MEETING

STATE OF CALIFORNIA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

BOARD OF ADMINISTRATION

PENSION & HEALTH BENEFITS COMMITTEE

OPEN SESSION

CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM

FECKNER AUDITORIUM

LINCOLN PLAZA NORTH

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SACRAMENTO, CALIFORNIA

TUESDAY, FEBRUARY 20, 2024

11:24 A.M.

JAMES F. PETERS, CSR
CERTIFIED SHORTHAND REPORTER
LICENSE NUMBER 10063

APPEARANCES

COMMITTEE MEMBERS:

Ramón Rubalcava, Chairperson

Kevin Palkki, Vice Chairperson

Malia Cohen, represented by Deborah Gallegos

David Miller

Eraina Ortega

Jose Luis Pacheco

Theresa Taylor

Yvonne Walker(Remote)

Mullissa Willette

BOARD MEMBERS:

Fiona Ma, represented by Patrick Henning

Lisa Middleton

Gail Willis, PhD(Remote)

STAFF:

Marcie Frost, Chief Executive Officer

Matt Jacobs, General Counsel

Kim Malm, Deputy Executive Officer

Donald Moulds, PhD, Chief Health Director

APPEARANCES CONTINUED

ALSO PRESENT:

Tim Behrens, California State Retirees

J.J. Jelincic

Rosemary Knox

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PROCEEDINGS

CHAIRPERSON RUBALCAVA: Hello, everybody. We're going to call to order the Pension and Health Benefits Committee. And the first order of business is roll call, please.

BOARD CLERK ANDERSON: Ramón Rubalcava?

CHAIRPERSON RUBALCAVA: Present.

BOARD CLERK ANDERSON: Jose Luis Pacheco?

VICE CHAIRPERSON PACHECO: Present.

BOARD CLERK ANDERSON: Deborah Gallegos for Malia Cohen?

ACTING COMMITTEE MEMBER GALLEGOS: Here.

BOARD CLERK ANDERSON: David Miller?

COMMITTEE MEMBER MILLER: Here.

BOARD CLERK ANDERSON: Eraina Ortega?

COMMITTEE MEMBER ORTEGA: Here.

BOARD CLERK ANDERSON: Kevin Palkki?

COMMITTEE MEMBER PALKKI: Good morning.

BOARD CLERK ANDERSON: Theresa Taylor?

COMMITTEE MEMBER TAYLOR: Here.

BOARD CLERK ANDERSON: Yvonne Walker?

COMMITTEE MEMBER WALKER: Here.

BOARD CLERK ANDERSON: Mullissa Willette?

COMMITTEE MEMBER WILLETTE. Here

CHAIRPERSON RUBALCAVA: Thank you.

And then the next item is the election of Pension and Health Benefits Committee Chair and Vice Chair. I will --

BOARD CLERK ANDERSON: Chair Rubalcava, I -- the attestation for members.

CHAIRPERSON RUBALCAVA: Attestation. Thank you. Of course. Of course.

The Chair of the Committee. Sorry -- of the Pension and Health Benefits Committee will need to read -- okay. I started at the wrong spot. Sorry, folks. Good morning, Board members. Because we are -- we are not all present in the same room and Board members are participating from remote locations that are not accessible to the public, Bagley-Keene requires the remote Board members to make certain disclosures about any other persons present with them during open session. Accordingly, the Board members participating remotely must each attest either, one, that they are alone, or two, if there are one or more persons present with them who are at least 18 years old, the nature of the Board member's relationship to each person.

At this time, I will ask each remote -- each remote Board member to verbally attest accordingly.

Please conduct the roll call.

BOARD CLERK ANDERSON: Yvonne Walker?

COMMITTEE MEMBER WALKER: Yes, I attest.

CHAIRPERSON RUBALCAVA: Thank you.

Now, at this point, I passed on the gavel to Mr. Pacheco.

VICE CHAIRPERSON PACHECO: Thank you. I will now take nominations for the Pension and Health Benefits Committee.

Kevin.

COMMITTEE MEMBER PALKKI: I'd like to nominate Director Rubalcava.

VICE CHAIRPERSON PACHECO: Director Rubalcava is nominate -- his nomination is made.

Are there any other nominations?

Are there any other nominations?

Are there any other nominations?

I have a motion to approve Ramón Rubalcava as Chair. Please do a roll call vote.

BOARD CLERK ANDERSON: Jose Luis Pacheco?

VICE CHAIRPERSON PACHECO: Aye.

BOARD CLERK ANDERSON: Deborah Gallegos?

ACTING COMMITTEE MEMBER GALLEGOS: Aye.

BOARD CLERK ANDERSON: David Miller?

COMMITTEE MEMBER MILLER: Aye.

BOARD CLERK ANDERSON: Eraina Ortega?

COMMITTEE MEMBER ORTEGA: Aye.

BOARD CLERK ANDERSON: Kevin Palkki?
COMMITTEE MEMBER PALKKI: Aye.
BOARD CLERK ANDERSON: Theresa Taylor?
COMMITTEE MEMBER TAYLOR: Aye.
BOARD CLERK ANDERSON: Yvonne Walker?
COMMITTEE MEMBER WALKER: Aye.
BOARD CLERK ANDERSON: Mullissa Willette?
COMMITTEE MEMBER WILLETTE: Yes.
VICE CHAIRPERSON PACHECO: The motion passes. Congratulations.
CHAIRPERSON RUBALCAVA: Thank you, everyone, and thank you for your continued support. I will now take nominations for Vice Chair of the Pension and Health Benefits Committee.
VICE CHAIRPERSON PACHECO: Yes.
CHAIRPERSON RUBALCAVA: Mr. Pacheco?
VICE CHAIRPERSON PACHECO: So I nominate Mr. Kevin Palkki.
CHAIRPERSON RUBALCAVA: A nomination of Mr. Kevin Palkki has been made.
Are there any other nominations?
Are there any other nominations?
Are there any other nominations?
I have a motion to approve Kevin Palkki as Vice Chair.

Please do the roll call.

BOARD CLERK ANDERSON: Jose Luis Pacheco?

VICE CHAIRPERSON PACHECO: Aye.

BOARD CLERK ANDERSON: Deborah Gallegos?

ACTING COMMITTEE MEMBER GALLEGOS: Aye.

BOARD CLERK ANDERSON: David Miller?

COMMITTEE MEMBER MILLER: Aye.

BOARD CLERK ANDERSON: Eraina Ortega?

COMMITTEE MEMBER ORTEGA: Aye.

BOARD CLERK ANDERSON: Kevin Palkki?

COMMITTEE MEMBER PALKKI: Aye.

BOARD CLERK ANDERSON: Theresa Taylor?

COMMITTEE MEMBER TAYLOR: Aye.

BOARD CLERK ANDERSON: Yvonne Walker?

COMMITTEE MEMBER WALKER: Aye.

BOARD CLERK ANDERSON: Mullissa Willette?

COMMITTEE MEMBER WILLETTE: Yes.

CHAIRPERSON RUBALCAVA: The motion passes. Congratulations.

COMMITTEE MEMBER TAYLOR: Give us a minute.

CHAIRPERSON RUBALCAVA: Yes.

Thank you. Okay. Now, we'll proceed to the Executive report. Ms. Kim and Mr. Moulds.

CHIEF HEALTH DIRECTOR MOULDS: Mr. Chair, I just wanted to congratulate you and Mr. Palkki, and I will turn

it over to Ms. Malm.

DEPUTY EXECUTIVE OFFICER MALM: Good morning, Mr. Chair, members of the Pension and Health Benefits Committee.

Kim Malm, CalPERS team member. I just have a couple of updates for you today. First, I thought I'd give you an update on our retiree warrant project. To date, almost 3,000 members have checked their -- retirees, sorry, have successfully used our IVR, or phone system, to check their pay warrants since it rolled out in October. I'm pleased to announce that the online link that just rolled out January 20th has already been used over 17,000 times successfully. I know there's a lot of interest in the retiree pay warrant, so I wanted to give you an update on the continued utilization.

And also, as part of my update today, I'd like to let you know that Renee Ostrander, who's the Division Chief over our Employer Account Management Division, has accepted a new position as the CEO of San Joaquin County Employees' Retirement System. Renee has been with CalPERS for over 27 years since September of 1996. I'd like to say thank you to Renee for her continued service to CalPERS members and her public service that continues at San Joaquin County.

Her loss of knowledge is going to be huge for

CalPERS and for the CSS team. So I just want to wish her very well in her new endeavors and say congratulations to Rene for such great service to CalPERS.

And that concludes my comments.

CHAIRPERSON RUBALCAVA: Thank you.

Now, we move on to action consent items.

COMMITTEE MEMBER TAYLOR: Move approval.

CHAIRPERSON RUBALCAVA: Okay. We move approval.

No vote required, correct?

CHAIRPERSON RUBALCAVA: We need a roll call. Okay. Do I have a second?

COMMITTEE MEMBER PACHECO: Second.

CHAIRPERSON RUBALCAVA: Mr. Pacheco seconds.

And now we do a roll call.

BOARD CLERK ANDERSON: Kevin Palkki?

VICE CHAIRPERSON PALKKI: Aye.

BOARD CLERK ORTEGA: Deborah Gallegos?

ACTING COMMITTEE MEMBER GALLEGOS: Aye.

BOARD CLERK ANDERSON: David Miller?

COMMITTEE MEMBER MILLER: Aye.

BOARD CLERK ANDERSON: Eraina Ortega?

COMMITTEE MEMBER ORTEGA: Aye.

BOARD CLERK ANDERSON: Jose Luis Pacheco?

COMMITTEE MEMBER PACHECO: Aye.

BOARD CLERK ANDERSON: Theresa Taylor?

COMMITTEE MEMBER TAYLOR: Aye.

BOARD CLERK ANDERSON: Yvonne Walker?

COMMITTEE MEMBER WALKER: Aye.

BOARD CLERK ANDERSON: Mullissa Willette?

COMMITTEE MEMBER WILLETTE: Yes.

CHAIRPERSON RUBALCAVA: Thank you, everybody.

And the next item is the informational consent item. I haven't received anything to pull, so I'm assuming we're good.

And unless there's anything else, I want to recess for lunch and we'll readjourn[sic] at 12: --55 actually make it 12:50, so we can be sure to be here at 1 o'clock starting to -- so we can start at 1 o'clock for the set presentation.

Thank you, everybody.

(Off record: 11:33 a.m.)

(Thereupon a lunch break was taken.)

AFTERNOON SESSION

(On record: 12:59 p.m.)

CHAIRPERSON RUBALCAVA: Good afternoon, everybody. We're resume -- reassuming[sic] our Pension and Health Benefits Committee with a 1 o'clock set item. And I think we'll start with Mr. Moulds.

CHIEF HEALTH DIRECTOR MOULDS: Great. Thank you, Mr. Chair.

The next item is a first in a series of discussions between leadership of our contracted health insurance plans and the CalPERS Board. Fittingly, we asked Greg Adams, who is the Chief Executive Officer of Kaiser Foundation Health Plan, to kick off the series. He's been CEO of Kaiser since 2019, taking over after the passing of the late Bernard Tyson.

A little bit about the upcoming series. We'll be scheduling meetings between you and leadership of our health plans over the remainder of 2024 and into 2025. The conversations are intended to run about an hour. We'll use the March PHBC meeting to schedule the next discussions, likely two of our smaller health plans, and then we'll take a break during the season when we negotiate health plans rates. We'll pick up again in July.

And a little bit about Kaiser. Kaiser is the

largest plan in the CalPERS Health Program by a lot. It's got about 647,000 CalPERS members. Kaiser offers a California-based plan in our basic portfolio, a very small out-of-state plan, and two Medicare Advantage plans, Senior Advantage and Senior Advantage Summit. With Greg Adams today is Brandon Cuevas who is Chief Executive Vice President -- sorry, is Chief -- is Executive Vice President of the Kaiser Health plan, and Cindy Striegel, who is Senior Vice President of California Sales and Account Management.

I'll say thanks to all three of them for joining us today and turn it over to you.

GREG ADAMS: There we go.

So good afternoon.

CHAIRPERSON RUBALCAVA: Good afternoon.

(Thereupon a slide presentation).

GREG ADAMS: Great to be here. I want to thank you for the opportunity, learning that we are the first in your spotlight engagement with health plans. You know, I'd like to start by just expressing our appreciation to you, to the 647,000 members that we have the privilege of taking care of. And as we kind of engage in our conversations today, I know that our mutual goals are about quality, affordability, access, and frankly improving the health of the CalPERS population, and for us

is improvement in the health of our communities, and we're hugely committed to equity as I know you are.

[SLIDE CHANGE]

GREG ADAMS: Our mission is to provide high quality affordable health care services to our members and to improve the health of the communities we serve.

I had the privilege of stepping into, as you heard, the CEO role in November of -- actually, Bernard passed in November of 2019. I stepped into the role in December. And as you know, in 2020, we all embraced COVID, and so we've been on this journey of really transforming our organization, and through this whole period looking at how we could lean in and provide care to the communities and the millions of people that we serve have.

You know, the pandemic will be a part of my discussion today, because I think in some ways, you know, the public, as a whole, is simply not aware of kind of the post-trauma American health care systems are still going through as a result of the pandemic. I mean, you know, in 2023, we thought we were out of the pandemic. I remember entering in and then we had a huge surge the first quarter of 2023. And we actually didn't disman[sic] our command center until May, June of that year.

So now we're in '24 and we're dealing with, you

know, multiple years of care preventative care, and certain interventions, certain elective care not being provided, because the health care system stopped and focused solely upon caring for the millions of people that had COVID. For us, it was close to 247,000 people that were hospitalized that our people were day in, day out taking care of. Increased utilization by more than 10 percent.

But I want to just pause for a moment. I'll go there, but I want to pause for a moment and just share that, you know, we remain committed to high quality. Over the past years, our commitment -- even as we've gone through all of this, our commitment to quality has been unwavering. You know, if one is a KP member, anywhere we are in the country, including California, you have a 33 percent less likely chance of dying prematurely of heart disease, a 33 percent less likely chance. If you're Black or African American, considering our commitment to equity, you have a 47 percent less likely chance of dying. If one has cancer and you're a Kaiser Permanente member, you literally have a 20 percent less likely chance of dying prematurely of cancer. If your African American, it goes up to 32 percent and so forth.

Our breast, cervical, colorectal, and lung cancer screening is five years better -- or actually, our life

span is five years better, our national average, than the U.S. For our CalPERS members, we've achieved a 90 percentile performance for blood pressure control, for eye examples, and for numerous screening.

Now, the issue I know that is on your mind, and I have to tell you it's on my mind, and it's on everybody's mind in Kaiser Permanente, as we do great in terms of quality, is our commitment to the affordability of health care. It's a part of our mission statement. It's part of who we are. It's part of our DNA. And if one steps back and looks at where we were prior to the pandemic, you know, seven years on average for all of our Kaiser Permanente membership, we had a 4.4 percent increase per year on average.

For our CalPERS patients, we had a three percent increase. For Medicare, it was actually 0.75. For -- if you look at Medicare for all of our patients, I think it was actually a negative 0.175 or 17. So we are absolutely committed to affordability. And you say, yeah, but what happened in 2014, right? What happened in 2014?

We spent a lot of time trying to understand where health care was post-pandemic, where is it going. I mean, you've heard the stories and understand that the facts of labor costs going up 24 percent, drug costs going up, inflation. And even as we see inflation nationally coming

down, we don't see the same decrease in health care.

Recall for those two years, preventative care, elective surgeries, you know, exams, diagnostic studies were delayed, and you had this huge increase. So we had to deal with how do we stabilize our organization and how do we get back to our long-term commitment to affordability and our long-term single low or middle digit rate increase.

We are a health plan and we are a delivery system, so we were facing those expenses real time. And as we looked at it, we made a decision that we can either struggle coming out of this over a three-year, four-year period of time, and in that period of time not be able to provide full access, not to be able to provide the kind of quality and the kind of services that we provide or we should own what has happened in terms of escalation, inflation own it now, fix the systems.

And I want to talk just a minute about our systems. You know, if you think about it, prevention, it is, you know, basically reaching out, getting people in, kind of knowing where they are in terms of screening et cetera. It is chronic disease management. It is case managers touching, going into homes. All of that was stopped. And so the question was how do -- how do we hardwire and reconstruct all of those systems.

We gave ourselves, and I said to the organization that we will lead the nation in reestablishing quality and reestablishing our systems or have a model called Care Without Delay, where we kind of look at our patients across the continuum and make sure that they're getting the right care at the right time with the right outcome. All of that was broken. How do we reinvest, how we re-establish all of that?

And that is what is -- it's called -- I call it our secret sauce. It is what allows us to have the quality, and have the outcome, to have the performance that we all so much want for ourselves and frankly for the rest of health care in this country.

So we made the decision real time, had an increase that was higher than we've had historically. And we're on a path to actually, as I said in 2025, get back to that single digit increase. I do want you to know that even during this period of time, and I've -- that, you know, in 2021, when we -- as we looked at inflation - we call it bend the curve - we reduced our costs by $2.3 billion. In 2022, in comparison to where the market was, we set a goal and reduced it by $3.6 billion. In 2023, in the middle of all that we were dealing with, internal holding positions, negotiating tough, we reduced our costs by 3.1 billion. And today, as we look at where we are in

our commitment to getting it getting back to kind of our path of continued affordability, we have, in our current budget, a forecast of reducing our costs by $3.9 billion.

So I hope that you hear from me that in terms of your goals for your population and our goals for our members that we're aligned. We like, you know -- all of us have had to deal with, how do we readjust, how do we restructure, how do we modify our approach based upon COVID and we've done that. And I think we're on a path, and we will continue to return to where we've been historically.

I do want to just mention a moment our commitment to community health, because it is about quality. It's about affordability. It's about also improving the health of our communities.

[SLIDE CHANGE]

GREG ADAMS: We are very focused on the communities we serve, very focused on the issues of equity and access for those communities, and, you know, during this period of time played a significant role and will continue to play a role in making sure that our communities are supported with the right resources, the right tools, and the model for that that sometimes people struggle with. But if you think about it, our population -- our CalPERS population, or our KP population

is only as healthy as the community in which it exists.

Our members, your employees, our patients are only as healthy as the population that they're in. So our providing care, focusing on the health of our population, and focused on the health of the communities we serve is really a part of what allows us to be the organization that we are. I know there are a lot of questions. I'm going to stop there and welcome your question and welcome the opportunity to dialogue.

CHAIRPERSON RUBALCAVA: Thank you. Thank you for joining us. I think we really have been looking forward to hearing from Kaiser, because as you pointed, 2020 -- this current plan year was quite an outlier. And I was pleased to hear that you -- that Kaiser remains committed to both quality and affordability.

And so let's -- before I ask questions have colleagues -- from our colleagues, I want to ask -- so what actions is Kaiser taking to make sure that Kaiser returns to the single digit rate increases that we've seen in the past? I mean, Kaiser used to be -- pride itself in being a low-cost, affordable, point-of-entry for working people, and we haven't seen that. We've seen the opposite trend.

GREG ADAMS: Right. Well, I think you've seen it up until 2024. I mean, I know there's a risk adjustment

model that our teams are talking about the implications of that. But the three percent increase in our expenses or our cost is what we've bought forward. And then there's been kind of an adjustment based upon your risk model.

And then, as I said, 2024, I think, we actually came in about nine percent. And that was really reflective of, again, post-COVID and all the things that we were dealing with.

But -- so let's speak to it. You know, in 2021, our operating margin was 0.6, which is about $600 million on a basis -- you know, essentially, 100 million -- $100 billion company in '21. I think we're at 95 billion. In '22, we lost 1.3 percent, so we lost about $1.3 billion. In '23, the year that we just finished, we made about $300 million. Now, we need about a two, three percent margin in order to actually kind of operate. So for that three-year period, we actually came in at about a 4 percent negative margin. So we actually lost money from operation. And again, that is just, you know, kind of framing kind of the reality of our situation or at least the situation that we've been in as we come out of COVID.

So what did we do? I mean, one, remember, all health systems lost people. I mean, they lost nurses. They lost doctors. And we went through this period where everybody was having to pay agency nurses, you know, and

they were making 273 percent of margin. I mean, it was a crisis. I mean, you know, our -- the American health care system is coming out of a crisis, health delivery systems, not health plan. And remember, we're both. And we're coming out of that now in terms of the fracture.

And, you know, if you look at across the country right now, and even in California, we're seeing health systems that are having to say to health plans we can't provide care unless you pay us more, because frankly, we're -- the cost is -- we're losing money. They're now not hiring those agency nurses, which means OB units are closing, ED units are closing, because they can't. And so we're in this period of time -- and remember, we said we're going to own it once. The other health systems are having to own it, you know, year one, year two, year three, because of the contractual relationships that they have with health plans. And frankly, health plans are pushing back. So we are kind of caught up in this place where, you know, as a system we're having to work through this.

For us, it is address it once in 2024, and then to your point -- and what are we doing to go forward. So I want to just talk a little bit about that. I mentioned that in '24 that we're looking at taking $3.9 billion out of our cost structure. So let's talk about -- I'll just

talk a little bit about how we're doing that. So in our hospitalization, in our continuum model -- and again, we work really hard to make sure care is being provided at the right place, at the right time, with the right outcome, for the right patient. You know, in this 2024, we're actually looking at taking $1.8 billion out.

In our ambulatory operation, which is, you know, we're looking at how do we kind of own where virtual care works, but we're also having to measure do we have quality with virtual care. One of the things that we're seeing with virtual care is it's actually increased costs, because people will be on the video with their doctor and it leads to an appointment. I mean, right, if they'd just come in initially for -- they would have actually gotten treated, had the right outcome, and we wouldn't have had one or two virtual visits.

So we're having it -- you know, even as we kind of come out of this thing with virtual care, we're having to get clear on where does virtual care produce the right quality, the right outcome, and where is it really efficient for us to do so? So ambulatory care we're looking at how do we take out you $700 million; pharmacy, $600 million. Administratively, I mean, we've reduced our administrative footprint. We've reduced our dollars over this -- dollars -- our cost over this period of time. And

between administration -- administrative costs, and redesign costs in 2024, we're looking at taking out $800 million.

Now, beyond 2024, which is really, I think, the -- you know, how do we stay there, because one -- I should kind of mention for a moment, kind of through the middle and toward the end of the pandemic, McKinsey, the big consulting company, very credible, looked at what COVID did in terms of en -- you know, we've now introduced a new illness into our -- into our lives, right, that has -- you've got COVID that we're still experiencing. You've got long COVID. So McKinsey -- and we had the inflation. So they looked at it and said essentially what we've introduced into the health care system is another $600 billion that we will all have to absorb over that period of time.

Now, we looked at what our part of that was, and I think it was like six plus billion, and we're focused on, you know, how do we reduce, how do we make sure that we -- I mean, all of this effort around taking costs out of it, trying to make sure that we adjust care, service, outcome, administration, costs in a way that we are able to absorb that without having to pass it on.

One of the things that McKinsey and that the national consultants say is that if we could move our

country more toward value-based care, and that is Kaiser Permanente's model, that we actually could save nationally more than a trillion dollars. So when we think about -- so, one it is, all the things that we can do from a system, from making sure that we're providing the right care, at the right time, with the right outcome, all of that we're doing, but we're also looking at how do we double down on our model, the outcomes, the evidence to make sure that we're eliminating variation where it exists. And we do have some.

And so I'm going to stop. But I think the answer is it's everything that we're doing. It is what we do every day. It is what I wake up every day doing. It is what our two hundred and, you know, thirty thousand employees and physicians are focused on. And the assurance that I will give you is that, you know, it's not -- this is not about just words. It's about who we are. It's about what this organization is about.

CHAIRPERSON RUBALCAVA: Thank you.

GREG ADAMS: So we will deliver.

CHAIRPERSON RUBALCAVA: Thank you.

I'll continue, unless we have other questions from the Board. A related issue --

COMMITTEE MEMBER TAYLOR: I have my hand up.

CHAIRPERSON RUBALCAVA: I don't -- I don't see.

I don't see the names. Anyway, I'll be quicker here, so if other people have questions.

You mentioned risk adjustment. I think we -- that system is in place - I'm sure your staff can tell you - to compensate for the -- Kaiser has a -- from what we understand, has a very healthy population from CalPERS group, and that's why we have that. But even given that, because they're healthy and they can walk away, and a 13 percent rate increase doesn't -- isn't attractive. A lot of people -- you lost a lot of members. So maybe you can speak to what actions are you taking -- Kaiser taking to win back a population that was lost?

GREG ADAMS: You know, no -- no

CHAIRPERSON RUBALCAVA: Or is it something that you plan to do that you wanted a -- for capacity question, that's something I keep hearing too.

GREG ADAMS: Thank you. I mean, I think it's a very fair question. You know, and again, I am not the expert on the risk model and I know people are owning that and looking at it. But I do want you to understand, or I do want to say, that the model doesn't take into account the thousands and the millions of things our physicians do, that we are -- staff do that we don't charge for. I mean, we don't charge for the times people email their physicians and the number of times our physicians respond,

and we could go on and on.

So from Greg Adams - now, the experts will look at it - I don't know that it's about our having a healthier population. I think it's about how we provide care. I mean, when we say that if you're a Kaiser Permanente member, you've got a 33 percent less chance -- less likely chance of dying, of premature heart disease, that doesn't just happen because you're healthy. That happens because of all the things that we do and the ways that we touch our members to keep them healthy. And that's not kind of reflective when you're comparing, trying to compare apples to apples. And it's not reflective in the way we charge. So, one, I guess people are going to work that -- work that out. But I just -- what I ask is to kind of keep that in mind. And remember, it's in every market. So it's not just -- so, I mean, it's about what we do.

The other thing I would say though in terms of what do we do, right? The other commitment that we made coming out of the pandemic -- remember, if any of you have had people that are receiving health care now, whether they're in Kaiser or out of Kaiser, you know, you hear the stories of the delays, the can't get this for this period of time. We made a commitment remember that we really work hard and would lead the nation in getting back to

where we are. You know, as I sit here today, we have reestablished our primary care access to where it was before the pandemic. And our goal is to actually exceed that. I mean, we're almost there in terms of specialty care. I mean, we've been on a March to look at all the surgeries that were delayed and to get them done during that period of time. So I think we're doing all the right things, but I think to your point at the end of the day, it's going to be about, you know, in '25 where are we in terms of rates, you know. And is everything that we're doing kind of moving us toward that single digit mid-increase? And, you know, my answer is it is and it will.

And then in '26 where are we? So I hope that as we are able to deliver on our commitment around affordability, as we're able to kind of hardwire and restructure our system and hopefully lead the nation in doing that, that we'll have a story to tell and people will be experiencing us in a way that they will -- they will come back and want to be a part of our organization.

CHAIRPERSON RUBALCAVA: Thank you, Mr. Adams. I want to leave -- allow my colleagues to speak. And so we'll start with President Theresa Taylor.

COMMITTEE MEMBER TAYLOR: Thank you. Thank you, Mr. Chair. Thank you very much for your presentation and

we do really, really appreciate you coming and talking to us, because yes, we all are concerned about this. But I have a couple of bones to pick I think is what I would call it.

You -- at the very beginning of your presentation, you talked about labor costs. And I have an expectation, as we all do, that we think that we're going to price in labor costs as they come up, right? We know that we're going to have to pay our labor and contracts are coming up, et cetera. So those -- I have an expectation that you guys are pricing those in. So that shouldn't be part of your issue for price increases.

I think even with your single digit increases, and we have had -- I've been on this Board for about nine years. We have had fights with you even back then, right, where we were trying to contain those prices and have to fight to get it down to where we thought was reasonable. But I will tell you as a person -- as a State employee who goes in my job and gets told by my members that in January I can't afford this, right? My -- I have five kids. I can't afford this $100, $200 increase in my health care. A four percent increase even in those good old days were above cost of living.

So I -- and then you mentioned -- I think the other thing you mentioned was our -- I'm trying to -- all

of a sudden my brain has turned off, but the increase in prices, right? Well, I don't think we started seeing that until 20 -- late '22, early '23. So during the pandemic, we were basic -- you probably were dealing with increase in prices of medical equipment or whatever, because of COVID.

GREG ADAMS: Right.

COMMITTEE MEMBER TAYLOR: Then the -- then we had the supply chain issues, and then we had the -- that, but I'm just -- it seemed like during COVID, it was every single year it was okay this is increasing, because -- I mean, we were slowly -- Kaiser was slowly creeping up every year, just like every other health care plan, because of COVID. So we are out of COVID and we thought -- you know, we were hoping our folks wouldn't have to worry about that, and understand they have to deal with inflation too. And when health care inflation normally is higher than regular inflation, and then you -- this kind of increase happens, my -- you know, our members are very upset and they can't afford it. You know, I have members that make as little as $15 -- minimum wage, $15 an hour. A huge health care increase for them is very impactful.

So as Mr. Rubalcava talked about, that's great that you're working to bring it down, but it has to come

down pretty fast, right? We can't -- we can't see this for several years in a row. So how do you plan on making sure that that's the case, that it is coming down substantially? And then how do we account for -- we know that Kaiser was looking at building out of state, et cetera. How do we account to make sure that that is not -- those costs aren't being covered by California people?

And then finally, I think my last thing was you were talking about the stats of healthy folks. And I think we could actually pull those stats. I mean, you know, we do have healthier lives in Kaiser. You have a very large population, so it helps, because you have a good mix of population as well.

But I also think that young folks used to gravitate towards Kaiser, because it was low cost. And if you're not providing that anymore, then where do our young folks with kids, and you know folks go? So these are my questions.

GREG ADAMS: Thanks. And I'll try and speak to them. I may not land everything, so -- and that's okay. I mean, just feel free to say, oh, you didn't land that.

You know, part of what happened during COVID was remember people left health care. The agencies came in with these huge costs and people left to go work for

agencies. So the escalation of costs was just real. You know, in 2020, right into COVID, our expense trend was 1.7. In 2021, we actually had an expense trend of 0.9. So we -- even in the middle of COVID, we were working very hard, and then 2022, 3.4, '23, 3.2. So, you know, the dynamics of kind of what was driving kind of the increase in COVID, I mean, it's -- you know, we can do it on paper, and yet it is complex, and I understand.

You know, so the labor cost wasn't fully there in terms of what we were experiencing. You know, one of my jobs, you know, one of the responsibilities I have is that, you know, we are a large labor organization. I mean, probably 80 percent of our employees are, you know, organized employees, right?

And so we value labor. We value our relationship with labor. And I will tell you, you remember in the middle of this, we had bargaining with the coalition. It was the largest health care strike in history, 88,000 people. And we were there thinking about the conversation we're having, you know, and the need for health care to be affordable, thinking and understanding that, you know, these 88,000 people had been on the front lines taking care of people. Some of our employees died during this.

COMMITTEE MEMBER TAYLOR: Yes. Yeah.

GREG ADAMS: We lost employees. We lost

physicians during this period of time. So I'm there trying to own all of this. And I was there at 5 o'clock in the morning when we landed that contract. And I walked down to the 500 people to say we did what was right and it was tough, because we had to kind of work through, you know, how do you balance all of this and how do you -- you know, how do you educate and kind of grasp all of this in the -- in the middle of it.

So it -- you know, to your point, you know, some of this did occur real time. So it wasn't we've got the contract and now, you know, we've built it in going forward. And part of that agreement with labor was owning the fact that we've got to be more affordable, and how do we do that together, and how do they participate with us in doing it.

So I think --

COMMITTEE MEMBER TAYLOR: Mr. Adams, let me ask you a question.

GREG ADAMS: Yeah.

COMMITTEE MEMBER TAYLOR: Do you think that it -- do you think the labor strike and this increase in labor then was predictive, because folks left because it was so much work for the pay they were getting. So do you -- you know, is that something where that's predictive, right?

GREG ADAMS: Well, you know, for us, Kaiser

Permanente, we have a commitment to pay at market or at least 10 percent above. So our people -- you know, and we have great benefits, as you probably know, if you've -- so you know, -- so we -- and, you know, we have to own what people were going through.

So I don't think it was -- you know, there's a lot involved in those negotiations, and where people were, and what people were experiencing in terms of what had happened in terms of inflation, and the fact that I'd been there giving my life, right? And so it was a moment where we all had to come together to really -- you know, really work it through. And I think we did. And there is a commitment to continue to work with us in terms of affordability and the things that we've got to do going forward.

You know, in terms -- I do want to speak just briefly to the out-of-state, because, I mean, I think it's a really important and relevant question that I appreciate your asking and I appreciate your giving me the opportunity to respond.

Remember I said that most of authorities when they look at American health care say that if we could move the nation as a whole toward value-based care, that we could take out a trillion dollars. Our health care system is broken. It doesn't matter where you are in our

country, it's broken. And yet, what we see happening now is we see large, mainly mostly for profit -- and I'm not beating up on for profit, but, you know, we're -- we are who we are as a nation, but amassing scale in terms of membership and numbers. We see them beginning to integrate physicians into that model. You know, one of the things that COVID did was it showed us that our pharmacies could also be a participant in care, right? And so now we've got health plans and pharmacies coming together.

So, I mean, I think our view is that we -- one, we're fragmented and we're fractured. Two, that as a nation, there isn't anyone really owning, you know, what we need to do to actually strengthen and kind of hold up our community health and our community health systems.

So Kaiser Permanente for many years has been asked by other health system help us, help us be who you are, help us provide the kind of care that we've talked about, so that the outside work, the rise at work is really about us partnering with community health systems, bringing to them our value-based care model, our tools, our resources. But it's also an opportunity for us to learn from them to disrupt to find more efficient ways of doing, right, because we've been in one model, and the world isn't going to always be in a -- you know, it's not

going to be -- everybody is not going to be in our model.

So in terms of our mission, there is this -- you know, we've got a commitment and a goal how do we help? How do we help community health systems? How do we help them learn Value-based care? How do we -- how do we begin to create kind of a path and a future for our community health systems so that they can survive in this competitive environment and can continue to provide community based health care.

You know, when I -- and I want to be -- I always want to be careful, because I think some of these organizations have got great missions. But if you look at what held health care up in this country during COVID, it was our community health systems. It was our hospitals, right? And yet, they're struggling now to survive, because, you know, they're struggling with what they're being reimbursed. So that effort is really about can we -- can we move value-based care forward in a bigger way in this country and can we begin to help the nation understand what is needed for health care, and the path that we're on, and the fragmentation that we're on isn't the right place for our organize -- for our country, we think, so...

And then I want to say finally, you know, these are healthy organizations. We're not buying them. They

are actually bringing their assets in in this new organization, so they're coming together. They're bringing their assets in. And what we're doing is bringing in the value-based, the clinical, the evidence-based outcome, all the things that we do. So, I think in the end, we -- California will benefit from what we learn and I hope that Kaiser Permanente, and I hope you guys would hope that we can play a role in helping us solve some of the problems that our nation has in terms of health care.

CHAIRPERSON RUBALCAVA: Thank you, Adams.

COMMITTEE MEMBER TAYLOR: Thank you.

CHAIRPERSON RUBALCAVA: Mr. Pacheco.

COMMITTEE MEMBER PACHECO: Thank you. Again, thank you, Dr. -- Mr. Adams for your presentation. I really do appreciate it. And yes, I -- these are -- these are incredible times in terms of our health care system and the complexity, especially after COVID. I'd like to ask you a question specifically in the area where I'm from. I'm actually from -- was born and raised in Watsonville, California. So, the Monterey Bay Area, Salinas, that's my whole area. And I know Kaiser has been expanding into the Northern California county. It's been encouraging, but we've been -- and we've been -- but we've been here before, as your previous efforts have not been

very successful. What are you doing differently this year to make this new service area a reality for the folks that live there and is there a timeline for a full county expansion? What are you doing in other parts of the state to bring high quality affordability to -- you know, to our CalPERS members.

Thank you.

GREG ADAMS: Thank you. That's a great question. You know, I was the President of Northern California when we kind of went into Santa Cruz and worked with Watsonville hospital. Because even as we were going there, we found it difficult to get local hospitals to work with us. And I get that, in terms of, you know, we're seen as a competitor. We certainly hope that by -- when we're in these communities, as we say, we improve the overall health of them. So we are and have been focused for -- even when I was the President of Northern Cal, which has been a number of years ago, I was trying very hard to bring us into Monterey.

We have a challenge there in that it -- the local hospitals have been somewhat reluctant to contract with us. So we are -- we did -- using the Watsonville Community Hospital, as we've identified, I think it's some 20 zip codes going in that we're going in with first. We're continuing to work with those local community

hospitals to really look at how we can create a win-win situation for them. And so what I will say is we're not fully there because of a lack of trying. There is a tremendous amount of lack of try -- of trying on our part and we're not going to give you up. So we're not giving up, but we are having to work it with the local hospitals to make sure that they -- you know, and they look at it in terms of, gee, are you going to build a hospital and what does that mean, right?

And so we've been very clear that's not a part of the strategy, that's not a part of the plan. So we are working with those organizations. And anything you can do to put a little whisper in the ear, that would be greatly appreciated. So we are doing that. I think the other thing is we look at other parts of California and we are kind of looking at some of the areas that are more rural that we've not been in. There is work underway in terms of how could we support those communities.

You know, one of the things that we had hoped that virtual care was really going to help us with expansion. And you just heard me say that we're having to look at does it really produce the outcomes in every case? But we are still looking at, you know, how can we use virtual care? You know, are there different ways in some of the smaller communities that we've not in -- that we've

not been in historically in California? Where there are gaps, we're looking at how we can fill them. So that work is underway.

Cindy, did you want to add?

CINDY STRIEGEL: Yeah. Just to add, you had asked timing. So January of '25. It is pending approval. So we're -- we are -- we have high hopes that it will be approved by then. And it is 14 zip codes. The northern part, which has access to the Watsonville community hospital.

COMMITTEE MEMBER PACHECO: So it's -- so from like Watsonville, Monterey, Pajaro, that whole --

GREG ADAMS: Yes.

CINDY STRIEGEL: Right. It's the, yep, the northern. And then because it's not full county, it is just commercial. So until -- Medicare requires that we're in the full county. They don't do split zip code counties. So because we're not in every zip code in the country, they won't allow you to go in and offer Medicare. So until that happens, it will be commercial only.

COMMITTEE MEMBER PACHECO: So the commercial aspects of the county then.

CINDY STRIEGEL: The commercial memberships.

GREG ADAMS: Converge.

COMMITTEE MEMBER PACHECO: Commercial

memberships.

CINDY STRIEGEL: So under 65, if they're not Medicare and they're covered as a early retiree or an active member, that would be considered commercial. They would be eligible in those 14 zip codes. If they're Medicare, even in those 14 zip codes, we are not able to offer them yet.

COMMITTEE MEMBER PACHECO: And the 14 zip codes are -- is just the beginning. That's just the start -- starting point.

CINDY STRIEGEL: That -- Yep.

COMMITTEE MEMBER PACHECO: And hopefully, that would be expanded if we get more approval, correct --

GREG ADAMS: That's correct.

COMMITTEE MEMBER PACHECO: -- is that my understanding?

GREG ADAMS: That's correct. And just so you know, I personally have been on the phone working this to make it happen. So, I mean, there's a huge commitment here and we've got to find a win-win.

COMMITTEE MEMBER PACHECO: Excellent. Thank you so much for your comments. I really do appreciate this. This is a -- this is a very huge priority for us. Thank you.

CHAIRPERSON RUBALCAVA: Thank you, Jose Luis.

David Miller, please, next.

COMMITTEE MEMBER MILLER: Thank you. And again, welcome. Thank you for coming in and spending some time with us. I want to kind of shift and talk a little about behavioral health. And it's been an ongoing issue for a long time. Pre-pandemic, and I won't say post-pandemic, because we're still -- it's a pandemic. And I'm sure you're very aware that this continues and we continue to have this struggle. But it did certainly change both the environment and people's awareness on mental health and behavioral health issues. But over the last decade or so, you know, it's really come to us as a Board and me personally from members and others, the challenges that they face accessing quality, behavioral health services, both in terms of timely, appropriate care, and access. And the pandemic certainly made that worse. It certainly increased the need, made the public's awareness, our awareness.

And for Kaiser, you know, it's where we hear it the most, where I hear it the most, but partly that's a matter of scale and a matter of the fact that Kaiser has been, I want to recognize, out front in this area in a lot of ways, certainly, if you look nationwide. But we're here in California. Our members have, you know, expectations that may be higher than typical. And so, I

would ask, you know, what is Kaiser doing to improve the quality and access for behavioral health services, for our members, given, you know, some of the unfortunate history with Kaiser and the issues that have been raised by regulatory agencies, Department of Managed Health Care, et cetera. And we don't have to go into all the particulars, but, you know, where are we going from here.

GREG ADAMS: Sure.

COMMITTEE MEMBER MILLER: What's the good news that we can take home and to reassure our members?

GREG ADAMS: Two things. One, I actually acknowledge and thank our regulatory organizations. I appreciate our labor union that represents our therapists, because I think we all, again, own the fact that mental health is, you know, a condition that as a society we've not understood, we've under invested in. And suddenly, you know, we're facing a crisis. You probably know nationally, mental health issues are up 39 percent. Within KP, our data shows that we're up by 36 percent.

So we've been in the middle of this. And, you know, it was -- we were in it before COVID. COVID really amplified it and we've had to move really fast and hard to really kind of embrace the work that we've done.

One, you know, our clinicians, and we have amazing therapists and amazing physicians, are very

focused on understanding evidence-based mental health care. I mean, you know, we talk about mental health as if we understand it and if we've got all the -- you know, the treatment that we've got for physical health, and we don't. And we're -- you know, so there's -- we're putting dollars and resources into how do we understand what treatments, you know, produce what outcome, and how do we get people healthy.

And so, I think, in many ways, we're leading the nation. And some of that has come out of, you know, all the challenges we had. But we're leading the nation in understanding. We know now, for example, how to treat post-traumatic stress and get the outcome that says gee it works. So I mean, some amazing clinicians that are doing amazing work.

In 2024, we will spend, get this, $2.1 billion on mental health in California. That's up 900 million from 2021, so in terms of the -- you know, the investment that we're making. And the things that we're doing, one, is evidence based. How do we understand that if we do these interventions, it will produce the kind of health that we're focusing on. So that work is occurring.

We've put -- and these are what we've invested in self-care. And self-care, you know, especially when you talk about AI, is going to become a huge part of care in

the future. And so we've invested in self-care modules that are -- again, our members are accessing without cost, going back to that whole risk model that's -- and it -- literally, we're tracking it from a research perspective. And it's showing that it's preventing people from going over and having to go into more clinical care. So we're investing in understanding that.

We've embedded mental health into our primary care modules. So, we've got clinicians that are there working with our physicians and working in a collaborative way. We -- you know, one of the big things that we -- and we've hired, you know, hundreds of mental health clinicians, which is another challenge. But one of the big things that we did was to really kind of begin to work with mental health providers outside of KP. And so that is in place now, where, you know, it varies whether in the north of the south. But, you know, 30 plus, 40 percent of our members are now receiving care outside of the system. And then we're connecting those therapists with our quality program, so that we can monitor and make sure that, you know, they're getting the -- you know, the right level of care and that we're focusing on the right outcome. So we're doing all of those things.

But I also think that going back to those investments that don't show up in a bill, it's about --

we've got to get up to prevention. I mean, what is creating all -- you know, all that we're seeing in terms of the increase in mental health in our society and in our communities. And so we're also working there to look at how do we intervene early. I mean, what does it -- you know, what -- how do we intervene with children and youth? I mean, we did the original study with the CDC around adverse childhood conditions and showed that, you know, there's certain trauma and things that happen early in young people's lives that create mental health issues going forward. So how do we intervene there and begin to provide the kind of prevention that's needed?

But, you know, 2.1 billion, up 900 million. Our members being able to go outside working with community providers, and make sure quality -- and frankly to share all of this with them, so -- and there's more to do and we will -- we will continue to do that.

CHAIRPERSON RUBALCAVA: All right.

COMMITTEE MEMBER MILLER: Thank you.

CHAIRPERSON RUBALCAVA: Okay. We also have trustee Yvonne Walker on virtual, if you can get her.

COMMITTEE MEMBER WALKER: Yes. Okay. I think I'm ready now. Thank you. And I really appreciate the presentation. And I just wanted to get a little more concrete, I guess. So there were a lot of things that

were said and a lot of examples. But I was wondering what are the three concrete things that you would offer that Kaiser is going to do to not only, you know, bring costs down, but, you know, keep access and affordability and everything in place.

GREG ADAMS: Thanks. So I think, one, I mentioned the kind of cost reduction and redesign. I mean, the fact that we're looking at taking out $3.9 billion in 2024. You know, the average health care inflation even now is still at about 7.1 percent. I mean, in our budget for 2024, our inflation is just under 5. Historically, you know, we've been about three -- three, four percent in terms of inflation. So getting back to that kind of trajectory is a big -- you know, it's a big part of this. I mean, we've just got to maintain cost.

The other thing though is that, you know, really, as I said, you know, focusing on outcomes, how do we make sure that our patients are getting the care that they're -- you know, that they're receiving, the outcome that they need. I mean, you know, that drives affordability. I mean, you know, managing -- you know, we talk about managing utilization. And the thing that -- for us, it is not about managing utilization. It is about manning sure our members receive the right care, the right outcome, so the right utilization.

So -- and our systems kind of broke during COVID around that. So re-establishing those systems. And I think, you know, we have with our labor partners, I don't know, I would -- I will get the number wrong, but thousands of unit-based teams, where our employees and our physicians are working daily to look at how do we improve what we're doing, how do we take costs out. The Alliance Union, which is, you know, a 35,000, 40,000 union, in their contract, there's an agreement that they will work with us. And I think the goal was to take out $100 million. And they actually are -- I think are on target to take out 70 million or something.

So I think it is -- you know, we will continue to be diligent about the right care, the right time, with the right outcome, not -- you know, that's good utilization. We will continue to be diligent about our efforts around cost reduction. And we will continue to innovate. I will tell you that we just introduced in the organization ambient technology the system called Abridge, and our physicians that we're kind of rolling it out across the organization, where if you go into the physician's office, the -- it's really kind of AI that's listening, that begins to kind of document for the physician, with the patient's consent. And, you know, we're working it, but it shows that, you know, for primary care that we might be

adding a couple of hours to our physician's day.

So it is really all of those things that we will do. So it's not one or two, and I apologize for it, but it is -- you know, it is managing costs. It's managing utilization. It's really innovating and it's really leading every day from the perspective of, you know, we are committed to that mission statement, which includes affordability.

CHAIRPERSON RUBALCAVA: Thank you, Mr. Adams, and thank you, Trustee Walker.

We also have a question from Dr. Willis remotely.

BOARD MEMBER WILLIS: Good afternoon, Mr. Adams. I just wanted to say I knew Bernard Tyson very well and I wanted to thank you for coming out this afternoon. And your presentation is wonderful thus far.

I have one question and you might have covered this already. I just logged in about 40 minutes ago. Kaiser is currently experiencing low levels of staffing. What do you (inaudible) this issue, the quality of health care for the patients. So can you please explain that to me?

CINDY STRIEGEL: Did you hear the whole question?

GREG ADAMS: I couldn't.

CINDY STRIEGEL: Yeah. Could you -- could you repeat it? Could you repeat it? You cut out a little

bit.

BOARD MEMBER WILLIS: (Inaudible) has low levels of staffing. What are you doing to resolve this issue, because that could affect the health care -- quality health care for the patients?

GREG ADAMS: Yeah. And I don't -- I don't know that I'll get the numbers exactly correct. But remember, when we were in the middle of the coalition bargaining, we talked about hiring 10,000 people that we were going to -- that's done. We -- coming out of COVID, we looked at, you know, how many agency nurses that we were using. We completely revamped our recruitment process. And in 20 -- the last -- and I actually kind of challenged the organization and said by X date, we're going to hire X number of nurses. And I think it was like 6,000 nurses. That was in the middle of 2022. By the end of 2022, we'd actually hired 5,000. In '23, we brought on board another almost 11,000 nurses.

So we are -- we're very focused on, you know, improving our staffing, making sure that we've got the people there to take care of our patients and our members. And it is something that -- you know, so I don't know that I would say, we're short staffed or hugely short staffed at this point. I think we've done a really good job of staffing the organization.

There are still pockets, Dr. Willis. And we're very focused working with our leaders, working with our unions. We're, you know, making sure that we get those positions filled. You know, one of the biggest challenge was physicians. I mean, you know physicians, you know, coming out. It's been huge that -- you know, and there are -- you know, there are equity companies now that physicians are going to. So the whole recruitment -- the space for them to go is different. So we've doubled down this past year working with our medical groups to really go after recruiting, you know, high quality, the right physicians into the organization, and we've been quite successful. So we're really appreciative of that.

CINDY STRIEGEL: And, Greg, one of the things I'll add as an --

BOARD MEMBER WILLIS: Thank you for that.

CINDY STRIEGEL: -- as an example on the nurse side is we needed to evaluate how long it took us to recruit, and hire, and onboard a nurse who was interested. We were interested in them. They were interested in us. So we dropped the number of days that it took us to jump through all of the steps that we had internally and reduce that significantly, so that we actually could hire that kind of volume of nurses in a short period of time.

CHAIRPERSON RUBALCAVA: Thank you, Ms. Striegel.

BRANDON CUEVAS: Yeah, one important piece, too, is as you think about --

BOARD MEMBER WILLIS: Thank you for that.

BRANDON CUEVAS: -- that number is large, you think about the affordability side. A lot of that is also us converting temporary labor into full-time labor, which -- so we're growing the staffing, and it's at the same time saving money as we're converting that over. And then you think about the consistency and quality of people that are full time here versus coming in at part time, which is work that we had to do because of the short staffing that you had during the pandemic.

CHAIRPERSON RUBALCAVA: Thank you, Dr. Willis.

BOARD MEMBER WILLIS: Thank you.

CHAIRPERSON RUBALCAVA: And than you, Brandon. Long time, no see.

I could tell, just by the look of your team, that you have -- you are hiring your executive team from without and promoting from within, so I grant you that.

I want to thank you for presenting to us. I also want to commend Don Moulds for having you here first, because I think you were -- Kaiser particularly is very important to CalPERS. You're the -- has the biggest population and also the biggest rate increase. And it was very imfactful[sic] -- impactful. And next month, we're

going to be looking at the open enrollment numbers.

And we -- then they'll be open -- you know, we're looking forward to these positive initiatives you guys implemented that to bear fruit, and that -- because one thing we always her about Kaiser is you have an internal model, internal -- interrogated model -- integrated model, which I think should serve Kaiser well and our members. But like everybody is saying, it's affordability, it's value, and it's access.

So thank you very much.

ACTING BOARD MEMBER HENNING: Mr. Chair, I just a questions.

CHAIRPERSON RUBALCAVA: Go ahead, Mr. Henning.

ACTING BOARD MEMBER HENNING: I appreciate it.

CHAIRPERSON RUBALCAVA: Go ahead. I didn't see that. You know what, I didn't -- need to. Yeah. Sorry.

ACTING BOARD MEMBER HENNING: Thank you.

CHAIRPERSON RUBALCAVA: I don't -- is that -- no, it's there.

ACTING BOARD MEMBER HENNING: Is this better.

CHAIRPERSON RUBALCAVA: Yeah, you're there. Five and six.

ACTING BOARD MEMBER HENNING: Thank you, all. I just -- I wanted to take just a moment, and a lot of this comes out of personal experience, so it may be more

anecdotal than I generally prefer, but, you know, particularly the other members of the Board brought up a couple issues that really spoke to some things that I've experienced through part of our journey as a family and the Kaiser system. One, particularly is that mental health care system.

The investments that you guys can make, particularly when it comes to youth and teens is incredibly important when it comes to mental health. Not only does that affect the adult results as they continue to get older, but I also believe it affects their health ratios and keeps those costs lower.

So, I would ask, if there's any investments more you could make there, I would really appreciate it.

Sorry. After lunch, my voice gets a little deeper, I guess.

And then lastly, you know, as Chairwoman Taylor brought up, you know, as a statewide elected official that I represent, that sometimes we struggle with the idea that while you have a $4.1 billion net operating income, that our rates are going up. How would you help us explain that to one of our CalPERS members?

GREG ADAMS: One -- and thank you. And that's a good question. You know, I think, as said to you over that three-year period, it actually results in us losing

from operation about -- an actual operating loss, right? So during that period of time, we're actually -- you know, we do have investments, so we're using that investment money. I mean, it's actually -- right? And as we look at kind of our operating expenses going forward, you know, we're not on a path to project that we're going to get back to 2 or 3 percent. I mean, we're being very intentional about we may not -- you know, we'd like to get there, but we may not get there, because we are committed to lower rates. We are committed to redesigning.

We are -- you know, and so every organization coming out of COVID right now have got to look at, you know, how do we do this differently, right? And we were very clear about the value base and what that does in terms of outcome. So what I would say is that we are using those dollars, as you look at -- you know, we may lose, we may be 200 million. I mean, we're actually using the investment dollars. And that will help us kind of mitigate and lower our rates going forward as we continue to redesign the system.

And that -- you know, what I said to the organization, and, you know, I hope almost anybody can tell you this in 2022 is this is what it's going to be like. I mean, we've got to double down on access, service, quality, all -- mental health, all the things

that we were -- you're talking about. We've got to invest in those things and we've got to tight -- you know, the billions that you heard me talk about out. And in '23, it's going to look like this, and in '24, it's going to look like this, in '25 -- So I mean, we frame that for the organization. We're basically saying we don't get back to where we were, and that's with rates coming down. I want to be very clear, right? We did it in '24. And the commitment is they come down as we go into '25 and '26. So we don't get back to where we were in our model until we're really looking at like '25, '26.

So we're committed to, you know, moving back to where we've historically been and we will do that.

Do you want to add, Brandon.

BRANDON CUEVAS: Yeah, just one other small thing is, you know, as Greg said, you know, we're both a payer and a delivery system all in one. And what's not obvious on that number is the amount that we have to keep reinvesting into our infrastructure. That's not -- like it shows up in other places on the balance sheet where you have to reinvest in seismic retrofit. We have to really make sure that our hospitals and everything that we have invested are up to standard. And so some of that money that you see that's being generated is going back into those investments also to make sure that we're keeping

infrastructure built. So, that's probably another big use of funds.

CHAIRPERSON RUBALCAVA: Thank you, Brandon.

Ms. -- Lisa, please.

BOARD MEMBER MIDDLETON: All right. Thank you.

CHAIRPERSON RUBALCAVA: Middleton.

BOARD MEMBER MIDDLETON: Mr. Adams, thank you for coming. Thank you for all the work that you organization has done historically. As I've sat here over the years that I've been on this Board and listened to you and your colleagues in Kaiser and in other organizations, one of the issues that strikes me is the inadequacy of the pipeline of people coming into the health care professions, be it physicians, nurses, or all of the various skills that are required.

So without taking too much time at what you've already expended, I would like to hear more about what you're doing, particularly being able to leverage the reputation that Kaiser has, and how we can help you to increase the number of people who are being trained and who are coming into the professions.

GREG ADAMS: Thank you. And I'll be quick. But for -- I have to do a shout-out for SEIU. You know, we worked with them and we created the Futuro organization. And I don't have off the top the number of people -- and

these are, you know, people who would normally not be able to come into health care as an entry level, that we actually have set up our school, and a program, and we're bringing those people in.

And I -- I mean, it's in the hundreds in terms of the number of people that we've brought. We -- in terms of our community health, we're investing significantly in nursing. We -- I think we've helped close to, I want to say, three or four hundred nurses get advanced degrees in their -- in our organization and in other organizations. We're putting dollars into, as we speak, mental health, a huge challenge for -- that we've talked about. So we are investing there. We are actually in the process of beginning to relook at our graduate medical education program. You know, we have a residency program across our organization and we have residents rather from UCSF or others that come in. We're looking at what can we do to strengthen that program.

So we are, and will continue to be, because I don't think we've solved it yet. But we are continuing to look at what do we do to help people enter the field. And we're also looking at some of our requirements around credentials. I mean, where can we, you know, change some of that, so that people who, you know, traditionally might not have been able to have opportunities, we can work with

them, and bring them in, and support them being successful.

So there is more to come. And I'd be glad to share more with you offline, but we are working it very, very much.

BOARD MEMBER MIDDLETON: Thank you.

CHAIRPERSON RUBALCAVA: Thank you, Ms. Middleton.

Any more trustees want to have questions?

If not, I want to thank you, Dr. -- Mr. Adams, and Ms. Striegel, and Mr. Brandon Cuevas. Thank you. It's good seeing you guys, and thank you for being here. This is very important to us, as you can tell, and we look forward to continuing to work positively for our members.

GREG ADAMS: Thank you. Yeah, and I just want to say I appreciate the dialogue. I mean, it's an opportunity for us to listen. It's an opportunity for us to learn. And I want you to know that as we lead, I mean, we'll carry the dialogue away, as we talk about our commitment to what we're doing, as we lead the organization. And I hope and would expect that in '25, you'll have me back and say you delivered and we're appreciative, or you didn't and we've got a problem.

So thank you. Appreciate the opportunity.

CHAIRPERSON RUBALCAVA: Thank you.

Now, we move into public comment on this item.

Rosemary Knox, please.

ROSEMARY KNOX: Is this on?

Thank you. I have a question for the speaker in regards to understanding a little bit more about the cost. Are they speaking on outpatient side or inpatient side, because there's different cost aspects to the Kaiser health care system? There is the nurse-to-patient ratios for inpatient side that is a cost versus outpatient, which is laypeople assisting the physicians in the clinic area. So what is the actual holdup in the cost, is it inpatient or is it outpatient?

CHAIRPERSON RUBALCAVA: We will --

CHIEF HEALTH DIRECTOR MOULDS: Mr. Chair, we can take these back.

CHAIRPERSON RUBALCAVA: Thank you, Mr. Moulds. Thank you.

At this point, we move on to Summary of Committee Direction.

VICE CHAIRPERSON PALKKI: Two more.

CHAIRPERSON RUBALCAVA: No, no. That's another item.

We'll move to Summary of Committee Direction. Mr. Moulds and Kim Malm.

CHIEF HEALTH DIRECTOR MOULDS: Mr. Chair, I did not record any Committee direction.

CHAIRPERSON RUBALCAVA: Okay.

DEPUTY EXECUTIVE OFFICER MALM: Nor did I.

CHAIRPERSON RUBALCAVA: Okay. Now, we'll move on to public comment. We have two speakers signed up. Mr. Tim Behrens and J.J. Jelincic.

TIM BEHRENS: Good afternoon, Committee and congratulations, Mr. Rubalcava and Mr. Palkki - I hope I didn't butcher that too bad - on your election today or this morning.

Tim Behrens, California State Retirees. I wanted to take this opportunity to say some positive things about health care and ask that the health care team continue to look at alternate dental plans, alternate to Delta Dental. I was fortunate enough last month to be able to talk to Board Member Ortega and was happy to hear that she is trying to tackle that problem and look forward to more dialogue with her and CalHR on that in the future.

Something happened to me last week when I went to my audiologist, I found out that my Anthem Blue Cross pays $2,000 towards my hearing aids. So thank you CalPERS for having Anthem Blue Cross Platinum available to us retirees. That takes a lot of worry away from me.

And then finally, I'd like to thank the CalPERS staff for making it easier to access online monthly warrants -- I couldn't read my own handwriting. It --

I've had a lot of positive feedback just in the last 30 days from our members, and I think it's because April 15th is coming on us, that had worries, and were concerned, and they hadn't got their IRS forms yet. And thank you CalPERS again, because they all were taken care of in a timely fashion, and are moving forward in a positive way.

Have a good day.

CHAIRPERSON RUBALCAVA: To you, too, sir.

J.J. JELINCIC: J.J. Jelincic, beneficiary.

In the world of CalPERS health care, risk adjustment is not related to the health of the insured. It's related to how much the insurance companies pay out. Board policy is not about ensuring against adverse selection, it's about ensuring against adverse provider contracts.

I'm sure the California Medical Association and the California Hospital Association supports such a policy, because it leads to higher reimbursement rates. Over the years, the government has learned it can influence the supply curve. It does so by subsidizing desirable conduct and taxes or hits with surcharges are undesirable contact -- conduct.

It will probably take a criminal investigation to learn why this Board prefers inefficient and high-cost insurers over efficient and low-cost insurers. AG Bonta,

the self-proclaimed chief law enforcement officer of California says his job is to defend agencies accused of illegal activity. It is not to investigate and enforce the law. I ask staff to pass out a handout that I -- and I see they have, that makes some of these points. And I'd like to ask that the handout be attached to the transcript of these remarks.

As you can see, Kaiser negotiated a $33 rate increase. Board policy added $79 to that. And then you complain about a 13 percent increase in premium. Blue Shield Access+ negotiated a $274 increase, and then Board policy gave them a $225 subsidy. And then they're the good guys, because they've got a six percent rate increase.

You really need to focus risk adjustment on the health of the insured population, not the health of the insurance companies.

And I thank you.

CHAIRPERSON RUBALCAVA: Thank you.

J.J. JELINCIC: Will that graph be added to my transcript.

CHAIRPERSON RUBALCAVA: If it's possible, yes.

J.J. JELINCIC: Okay. Thank you.

CHAIRPERSON RUBALCAVA: Um-hmm.

Thank you. That concludes public comment. And

the Committee meeting of the Pension and Health Benefits committee is adjourned until next month.

Thank you.

(Thereupon California Public Employees' Retirement System, Pension and Health Benefits Committee open session meeting adjourned at 2:13 p.m.)

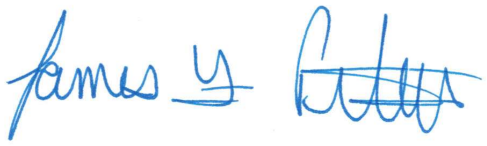
CERTIFICATE OF REPORTER

I, JAMES F. PETERS, a Certified Shorthand Reporter of the State of California, do hereby certify:

That I am a disinterested person herein; that the foregoing California Public Employees' Retirement System, Board of Administration, Pension and Health Benefits Committee open session meeting was reported in shorthand by me, James F. Peters, a Certified Shorthand Reporter of the State of California, and was thereafter transcribed, under my direction, by computer-assisted transcription;

I further certify that I am not of counsel or attorney for any of the parties to said meeting nor in any way interested in the outcome of said meeting.

IN WITNESS WHEREOF, I have hereunto set my hand this 25th day of February, 2024.



JAMES F. PETERS, CSR
Certified Shorthand Reporter
License No. 10063

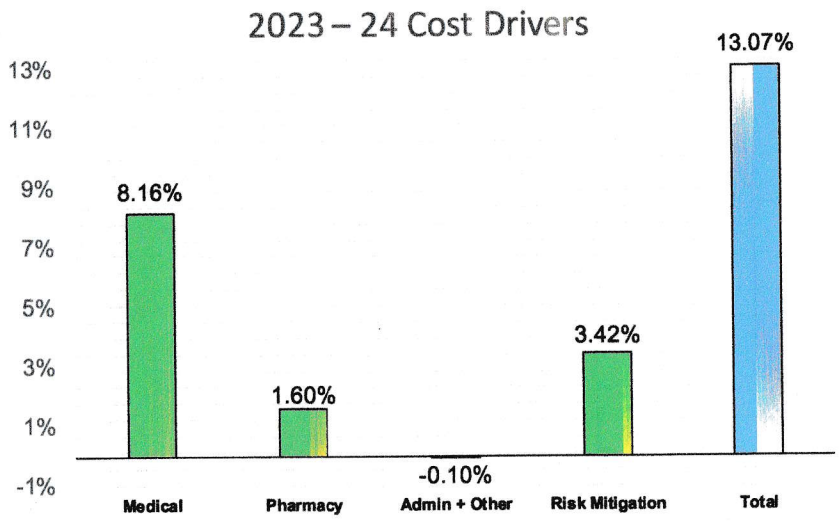
Approval of 2024 HMO and PPO Premiums

Kaiser Permanente (Basic)

2023 Premium	2024 Premium Before Risk Mitigation	Adjusted Risk Score for 2024	Risk Mitigation Impact	2024 Premium	Percent Change from 2023
$852.68	$885.23	0.9312	$78.92	$964.15	13.07%

$33 Negotiated Increase

Board Policy Increase



2023 Total Covered Lives: 550,099

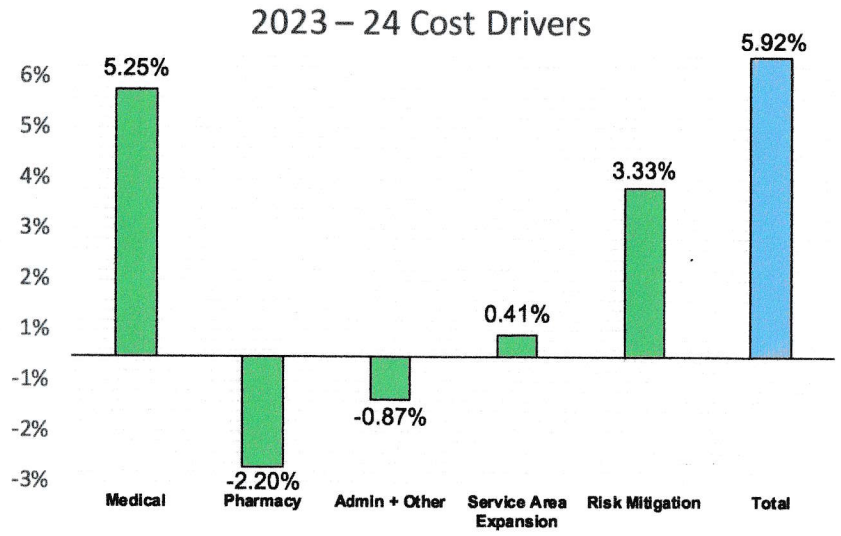
Approval of 2024 HMO and PPO Premiums

Blue Shield Access+ HMO and EPO (Basic)

2023 Premium	2024 Premium Before Risk Mitigation	Adjusted Risk Score for 2024	Risk Mitigation Impact	2024 Premium	Percent Change from 2023
$842.61	$1,116.68	1.2898	($224.19)	$892.49	5.92%

$274 Negitiated Increase

Board Policy Subsidy



2023 Total Covered Lives: 94,876