Finance and Administration Committee

Agenda Item 6b

November 19, 2024

Item Name: Semi-Annual Health Plan Financial Report

Program: Health Benefits

Item Type: Information

Executive Summary

This report provides the committee with an update on the financial status for the California Public Employees' Retirement System (CalPERS) four self-funded Preferred Provider Organization (PPO) health plans and the ten flex-funded Health Maintenance Organization (HMO) health plans as of June 30, 2024.

Strategic Plan

This item supports the CalPERS 2023-27 Strategic Goal: Ensure our members have access to equitable, high-quality, affordable health care.

Background

CalPERS has been self-funding PPO Basic and Medicare Supplemental plans since 1987. Each self-funded PPO plan is managed in a separate subaccount under the Health Care Fund to deposit premiums, pay claims and other expenses, and maintain prudent levels of reserves.

Starting in 2014, CalPERS began flex-funding most of its HMO Basic plans. Flex-funding is an arrangement with a health plan wherein the contracted health plan pays the capitated portion of the health care services and CalPERS pays the fee-for-service portion of the health care services. If capitation and fee-for-service expenses come in lower than anticipated, CalPERS retains that funding in its Health Care Fund. The flex-funded HMO plans also have subaccounts within the Health Care Fund to deposit the fee-for-service portion of premiums and pay claims and other expenses.

In September 2018, CalPERS implemented a revised Health Care Fund reserve policy. This policy provides the CalPERS team with a framework with which to review the appropriateness of the PPO reserve level and with a methodology for managing surpluses or deficits in the PPO subaccounts. The policy also addresses any surpluses or deficits that may accumulate in the HMO subaccounts.

As part of the monitoring and reporting process, CalPERS reports the Health Care Fund account balances, the PPO plans' actuarial reserve amounts, and any surpluses or deficits for each health plan's subaccount to the Finance & Administration Committee semi-annually. Fully insured plans and association plans are not included in this report.

Analysis

PPO Plans

Attachment 1 summarizes the PPO financial status for calendar years 2022 and 2023 and January through June 2024:

- The "Total Revenues vs. Total Expenses" graphs illustrate the financial performance of the total PPO program and for each PPO plan subaccount by showing fund inflows and outflows. Total revenues include premiums, outpatient prescription drug rebates, Federal Employer Group Waiver Plan (EGWP) subsidies, and investment income. Total expenses include medical and pharmacy fee-for-service claims payments, third-party administrator fees, and other administrative expenses. PPO plan medical costs are paid entirely on a fee-for-service basis.
- The "Fund Balance vs. Actuarial Reserves" graphs represent the subaccount balances and the actuarially prudent levels of reserves at the end of each period. The actuarial reserves for the PPO plans consist of Medical and Pharmacy Incurred-But-Not-Reported (IBNR) Claim Liability, Continuity of Care Liability, Administrative Liability, and Risk-Based Capital components.

As of June 30, 2024, the self-funded PPO plans had a total projected fund balance of $231 million, an increase of $164 million from the end of December 2023. The total actuarial reserves amount was $752 million, an increase of $54 million from the end of December 2023.The self-funded PPO program had a projected fund balance that was $521 million lower than the actuarial reserve level.

Each year, the PPO Basic plans experience lower medical costs in the first half of the year and higher medical costs in the second half of the year. This seasonality pattern is due to members satisfying their annual deductibles earlier in the year. PPO Medicare plans have an opposite seasonality pattern since the plans cover Medicare deductibles for the member, so medical costs are higher in the first half of the year and lower in the second half of the year.

The increase in fund balance was primarily driven by PPO Basic plans premium surcharge and lower medical fee-for-service claims in the first half of 2024. This is counteracted by higher-than-expected pharmacy costs and higher medical costs in the first half of the year for PPO Medicare. In the second half of 2024, medical costs are anticipated to increase for PPO Basic plans and decrease for PPO Medicare plans as part of seasonality patterns.

HMO Plans

As of June 30, 2024, there were seven flex-funded HMO Basic plans including Anthem Blue Cross Select and Traditional, Health Net Salud y Más, Sharp, UnitedHealthcare Alliance and Harmony, and Western Health Advantage.

Blue Shield Access+ and Blue Shield Trio converted from a flex-funded model to a fully insured model in 2024. Health Net SmartCare is no longer a part of CalPERS plan offerings as of 2024.

The financial status for these three plans will be reported for an additional 18 months to account for claims run-out and reconciliations for years prior to 2024.

Medical costs for flex-funded HMO plans are paid on both a capitation and fee-for-service basis. Capitation is a payment arrangement with health care service providers and is a set amount per person per month that is paid to cover the risk for a defined set of health care services, whether those services are provided or not. CalPERS reimburses the flex-funded HMO plans for the actual capitation amounts that the plans pay to their contracted capitated health care providers.

Once CalPERS remits the capitation amounts to the plans from the Contingency Reserve Fund, the remainder of the premium is deposited into the Health Care Fund. These funds are used to pay third-party administrative service fees, CalPERS internal administrative expenses, and medical and pharmacy fee-for-service claims, as well as Affordable Care Act Taxes and Fees when the plan submits an invoice to CalPERS for reimbursement.

Attachment 2 summarizes the financial status for the flex-funded HMO plans for calendar years 2022 and 2023, and January through June 2024:

- The “Total Revenues vs. Total Expenses” graphs represent the financial performance of the total HMO program and for each HMO subaccount by showing fund inflows and outflows. Total revenues include premiums, pharmacy rebates, and investment income. Total expenses include medical and pharmacy fee-for-service claims payments, medical capitation payments, third party administrator fees and other administrative expenses. Although capitation payments are handled and remitted through the Contingency Reserve Fund, the capitation figures are included in both revenues and expenses of the Health Care Fund to more accurately reflect the total costs of the HMO plans.
- The “Fund Balance vs. Estimated Claims Liabilities” graphs show the account balances and any surpluses or deficits as of the end of each period. The total flex-funded HMO projected fund balance was $244 million as of June 30, 2024, with estimated liabilities of $106 million. The medical fee-for-service costs are also protected by the flex-funded arrangement.

Budget and Fiscal Impacts

This item serves as a preliminary analysis. Any budget or fiscal impact this item may have on future health plan premiums will be addressed during CalPERS annual Rate Development Process that generally occurs from January through July and is overseen by the Pension & Health Benefits Committee.

Benefits and Risks

Benefits

- These semi-annual reports provide better insight into the financial performance and status of the CalPERS PPO and HMO health program.

Risks

- The projected dollar amounts may change due to other factors like account adjustments, timing issues, and higher than expected medical and pharmacy claims.

Attachments

Attachment 1 – Key graphical analyses of financial and historical data for the PPO plans

Attachment 2 – Key graphical analyses of financial and historical data for the HMO plans

Attachment 3 – Semi-Annual Health Plan Financial Report PowerPoint

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