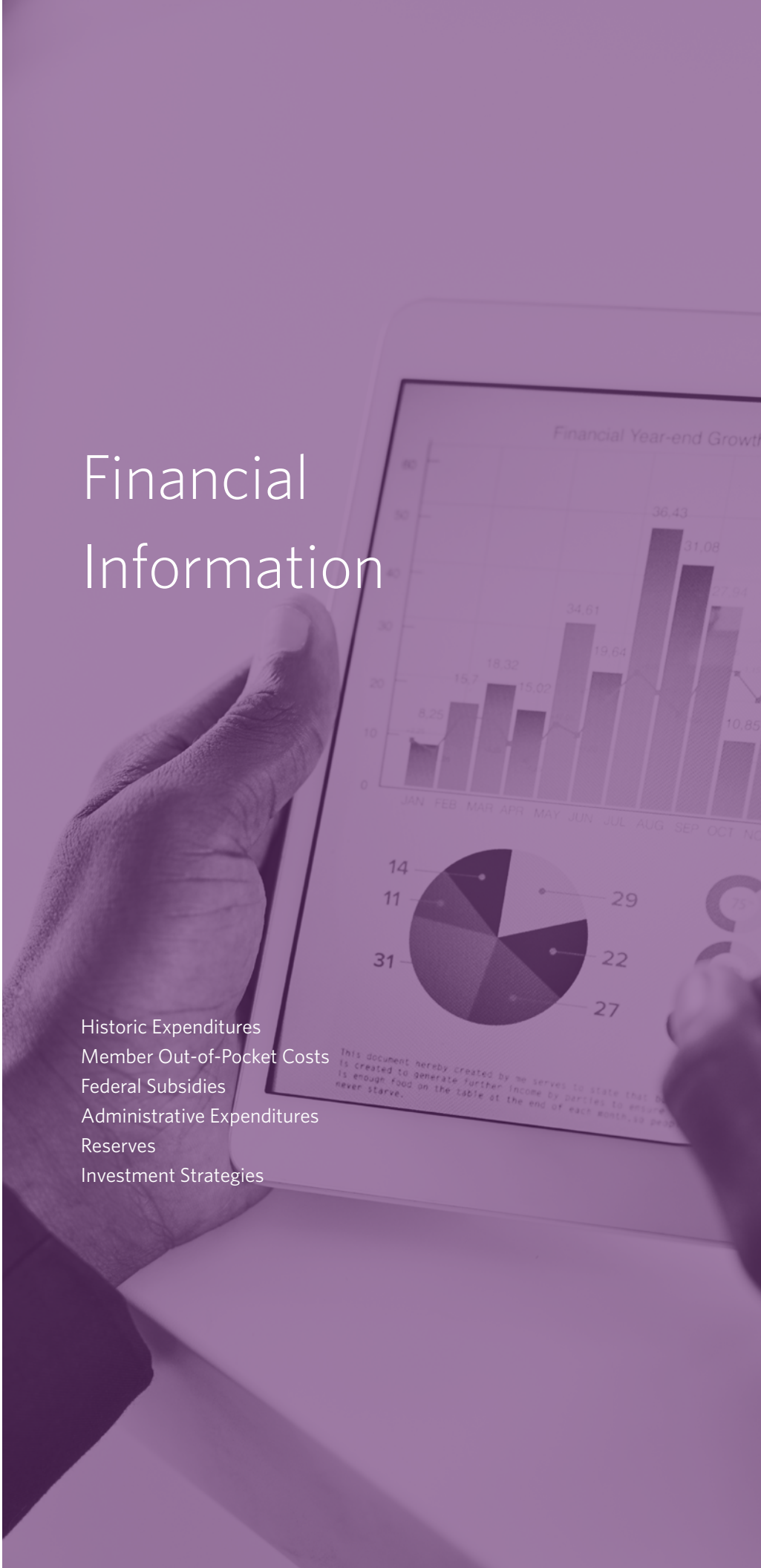
Other Quality Measurements

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

Table 5: 2021 Health Plan Contract Quality Measures

Item	Health Plan Contractor Requirements
Behavioral Health Program	Provide a behavioral health program for mental health and substance abuse designed to objectively monitor and evaluate the efficiency, appropriateness and quality of mental health and substance abuse care provided to plan members.
CalPERS Staff Satisfaction Survey	Responsiveness and quality of administrative services as measured on an account management survey.
Evidence-Based Medicine (EBM)	Have clinical committees that establish clinical practice pathways and guidelines and use national sources to identify EBM practice guidelines (e.g., from the Agency for Healthcare Research and Quality or Milliman).
Leapfrog Group Initiatives Participation	Use best efforts to require its participating provider hospitals to undertake the safety and quality initiatives supported by the Leapfrog Group consisting of computer physician order entry, evidence-based hospital referral, and appropriate intensive care unit physician staffing.
Office of the Patient Advocate's Health Care Quality Report	Maintain a minimum of a two-star rating for "Getting Care Easily" in the "Member Ratings" section from the Office of the Patient Advocate's Health Care Quality Report Card.
Performance Measures	Provide data on 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 2021 plan year, the total estimated expenditure exceeded $10.2 billion.

The Historic Expenditures tables (see Appendix F) are estimated expenditures for plan years 2019-2021. 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., 2021 expenditures were calculated based on 2021 premiums and January 2021 enrollment counts).

Appendix F also displays expenditures by plan name, health coverage type (Basic or Medicare), program (state or contracting agency [i.e., public agencies and schools]), status (active or retired), and subscriber and dependent tier (single, two-party, or family).

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

Member Out-of-Pocket Costs

Member out-of-pocket costs are members' expenses for medical care and prescription drugs that are not reimbursed by insurance. These costs include deductibles, coinsurance, copayments, and other out-of-pocket costs as specified in 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 health care and prescription drug out-of-pocket costs in 2021 depending on whether the CalPERS member chose an HMO or PPO or was enrolled in a Basic or Medicare health plan. A typical copay for a physician office visit for members enrolled in a Basic HMO plan was $15. For members enrolled in Basic PPO plans, the copay was $20 for PERSCare and PERS Choice. For PERS Select, the copay was $35 and reduced to $10 if the member enrolled with a personal doctor. 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[13] for individuals and $1,000 for a family. There were no deductibles for members enrolled in a Basic HMO plan or a Medicare plan. For further details about plan benefits, copays, and deductibles, review our publication, ***Health Benefit Summary*** (HBD-110), in **Forms & Publications** at **www.calpers.ca.gov**.

In 2021, our members paid on average $326 out-of-pocket for health care services and prescription drugs. On average, a member in a Basic HMO plan paid $110 in out-of-pocket costs, while a member in a Medicare Advantage plan paid $280. On average, a member in a Basic PPO plan paid $1,141 in out-of-pocket costs, while a member in a Medicare Supplement plan paid on average $296 annually (see Appendix H Average Member Out-of-Pocket Annual Costs by Plan).

[13] Deductibles for PERS Select 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 2021, we collected nearly $8.3 million in federal subsidies, which makes up less than 1% of total health premiums collected.

Direct subsidies are fixed amounts that the Centers for Medicare & Medicaid Services (CMS) pays to plan administrators to reimburse for Medicare Part D administrative costs. Reinsurance payments subsidize plan administrators for a portion of gross prescription drug costs incurred after a member exceeds the annual True Out-Of-Pocket (TrOOP) cost threshold. The Coverage Gap Discounts are pharmaceutical drug discounts paid by pharmaceutical manufacturers to plan administrators to offset the reduced member cost-sharing for eligible members in the coverage gap.

Our Medicare Advantage Plans and the PERSCare, PERS Choice, and PERS Select Supplement 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 2021–22, we expended $78.3 million to support our Health Benefits Program. These administrative expenditures included both personal services costs (salaries, wages, and benefits), and operating expenses and equipment.

Of the total 2,843 authorized positions, 436.7 directly and indirectly supported the Health Benefits Program in fiscal year 2021–22 (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 the Legal Office, Financial Office, and the Operations & Technology Branch. Personal services expenditures totaled $56.3 million in fiscal year 2021–22 (see Table 7).

Table 6: Staff Levels

Direct Support Positions	249.6
Enterprise Support Operations Positions	187.1
Total Staffing Levels	**436.7**

Table 7: Personal Services
(Dollars in Thousands)

Salary and Wages	$37,380
Staff Benefits	18,905
Total Personal Services	**$56,285**

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 2021–22 totaled $22 million (see Table 8).

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

Consultant and Professional Services – Internal	$127
Consultant and Professional Services – External	7,329
General Operating Expenses	9,684
Statewide Administrative Cost (Pro-Rata)	4,844
Total Operating Expenses & Equipment	**$21,984**

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	$31,657
Public Employees' HCF	46,612
Total Funding	**$78,269**

Reserves

Reserve Levels/Adequacy

As of December 31, 2021, the actuarial reserve level for the self-funded PPO plans was $684.4 million,[17] and the total assets level was $438.5 million.[17, 18] 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. 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 $30.5 million[14] as of December 31, 2021.

The total assets levels account for encumbered dollars for the buy-downs to smooth premiums for the 2022 plan year approved by the board.

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 purposes of the policy are to review the appropriate PPO reserve level and the methodology for handling surpluses or deficits based on predetermined thresholds:

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

The PPO assets total is 64%[14, 15] of the actuarial reserve as of December 31, 2021. An additional surcharge for Basic PPO plans will be applied to 2023 premiums and future year premiums until the reserve is replenished.

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.

[14] The 2021 actuarial reserve level reflects claims processed as of March 31, 2022.

[15] The total assets level as of December 31, 2021 includes the encumbered dollars used to buy down the 2022 plan premiums.

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
17/18	Surplus Money Investment Fund (SMIF)	658,269,063	1.45%
18/19		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%

* See Appendix G 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
17/18	State Street Global Advisors (SSGA) U.S. Aggregate Bond Index Fund	443,267,916	(0.33%)
18/19		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%)
17/18	Surplus Money Investment Fund (SMIF)	583,267,337	1.45%
18/19		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%

* See Appendix G 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, 2022, is 1.54%, 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 in **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[16]

	2019	2020	2021
Basic HMO Plans			
Anthem Blue Cross Select	33,305	43,478	48,692
Anthem Blue Cross Traditional	15,709	14,165	12,848
Blue Shield Access+	127,725	93,869	81,127
Blue Shield Trio	—	8,336	12,590
Health Net - Salud y Más	9,446	10,790	11,819
Health Net - Smartcare	26,155	18,213	14,918
Kaiser Permanente	529,710	548,287	555,002
Kaiser Out-of-State	789	849	950
Sharp Health Plan	12,576	14,024	14,583
UnitedHealthcare	79,034	85,684	82,927
Western Health Advantage	9,788	11,038	11,347
Basic EPO and PPO Plans			
Anthem Blue Cross Del Norte EPO	107	81	81
Blue Shield EPO	1,070	966	880
PERSCare	31,782	28,275	25,689
PERS Choice	148,957	146,790	142,946
PERS Select	70,215	91,972	107,287
Basic Association Plans			
California Association of Highway Patrolmen	28,403	28,049	27,304
California Correctional Peace Officers Association North	8,693	8,324	7,675
California Correctional Peace Officers Association South	31,667	31,547	30,662
Peace Officers Research Association of California	21,454	21,236	21,363
Basic Total	1,186,585	1,205,973	1,210,690

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

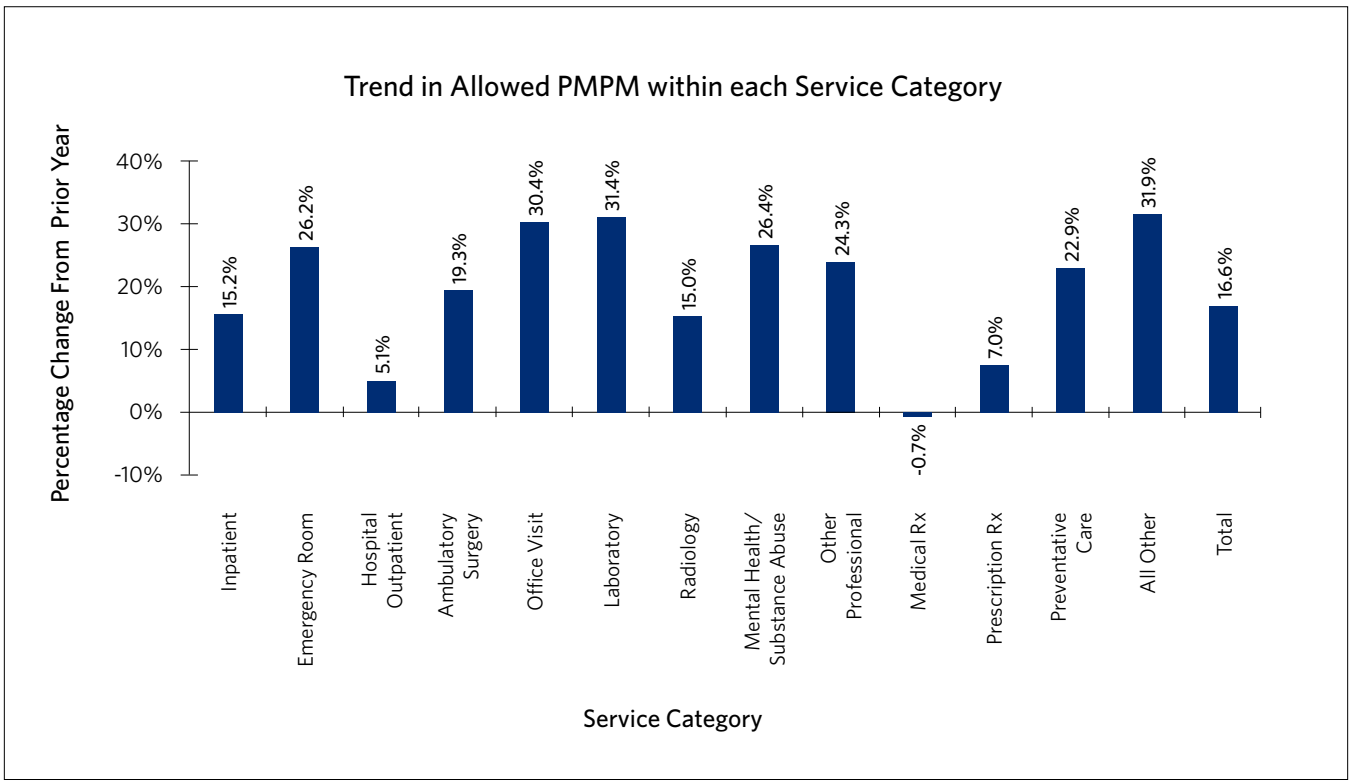
	2019	2020	2021
Medicare Advantage Plans			
Anthem Medicare Preferred PPO	1,799	2,901	4,177
Kaiser Permanente Senior Advantage	99,111	103,846	107,545
Kaiser Permanente Senior Advantage Out-of-State	2,220	2,338	2,454
Sharp Health Plan	—	—	24
UnitedHealthcare Medicare Advantage	41,039	43,094	44,920
Supplement to Original Medicare Plans			
PERSCare	62,653	64,237	65,898
PERS Choice	72,260	75,126	77,911
PERS Select	2,136	2,421	2,913
Medicare Association Plans			
California Association of Highway Patrolmen	4,415	4,469	4,516
California Correctional Peace Officers Association North	581	636	687
California Correctional Peace Officers Association South	694	797	886
Peace Officers Research Association of California	2,425	2,573	2,722
Medicare Total	289,333	302,438	314,653
Grand Total	**1,475,918**	**1,508,411**	**1,525,343**
Program			
State	870,085	884,106	887,580
Contracting Agency	605,833	624,305	637,763
Total	1,475,918	1,508,411	1,525,343
Employment Status			
Active	1,001,983	1,022,926	1,025,477
Retired	473,935	485,485	499,866
Total	1,475,918	1,508,411	1,525,343
Subscriber and Dependent Tier			
Single	326,040	336,699	346,222
2-Party	407,846	416,460	421,724
Family	742,032	755,252	757,397
Total	1,475,918	1,508,411	1,525,343

Appendix C – Medical Trends

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

The trend in allowed PMPM[17] cost[18] is examined across 13 service categories,[19] revealing the key drivers of medical trend changes in 2021, compared to 2020, which saw a decrease in utilization due to COVID-19.

The chart below shows the trend for each individual service category. Most categories experienced an increase. The category that experienced the largest increase was the All Other category. The only service category to experience a decrease was Medical Prescription.



Data as of June 24, 2022

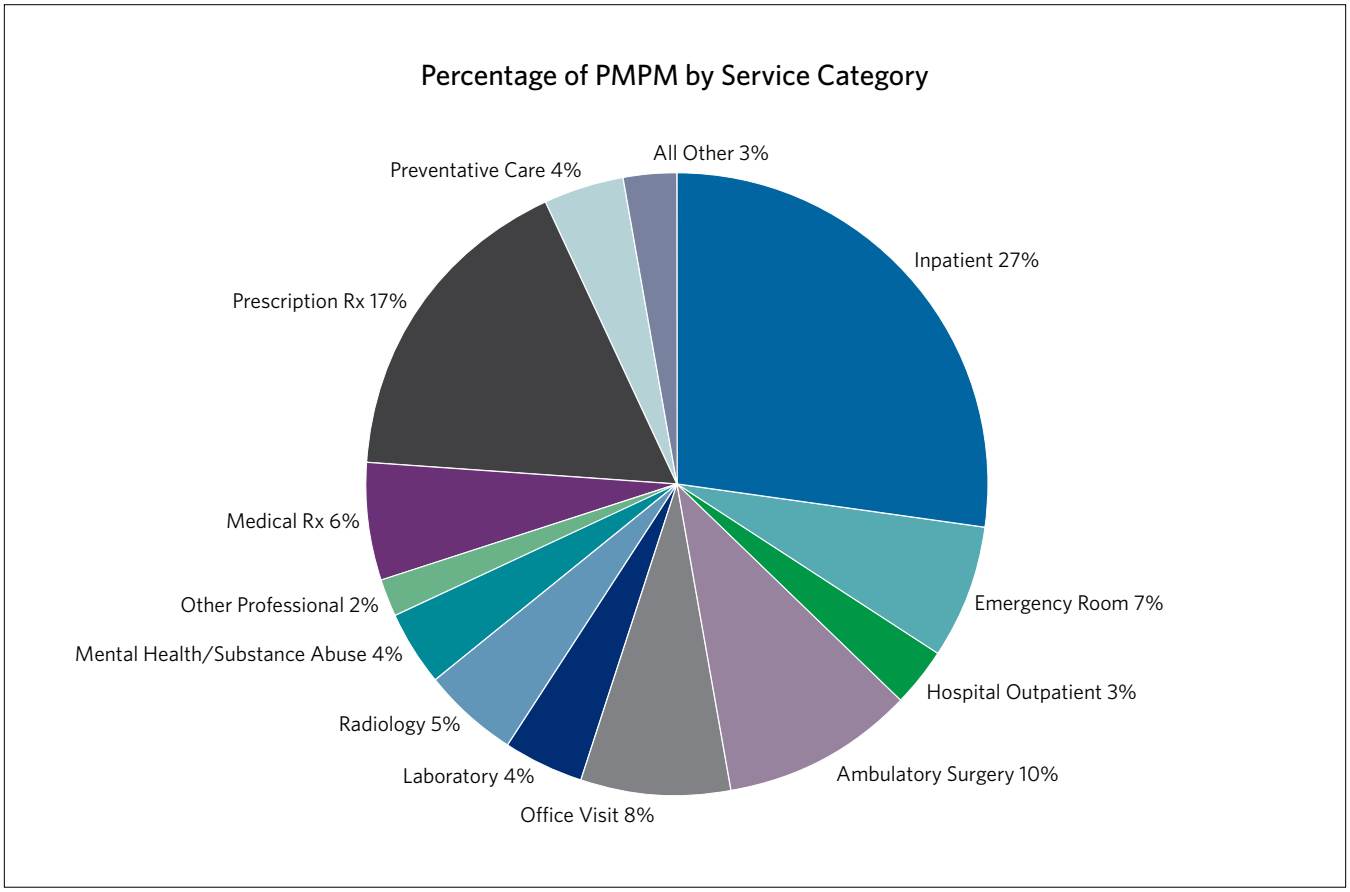
[17] Allowed cost divided by sum of member months in period, adjusted for population size.

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

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

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

The chart below shows the composition of total allowed PMPM by percentage of each category [20] in 2021. The three major drivers that account for 54% of the total allowed PMPM are inpatient (27%), prescription drug (17%), and ambulatory surgery (10%).



Data as of June 24, 2022

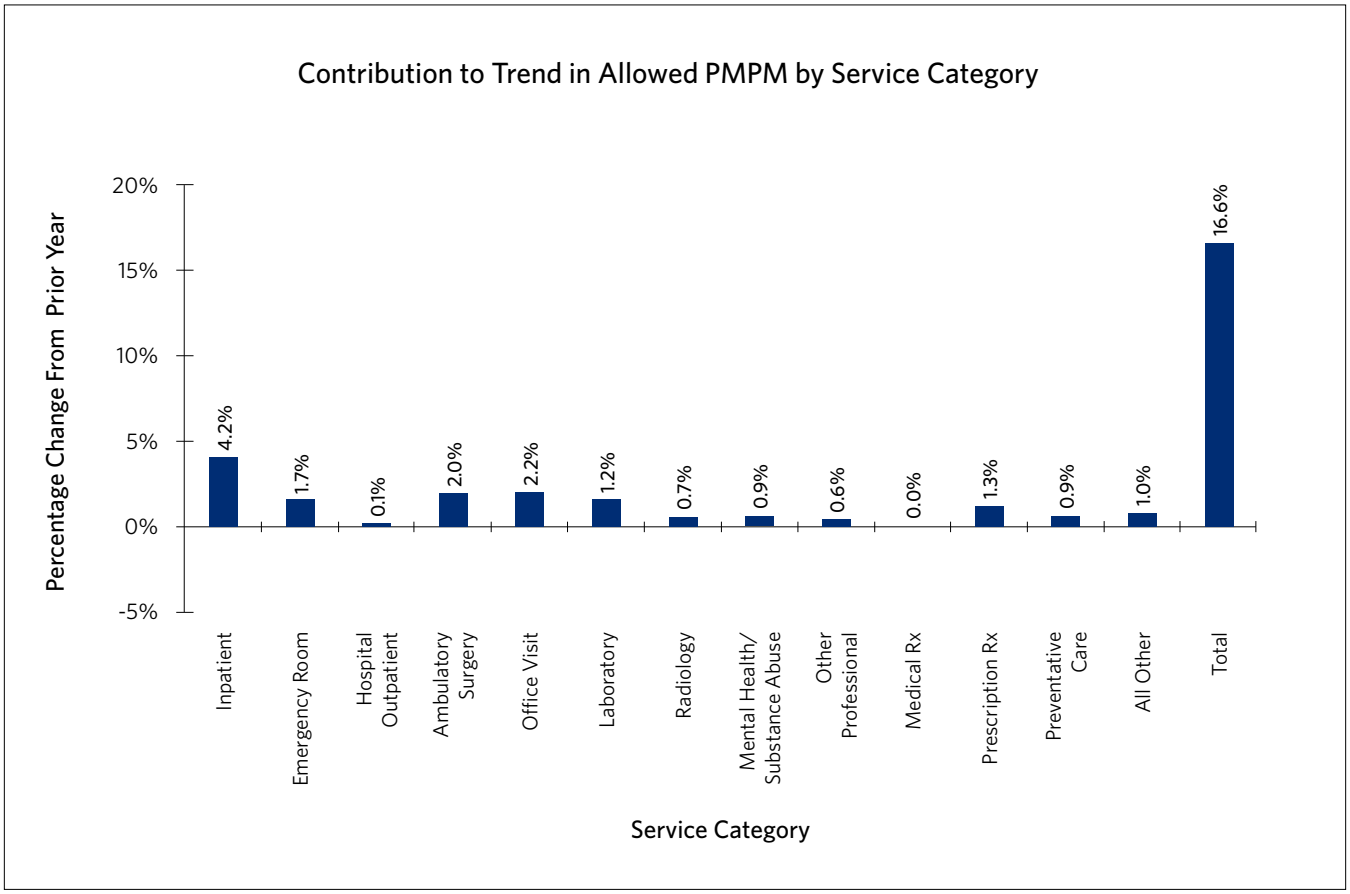
[20] The Prescription Rx service category data does not include rebates.

Appendix C – Medical Trends, cont.

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

In calendar year 2021, the total allowed PMPM increased 16.6% across all service categories.[21]

The chart below shows the major drivers that contributed to trend in the allowed PMPM for calendar year 2021. Inpatient accounted for 4.2%, office visits was 2.2%, and ambulatory surgery was 2.0%.[22]



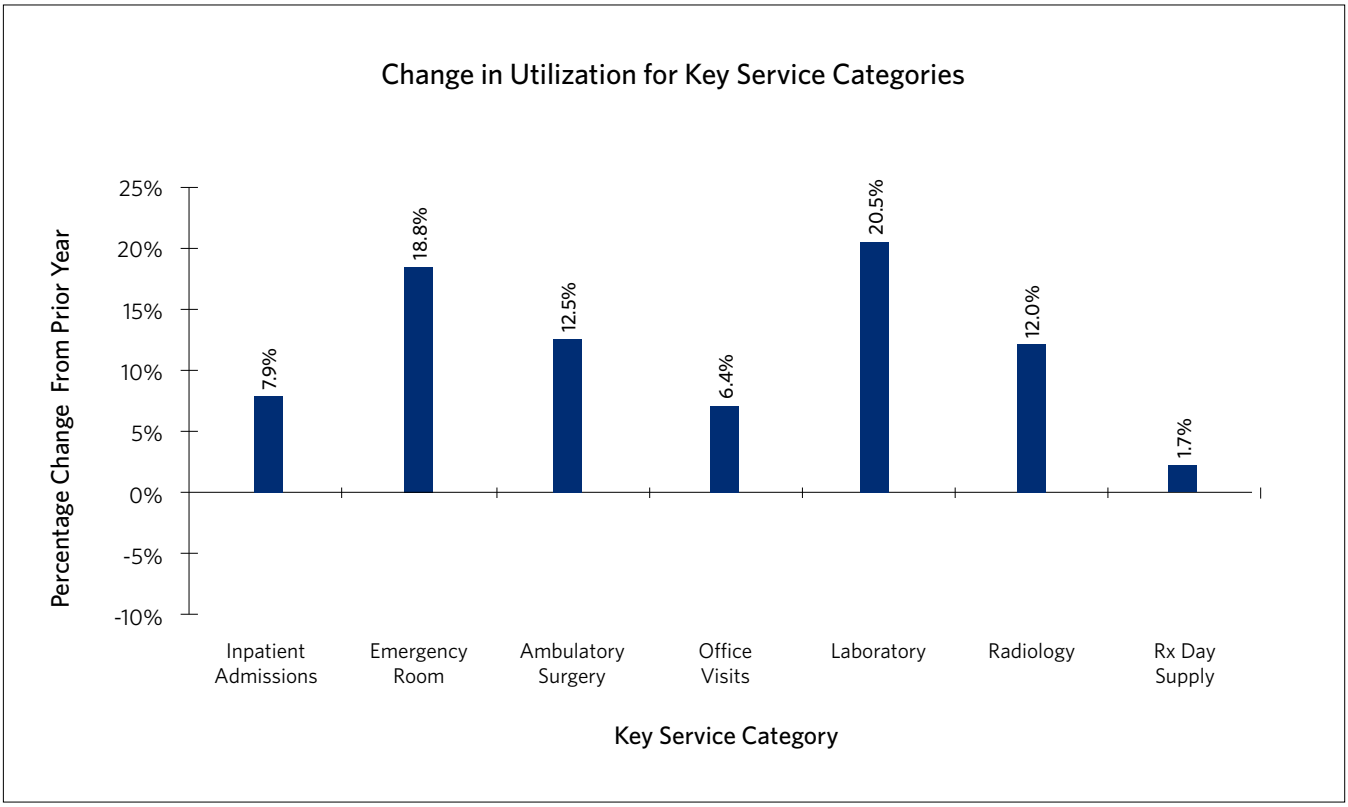
Data as of June 24, 2022

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

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

Change in Utilization by Key Service Categories

Among the largest service categories,[23] allowed PMPM is driven by change in utilization per unit. In 2021, an increase in utilization occured in all key service categories with the largest occurring in laboratory (20.5%) and emergency room (18.8%).



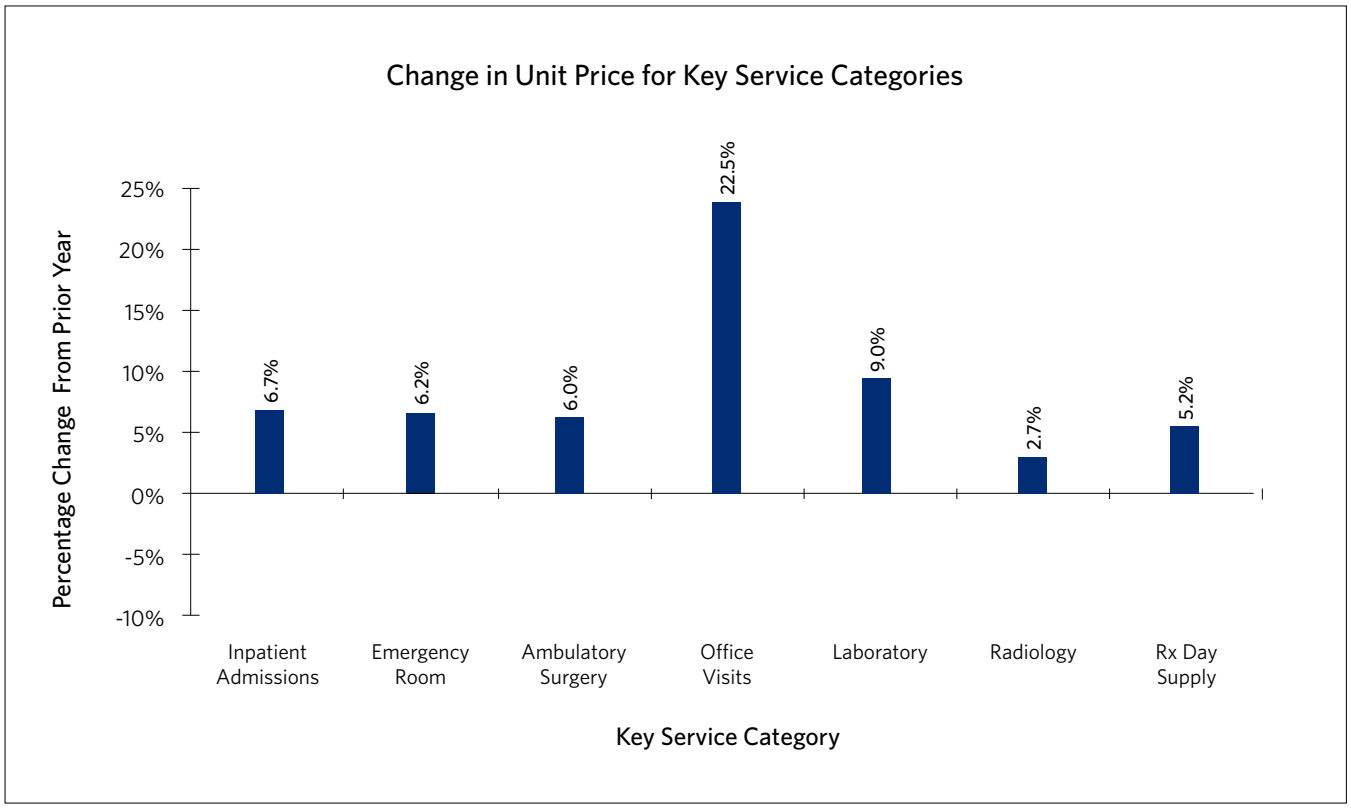
Data as of June 24, 2022

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

Appendix C – Medical Trends, cont.

Change in Unit Price by Key Service Categories

Among the largest service categories,[24] allowed PMPM is driven by change in price per unit. In 2021, an increase in unit price occured in all key service categories with the largest occuring in office visits (22.5%).



Data as of June 24, 2022

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

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

Measure	Anthem HMO	BSC	Kaiser	UHC
Prevention and Screening				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents — BMI percentile (Total)*	26.0%	68.4%	94.1%	66.3%
Childhood Immunization Status — Combination 3*	50.0%	78.3%	85.4%	78.9%
Childhood Immunization Status — Combination 10*	35.1%	54.4%	69.9%	58.5%
Immunizations for Adolescents — Combination 1*	50.0%	79.6%	86.8%	71.3%
Breast Cancer Screening — Total	76.7%	73.8%	76.5%	75.3%
Cervical Cancer Screening*	71.3%	74.0%	83.1%	78.5%
Colorectal Cancer Screening*	52.7%	66.5%	75.9%	62.8%
Chlamydia Screening in Women — Total	46.3%	50.8%	62.4%	58.1%
Respiratory Conditions				
Appropriate Treatment for Children with Pharyngitis	47.4%	45.5%	19.9%	42.3%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	48.9%	41.4%	28.6%	47.8%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	28.9%	28.3%	32.5%	30.3%
Pharmacotherapy Management of COPD Exacerbation — Systemic Corticosteroid	44.4%	66.7%	84.9%	62.8%
Pharmacotherapy Management of COPD Exacerbation — Bronchodilator	66.7%	92.5%	93.0%	69.7%
Cardiovascular Conditions				
Persistence of Beta-Blocker Treatment after a Heart Attack	88.9%	79.9%	87.6%	77.4%
Diabetes				
Comprehensive Diabetes Care — HbA1c Testing*	86.9%	89.1%	92.7%	88.8%
Comprehensive Diabetes Care — HbA1c Control (<8%)*	53.6%	63.8%	61.2%	65.0%
Comprehensive Diabetes Care — Eye Exams*	38.0%	55.0%	69.5%	53.0%
Overuse/Appropriateness				
Use of Imaging Studies for Low Back Pain	81.7%	85.5%	86.5%	81.3%
Use of Opioids at High Dosage	3.5%	N/A	1.8%	2.2%

Measure	Anthem HMO	BSC	Kaiser	UHC
Prevention and Screening				
Antidepressant Medication Management — Effective Acute Phase Treatment	67.7%	67.3%	82.5%	60.2%
Antidepressant Medication Management — Effective Continuation Phase Treatment	52.1%	52.8%	58.1%	44.6%
Follow Up Care for Children Prescribed ADHD Medication — Initiation Phase	45.6%	30.9%	71.7%	24.4%
Follow Up Care for Children Prescribed ADHD Medication — Continuation & Maintenance Phase	41.7%	33.3%	72.9%	23.3%
Follow Up after Hospitalization for Mental Illness — 7-days	42.9%	46.9%	66.1%	42.5%
Follow Up after Hospitalization for Mental Illness — 30-days	63.5%	67.1%	76.0%	55.4%
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment — Initiation — Total	23.9%	35.4%	49.0%	34.5%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment — Engagement — Total	6.9%	9.5%	25.6%	11.8%
Prenatal and Postpartum Care — Timeliness of Prenatal Care*	59.0%	78.6%	92.6%	86.4%
Prenatal and Postpartum Care — Postpartum Care*	54.9%	79.2%	93.8%	86.0%

* "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.

Notes:

- The measures presented are from HEDIS® 2021 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 3," "Combination 10," and "Combination 1" refer to different sets of recommended vaccines; see NCQA website for details.
- Acronyms used in measures: ADHD = Attention Deficit Hyperactivity Disorder; BMI = Body Mass Index; COPD = Chronic Obstructive Pulmonary Disease; and HbA1c = Hemoglobin A1c

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

Measure	Health Net	Sharp	WHA
Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents — BMI percentile (Total)*	66.1%	87.5%	48.7%
Childhood Immunization Status — Combination 3*	74.5%	84.4%	71.3%
Childhood Immunization Status — Combination 10*	61.0%	68.3%	57.2%
Immunizations for Adolescents — Combination 1*	76.6%	78.6%	76.9%
Breast Cancer Screening — Total	73.2%	79.8%	74.1%
Cervical Cancer Screening*	75.7%	83.3%	75.4%
Colorectal Cancer Screening*	69.5%	74.1%	68.6%
Chlamydia Screening in Women — Total	51.2%	60.3%	61.6%
Respiratory Conditions			
Appropriate Treatment for Children with Pharyngitis	44.3%	74.3%	63.2%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	47.9%	58.5%	N/A
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	32.7%	30.0%	31.8%
Pharmacotherapy Management of COPD Exacerbation — Systemic Corticosteroid	68.6%	65.2%	N/A
Pharmacotherapy Management of COPD Exacerbation — Bronchodilator	80.0%	82.6%	N/A
Cardiovascular Conditions			
Persistence of Beta-Blocker Treatment after a Heart Attack	75.7%	86.7%	N/A
Diabetes			
Comprehensive Diabetes Care — HbA1c Testing*	85.4%	91.2%	92.9%
Comprehensive Diabetes Care — HbA1c Control (<8%)*	57.2%	68.0%	68.0%
Comprehensive Diabetes Care — Eye Exams*	51.8%	68.8%	50.4%
Overuse/Appropriateness			
Use of Imaging Studies for Low Back Pain	79.6%	N/A	83.5%
Use of Opioids at High Dosage	5.0%	3.2%	N/A

* "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	WHA
Behavioral Health			
Antidepressant Medication Management — Effective Acute Phase Treatment	68.6%	74.7%	N/A
Antidepressant Medication Management — Effective Continuation Phase Treatment	53.9%	58.5%	N/A
Follow Up Care for Children Prescribed ADHD Medication — Initiation Phase	33.5%	28.6%	N/A
Follow Up Care for Children Prescribed ADHD Medication — Continuation & Maintenance Phase	39.7%	58.5%	N/A
Follow Up after Hospitalization for Mental Illness — 7-days	50.9%	41.2%	36.7%
Follow Up after Hospitalization for Mental Illness — 30-days	73.0%	54.9%	55.1%
Access/Availability of Care			
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment — Initiation — Total	28.8%	28.4%	26.4%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment — Engagement — Total	12.1%	9.7%	4.7%
Prenatal and Postpartum Care — Timeliness of Prenatal Care*	92.4%	96.6%	70.6%
Prenatal and Postpartum Care — Postpartum Care*	85.2%	93.9%	72.4%

* "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® 2021 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 3," "Combination 10," and "Combination 1" refer to different sets of recommended vaccines; see NCQA website for details.
- Acronyms used in measures: ADHD = Attention Deficit Hyperactivity Disorder; BMI = Body Mass Index; COPD = Chronic Obstructive Pulmonary Disease; and HbA1c = Hemoglobin A1c

Appendix E – Basic PPO Health Plan HEDIS Measures

Measure	PERSCare	PERS Choice	PERS Select
Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents — BMI percentile (Total)*	20.4%	21.0%	23.1%
Childhood Immunization Status — Combination 3*	57.7%	47.8%	51.9%
Childhood Immunization Status — Combination 10*	55.3%	36.0%	33.8%
Immunizations for Adolescents — Combination 1*	77.3%	69.9%	60.8%
Breast Cancer Screening — Total	72.1%	70.9%	65.9%
Cervical Cancer Screening*	71.3%	72.1%	71.0%
Colorectal Cancer Screening*	61.6%	63.4%	54.8%
Chlamydia Screening in Women — Total	45.5%	43.5%	40.0%
Respiratory Conditions			
Appropriate Treatment for Children with Pharyngitis	47.3%	55.2%	48.8%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	54.9%	52.5%	51.2%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	39.3%	33.3%	33.7%
Pharmacotherapy Management of COPD Exacerbation — Systemic Corticosteroid	62.5%	40.5%	75.0%
Pharmacotherapy Management of COPD Exacerbation — Bronchodilator	100%	83.3%	62.5%
Cardiovascular Conditions			
Persistence of Beta-Blocker Treatment after a Heart Attack	77.8%	80.5%	71.0%
Diabetes			
Comprehensive Diabetes Care — HbA1c Testing*	89.9%	88.5%	85.5%
Comprehensive Diabetes Care — HbA1c Control (<8%)*	37.5%	35.2%	33.2%
Comprehensive Diabetes Care — Eye Exams*	45.0%	38.3%	36.5%
Overuse/Appropriateness			
Use of Imaging Studies for Low Back Pain	83.9%	82.8%	84.7%
Use of Opioids at High Dosage	6.4%	5.7%	3.3%

Measure	PERSCare	PERS Choice	PERS Select
Behavioral Health			
Antidepressant Medication Management — Effective Acute Phase Treatment	73.9%	73.1%	71.7%
Antidepressant Medication Management — Effective Continuation Phase Treatment	59.2%	58.3%	55.1%
Follow Up Care for Children Prescribed ADHD Medication — Initiation Phase	65.0%	35.5%	33.3%
Follow Up Care for Children Prescribed ADHD Medication — Continuation & Maintenance Phase	60.0%	50.0%	38.5%
Follow Up after Hospitalization for Mental Illness — 7-days	62.1%	50.7%	46.3%
Follow Up after Hospitalization for Mental Illness — 30-days	82.8%	72.4%	59.3%
Access/Availability of Care			
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment — Initiation — Total	33.0%	32.2%	31.2%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment — Engagement — Total	14.7%	11.7%	12.4%
Prenatal and Postpartum Care — Timeliness of Prenatal Care*	58.0%	56.4%	56.9%
Prenatal and Postpartum Care — Postpartum Care*	48.6%	54.1%	53.8%

* "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® 2021 Volume 2: Technical Specifications for Health Plans.
- Due to space limitations, measures focusing on specific age groups (e.g., "16-20 Years" vs "21-24 Years" for "Chlamydia Screening in Women"), as well as measures unavailable for all HMO and PPO plans, are excluded from this table.
- In the immunization measures, "Combination 3," "Combination 10," and "Combination 1" refer to different sets of recommended vaccines; see NCQA website for details.
- Acronyms used in measures: ADHD = Attention Deficit Hyperactivity Disorder; BMI = Body Mass Index; COPD = Chronic Obstructive Pulmonary Disease; and HbA1c = Hemoglobin A1c.

Appendix F – Historic Expenditures

Estimated Expenditures (dollars in thousands) [25]

	2019	2020	2021
Basic HMO Plans			
Anthem Blue Cross Select	$227,092	$310,929	$362,294
Anthem Blue Cross Traditional	162,288	155,277	152,627
Blue Shield Access+	939,811	812,836	712,950
Blue Shield Trio	—	52,564	86,238
Health Net Salud y Más	33,023	40,158	47,018
Health Net SmartCare	184,787	149,058	129,376
Kaiser Permanente	3,562,206	3,794,672	4,027,970
Kaiser Out-of-State	8,386	9,265	11,406
Sharp Health Plan	69,283	78,843	85,927
UnitedHealthcare	506,862	571,301	578,984
Western Health Advantage	64,119	75,523	81,030
Basic EPO and PPO Plans			
Anthem Del Norte EPO	689	572	605
Blue Shield EPO	8,833	9,272	8,470
PERSCare	305,912	291,458	175,944
PERS Choice	1,121,899	1,136,287	1,187,352
PERS Select	318,984	415,729	531,714
Basic Association Plans			
California Association of Highway Patrolmen	157,930	160,639	165,111
California Correctional Peace Officers Association North	57,541	59,029	56,028
California Correctional Peace Officers Association South	167,591	179,051	181,111
Peace Officers Research Association of California	152,782	150,120	146,468
Basic Total	$8,050,018	$8,452,584	$8,844,176*

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

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

Appendix F – Historic Expenditures, cont.

	2019	2020	2021
Medicare Advantage Plans			
Anthem Medicare Preferred PPO	7,712	13,508	21,138
Kaiser Permanente Senior Advantage	385,023	422,944	433,964
Kaiser Permanente Senior Advantage Out-of-State	8,624	9,523	9,512
Sharp Direct Advantage HMO	—	—	199
UnitedHealthcare Medicare Advantage	147,423	169,105	169,962
Supplement to Original Medicare Plans			
PERSCare	9,242	10,209	12,813
PERS Choice	312,532	316,740	330,671
PERS Select	296,904	296,587	301,378
Medicare Association Plans			
California Association of Highway Patrolmen	20,952	24,110	26,666
California Correctional Peace Officers Association North	3,384	3,720	4,059
California Correctional Peace Officers Association South	4,042	4,661	5,453
Peace Officers Research Association of California	14,895	15,798	20,537
Medicare Total	$1,210,734	$1,286,905	$1,326,842*
Grand Total	$9,260,752	$9,739,488	$10,171,019**

Program			
State	$5,369,543	$5,627,611	$6,991,945
Contracting Agency	3,891,210	$4,111,877	3,179,680
Total	$9,260,752	$9,739,488	$10,171,625
Employment Status			
Active	$6,585,525	$6,951,284	$7,238,112
Retired	2,675,228	2,788,204	2,932,907
Total	$9,260,752	$9,739,488	$10,171,625*
Subscriber and Dependent Tier			
Single	$2,228,237	$2,359,470	$2,575,767
2-Party	2,863,765	2,996,081	3,063,420
Family	4,168,751	4,383,937	4,531,831
Total	$9,260,752	$9,739,488	$10,171,018**

*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 G – 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
3/31/2011	0.508%	12/31/2016	0.672%
6/30/2011	0.480%	3/31/2017	0.769%
9/30/2011	0.377%	6/30/2017	0.922%
12/31/2011	0.378%	9/30/2017	1.069%
3/31/2012	0.374%	12/31/2017	1.128% (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)

(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 H – Average Member Out-of-Pocket Annual Costs by Plan*

Basic EPO and HMO Plans	2021
Anthem Blue Cross Del Norte County EPO	$151.00
Anthem Blue Cross Select HMO	151.00
Anthem Blue Cross Traditional HMO	200.00
Blue Shield Access+ EPO	185.00
Blue Shield Access+ HMO	184.00
Blue Shield Trio HMO	126.00
Health Net Salud y Más	89.00
Health Net SmartCare	220.00
Kaiser Permanente	84.00
Sharp Health Plan	127.00
UnitedHealthcare SignatureValue Alliance	151.00
Western Health Advantage HMO	174.00
Average Member Out-of-Pocket for Basic EPO and HMO Plans	$110.00

Basic PPO Plans	
PERSCare	$ 1,492.00
PERS Choice	1,256.00
PERS Select	936.00
Average Member Out-of-Pocket for Basic PPO Plans	$1,141.00

Medicare Advantage Plans	
Anthem Medicare Preferred PPO	$421.00
Kaiser Permanente Senior Advantage	250.00
Sharp Direct Advantage HMO	244.00
UnitedHealthcare Group Medicare Advantage PPO	354.00
Average Member Out-of-Pocket for Medicare Advantage Plans	$280.00

Supplement to Original Medicare Plans	
PERSCare	$317.00
PERS Choice	282.00
PERS Select	228.00
Average Out-of-Pocket for Supplement to Original Medicare Plans	$296.00

*Average annual costs rounded to nearest dollar

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

Ⓓ November 2022