MEETING

STATE OF CALIFORNIA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

BOARD OF ADMINISTRATION

PENSION & HEALTH BENEFITS COMMITTEE

OPEN SESSION

CALPERS AUDITORIUM

LINCOLN PLAZA NORTH

400 P STREET

SACRAMENTO, CALIFORNIA

TUESDAY, NOVEMBER 16, 2021

2:41 P.M.

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

APPEARANCES

COMMITTEE MEMBERS:

Rob Feckner, Chairperson

Ramon Rubalcava, Vice Chairperson

Margaret Brown

Henry Jones

David Miller

Eraina Ortega, represented by Nicole Griffith

Theresa Taylor

Betty Yee, represented by Ms. Karen Greene-Ross

BOARD MEMBERS:

Fiona Ma, represented by Mr. Frank Ruffino

Lisa Middleton

STAFF:

Marcie Frost, Chief Executive Officer

Matt Jacobs, General Counsel

Donald Moulds, PhD, Chief Health Director

Anthony Suine, Deputy Executive Officer

Kelly Fox, Chief, Stakeholder Relations

Pam Hopper, Committee Secretary

Julia Logan, MD, Chief Medical Officer

Karen Páles, Acting Division Chief, Health Plan Research & Administration Division

APPEARANCES CONTINUED

ALSO PRESENT:

David Haxton

Stephanie Hueg, California State Retirees

J.J. Jelincic, Retired Public Employees Association

Larry Woodson, California State Retirees

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1 PROCEEDINGS
2 CHAIRPERSON FECKNER: Everybody, we'd like to
3 call the Health Benefits and Pension Committee to order.
4 The first order of business will be to call the roll.
5 Before I call roll however, I do want to announce that
6 our -- all our meetings are being transcribed by our court
7 remotely. So you don't see him sitting over here, he's
8 still doing his transition elsewhere.
9 So with that, Ms. Hopper, please call the roll.
10 COMMITTEE SECRETARY HOPPER: Rob Feckner?
11 CHAIRPERSON FECKNER: Good afternoon.
12 COMMITTEE SECRETARY HOPPER: Margaret Brown?
13 COMMITTEE MEMBER BROWN: Here.
14 COMMITTEE SECRETARY HOPPER: Henry Jones?
15 COMMITTEE MEMBER JONES: Here.
16 (Laughter.)
17 COMMITTEE SECRETARY HOPPER: David Miller?
18 COMMITTEE MEMBER MILLER: Here.
19 COMMITTEE SECRETARY HOPPER: Nicole Griffith for
20 Eraina Ortega?
21 ACTING COMMITTEE MEMBER GRIFFITH: Here.
22 COMMITTEE SECRETARY HOPPER: Ramon Rubalcava?
23 VICE CHAIRPERSON RUBALCAVA: Here.
24 COMMITTEE SECRETARY HOPPER: Theresa Taylor?
25 COMMITTEE MEMBER TAYLOR: Here.

1 COMMITTEE SECRETARY HOPPER: Shawnda Westly?
2 CHAIRPERSON FECKNER: Excused.
3 COMMITTEE SECRETARY HOPPER: Lynn Paquin for
4 Betty Yee?
5 No. Karen Greene-Ross for Betty Yee?
6 ACTING COMMITTEE MEMBER GREENE-ROSS: Here.
7 COMMITTEE SECRETARY HOPPER: And, Mr. Chair, all
8 the Committee members are in attendance with Shawnda
9 Westly excused.
10 CHAIRPERSON FECKNER: Thank you, Ms. Hopper.
11 Item 2 will be approval of the November 16th,
12 Pension and Health Benefits Committee meeting timed
13 agenda. What's the pleasure of the Committee?
14 COMMITTEE MEMBER TAYLOR: Move approval.
15 ACTING COMMITTEE MEMBER GREENE-ROSS: Second.
16 CHAIRPERSON FECKNER: It's been moved by Ms.
17 Taylor, seconded by Ms. Greene-Ross.
18 Any discussion on the motion?
19 Seeing none.
20 All in favor say aye?
21 (Ayes.)
22 CHAIRPERSON FECKNER: Opposed, no?
23 Motion carries.
24 Item 3, Executive Report. Mr. Suine, would you
25 like to begin?

1 DEPUTY EXECUTIVE OFFICER SUINE: Yes, please.
2 Good afternoon, Mr. Chair and members of the
3 Committee. Anthony Suine, CalPERS steam member and happy
4 to be with you in person here this month. I was
5 complaining to my son this morning that I had to wear a
6 mask all day in the Board room and, you know, he said get
7 used to it, dad. I've been doing it all year.
8 (Laughter.)
9 DEPUTY EXECUTIVE OFFICER SUINE: So no sympathy
10 there.
11 CHAIRPERSON FECKNER: None.
12 DEPUTY EXECUTIVE OFFICER SUINE: In my update
13 today, I want to share some retirement trends and then
14 give an update on some key activities in our Customer
15 Services and Support Branch. Overall, our retirements are
16 up about three percent looking at this time in 2021 to
17 2020. But if we look more specifically at our three
18 sectors of employers, there are some noticeable trends in
19 there. There's been a significant uptick in school
20 retirements of more than 14 percent, and public agencies
21 are up more than eight percent. Although, in public
22 safety -- in public safety, those have remained fairly
23 stable. So it's really the miscellaneous public agencies
24 that are going up.
25 But those increases are offset by a decline in

1 State retirements of approximately 14 and a half percent.
2 And those are led by a down tick in State safety
3 retirements of 26 percent. So that would be typically CHP
4 or correctional officers.
5 And then I looked back at 2019 to compare, and we
6 are up compared to 2019 approximately six percent overall.
7 And the numbers are fairly consistent in the three groups.
8 And then, President Jones, to answer your question from
9 earlier in the Finance Committee meeting, the total
10 benefits paid in 2021 was 27.4 billion, as documented in
11 Michele, our Controller's, slides. And this number is
12 equivalent to -- comparable to the facts at the glance
13 that you probably use on the website. And that number for
14 19-20 was 25.8 billion. So that 27.4 is comparable, if
15 you use that number out in public, so very comparable.
16 You're spot on on those numbers.
17 So anyway, as our members are navigating their
18 life event of retirement, they're using our counselors and
19 they -- our counselors have continued to service our
20 members. And since January, we've counseled over 50,000
21 members on retirement. Most of those have been phone
22 appointments, but as I've mentioned previously, we have
23 had an uptick in our video face-to-face appointments.
24 We've had over a thousand appointments face-to-face in
25 each of the last few months.

1 Just a great story about that is we had a member
2 who was retiring early to care for her elderly father.
3 She was grieving the death of her spouse and her children
4 moving away to college. She lived alone in a rural area
5 and was able to take advantage of the video meeting. And
6 she just kept reiterating how much -- how nice it was to
7 be able to visit with these counselors face-to-face rather
8 than just having a phone conversation.
9 And her location and situation would have made it
10 difficult for her to actually come in person to one of our
11 regional offices -- offices, so it's reassuring to learn
12 that the way we're evolving our services are meeting our
13 customer's needs.
14 We're also working on a broader scale. We're
15 working on our next virtual CalPERS Benefit Education
16 Event, which is scheduled for next month, about three
17 weeks away, on December 8th and 9th. So as you know, this
18 is a popular event where we educate the members on their
19 CalPERS benefits. And once again, we'll host several
20 classes and have a virtual ask-the-experts hall where the
21 members can come in and get personalized advice
22 face-to-face virtually with our team members.
23 We're even doing some evening sessions and we'll
24 monitor participation of that to make sure it's viable and
25 provide that flexibility to our members. Our CalPERS

1 website has this information and the link to register.
2 And we are looking at opportunities for an in-person CBEE
3 at some point next year. So I'll report back on that when
4 we meet earlier next year.
5 As you are aware, we did complete our health open
6 enrollment towards the end of last month. And open
7 enrollment can typically be a challenging time for our
8 Contact Center, but our team did amazing -- an amazing job
9 making this year a success working with our partners
10 across the organization to make that happen.
11 Our contact center saw a 78 percent decrease in
12 wait times this year compared to last, and we answered 34
13 percent more calls than we did last year. Last year, some
14 of our wait times were close to an hour. And this year,
15 the greatest average on any one day was under 15 minutes.
16 So it's just a great effort by our agents and everybody
17 else who helped pitch in to answer phones, or pick up
18 another workloads, or do administrative duties, and, you
19 know, just everything in place to manage those efforts.
20 So it was a great collaboration across the enterprise and
21 I just want to extend a huge thank you to our call center
22 agents, as well as the administrative and leadership teams
23 for making this happen.
24 Our annual Educational Forum for employers was
25 another milestone in October. It was a huge success and

1 our Customer Services and Support Branch teams were
2 responsible for delivering 10 informational sessions and
3 hosting over 15 booths for our employers to visit. They
4 educated them on topics such as working after retirement,
5 survivor and beneficiary information, proper reporting,
6 and retirement basics. We had over 6,000 attendees just
7 for our sessions alone listen in, and we received positive
8 feedback from our employers who were in attendance.
9 One of the topics that we covered in one of your
10 presentations was SB 278, which passed on September 27th.
11 And this bill is related to when employers report
12 compensation for a member that is later reviewed and
13 disallowed by CalPERS because it doesn't meet the
14 Government code.
15 Previously, we would perform a downward
16 adjustment on the member's retirement allowance and charge
17 the member up to three years of overpayment. With the
18 passage of 278, if the employer did not have that
19 compensation reviewed and validated by CalPERS, they would
20 now be liable for covering that member's overpayment, as
21 well as compensate the member for the ongoing downward
22 adjustment in their retirement allowance to make them
23 whole.
24 Our Employer Account Management Division
25 continues to do a significant amount of outreach on proper

1 reporting and MOU language and has recently released an
2 employer page on our CalPERS website to provide
3 information and resources to our employers to help reduce
4 any impacts. In addition, a circular letter is coming out
5 next month to further inform our employers of the impacts
6 of the bill and resources to assist them.
7 In closing, I'm happy to report, in general, our
8 benefit payments and customer satisfaction have been
9 performing well and our teams continue to meet the
10 customer's needs in this virtual environment, and I'm very
11 proud of those efforts.
12 As we go forward, I won't have the opportunity to
13 meet with you before the end of the year, so I wish you
14 all a safe, happy and healthy holiday season, and that
15 concludes my report, and I'm happy to take any questions.
16 CHAIRPERSON FECKNER: Thank you, Mr. Suine. And
17 on behalf of myself and the Committee, as you know, I've
18 done a lot of Zoom, WebEx meetings over this pandemic, and
19 I will tell you the comments I've received from the
20 members out there have been nothing more than glowing for
21 all of the organization, but especially your staff and the
22 call center in particular, for just he great outreach
23 they've done for our members during this pandemic time.
24 So please pass on our thanks to all of them.
25 DEPUTY EXECUTIVE OFFICER SUINE: I will do.

1 Thank you, Mr. President.
2 CHAIRPERSON FECKNER: Thank you.
3 Mr. Moulds.
4 CHIEF HEALTH DIRECTOR MOULDS: Great. How's the
5 volume there?
6 CHAIRPERSON FECKNER: A little louder, please.
7 CHIEF HEALTH DIRECTOR MOULDS: A little louder?
8 CHAIRPERSON FECKNER: There you go.
9 CHIEF HEALTH DIRECTOR MOULDS: Better?
10 CHAIRPERSON FECKNER: Perfect.
11 CHIEF HEALTH DIRECTOR MOULDS: Okay. I will do
12 my best to almost shout.
13 Good afternoon, Mr. Chair and members of the
14 Committee. Don Moulds with the CalPERS Health Program.
15 Today, you'll be presented with plan proposals and CalPERS
16 health team proposals for the 2023 plan year. I want to
17 begin by setting the stage for that conversation.
18 As part of the stakeholder engagement process
19 ahead of the Board's decision last November to adopt the
20 two-plan model for our PPO products, as well as the
21 transition to portfolio rating, we committed to modeling
22 alternative benefit designs for the PPO Basic program and
23 sharing the results of that work with stakeholders this
24 fall. The goal was to see how changes to benefits would
25 affect monthly premiums as well as the amount our PPO

1 members would pay out of pocket for their care.
2 As we model various options, it became clear that
3 even modest savings to premium would result in large
4 cost-shifting to members. So as you see today, there are
5 no proposals to make any changes to the PPO benefit design
6 that shift costs to our members. There are only positive
7 proposals to some benefit coverage areas, which you'll
8 hear about during the presentation momentarily.
9 We had a special stakeholder meeting on October
10 25th to share the modeling and collect feedback on
11 different benefit design scenarios for the PERS Gold and
12 PERS Platinum Basic plans. At that meeting, both employer
13 and member representatives were adamant that they would
14 not support alternatives that shift costs to the member,
15 so the consensus feedback at the meeting was that we
16 should be looking elsewhere for ways to bring down
17 premiums.
18 That's also the recommendation from the CalPERS
19 team. Research in this area shows that when cost sharing
20 is high, people, particularly low-income people,
21 frequently defer needed care. That can lead to worse
22 health outcomes and additional costs down the road. I'll
23 note that, at that meeting, I also reiterated our goal to
24 have an HMO or an EPO plan in every county, so that
25 members could have access to a high quality plan with

1 lower cost sharing. In the proposals, you'll see today,
2 we're bringing forward an EPO option in 11 counties, where
3 currently the only option is PPO plan. If you approve
4 that proposal and if those plans receive approval by the
5 Department of Managed Health Care, CalPERS will have an
6 EPO or HMO in every county starting in 2023.
7 Next, I want to update you on our Biosimilars
8 First pharmaceutical initiative. Biosimilars First makes
9 the default prescription for certain conditions a generic
10 biologic, instead of a name brand biologic for new
11 prescriptions or starts only. That means it's not a
12 replacement for an existing prescription a member is
13 already taking. It's new prescriptions only, so the risk
14 of disruption is significantly lower.
15 In January of this year, we launched the use of
16 biosimilars in place of the drug Remicade. We started
17 with one drug affecting a small number of members and our
18 preliminary results show that the program was successful.
19 We're set to launch the next phase in January
20 1st, 2022 expanding the use of biosimilars to six more
21 drugs again for new starts only. We will evaluate the
22 program in early 2022 and continue to monitor it for
23 success. Our goal here is to broaden the sue of
24 biosimilars to help increase competition in the
25 pharmaceutical space and drive down rising drug costs.

1 Next, I'll just very briefly reiterate what Mr.
2 Suine said, which is that we had a very smooth and
3 successful open enrollment period. Just to elaborate a
4 bit, this was a complex year because we made several
5 changes that really improved the health benefits for our
6 members. We added new Medicare Advantage Plans, had
7 various plan expansions, and transitioned from three PPO
8 plans to two. We delivered extensive communications and
9 saw a 52 percent increase in open enrollment transactions
10 compared to last year. I want to thank our Health Account
11 Management Division, the Office of Public Affairs, IT, and
12 Mr. Suine's team at Customer Service and Support, who did,
13 as you noted, just a terrific job this year.
14 Finally, two quick items. I want to draw your
15 attention to Item 5c on your agenda today. This is our
16 Health Benefits Annual Report for the 2020 plan year. We
17 hope you find it informative and a good resource. I'd
18 like to thank the member CalPERS team members across the
19 enterprise who contributed to the development and delivery
20 of that report. And lastly, I want to let the Committee
21 and our members know that our 2022 Health Plan Member
22 Survey will kick-off in January. This annual survey asks
23 members to rate their experience with their plan and their
24 pharmacy benefits during the 2021 plan year.
25 We also use the survey results to measure

1 outcomes and trends, members care experiences, and their
2 access to care. We would ask all members who receive a
3 survey to respond. It goes a long way to helping make the
4 health program better for everyone.
5 And with that, I'll go ahead and stop and happy
6 to answer any questions that you have.
7 CHAIRPERSON FECKNER: Thank you, Mr. Moulds. I
8 see no questions, but I, too, want to thank you and your
9 entire team, especially for a successful open enrollment.
10 I know you had a lot of changes this year, which is
11 unprecedented, so we thank you and the team for all the
12 hard work.
13 Moving on to Item 4, action item, approval of the
14 September 14th meeting minutes. What's the pleasure of
15 the Committee?
16 COMMITTEE MEMBER TAYLOR: Move approval.
17 COMMITTEE MEMBER BROWN: Second.
18 CHAIRPERSON FECKNER: It's been moved by Ms.
19 Taylor, seconded by Ms. Brown.
20 Any discussion on the motion?
21 Seeing none.
22 All in favor say aye?
23 (Ayes.)
24 CHAIRPERSON FECKNER: Opposed, no?
25 Motion carries.

1 Item 5 is the information consent items. Having
2 no requests to move anything off, I would encourage you
3 all to make sure that you read through that.
4 Item 6. 6a, Approval of the Health Benefits
5 Program Proposals for the 2023 plan year.
6 Mr. Moulds.
7 CHIEF HEALTH DIRECTOR MOULDS: Great. Thank you.
8 So Karen Páles who is the Acting Chief in the Health
9 Research and Administration Division and Dr. Logan are
10 going to be presenting. Karen will be doing the plan
11 proposals and Julia will be doing the team proposals.
12 CHAIRPERSON FECKNER: Welcome.
13 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
14 DIVISION CHIEF PÁLES: Thank you. Good afternoon, Mr.
15 Chair and members of the Committee, Karen Páles, CalPERS
16 team member. This is Agenda Item 6a, Approval of Health
17 Benefits Program Proposals for the 2023 Plan Year, and
18 it's an action item.
19 In 2020, CalPERS implemented a formalized process
20 separate from the rate development process that allows
21 health plans to propose one or more of the following items
22 for CalPERS consideration for the upcoming benefit year:
23 new Basic or Medicare health plans, benefit design
24 changes, new health benefit programs, or service area
25 changes.

1 Next slide, please.
2 --o0o--
3 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
4 DIVISION CHIEF PÁLES: Today, I'll walk you through our
5 timeline and each of the carrier's proposals and then I'll
6 turn it over to Dr. Julia Logan to cover proposals that
7 the CalPERS team analyzed for your consideration today.
8 I'll conclude with our next steps.
9 Next slide, please.
10 --o0o--
11 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
12 DIVISION CHIEF PÁLES: As a reminder, here's our proposal
13 timeline, CalPERS put out the call to our carriers to
14 submit proposals for 2023. Our health plans submitted new
15 proposals for the 2023 plan year in August, and new to our
16 process this year, we asked the plans to assess the impact
17 their proposals would have on health equity. The team
18 analyzed each proposal and we're bringing you our
19 recommendations today. Any approved plan proposals will
20 be incorporated into the rate development process next
21 year. Not every plan in our portfolio submitted a
22 proposal requiring Board approval. So while not every
23 plan will be mentioned in today's presentation, all of our
24 carriers remain in the portfolio for 2023.
25 Next slide.

1 --o0o--

2 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
3 DIVISION CHIEF PÁLES: To align with our strategic vision,
4 we look for proposals that will improve health care
5 quality, improve access, maintain affordability, and
6 address equity. CalPERS team members conducted an
7 extensive analysis of each proposal, including network
8 coverage areas, the number of medical groups, group
9 physician counts, coverage overlaps, projected
10 administrative service fees, estimates of capitation and
11 fee-for-service costs, and the review of benefit design
12 changes.

13 The CalPERS team also evaluated the service area
14 expansion proposals through the Bates White economic model
15 to understand competitive dynamics. You'll recall we
16 engaged Leemore Dafny with the Harvard Business School and
17 an academic affiliate at Bates White Economic Consulting
18 to build CalPERS an economic model that predicts the
19 impacts of basic plan expansions and proposals on our
20 overall health plan premiums. The competition model
21 anticipates member migration among plans, competitive
22 dynamics within geographic areas, and overall impacts on
23 geographic regions, as well as statewide.

24 I'll walk you through each carrier proposal, and
25 when it appears to be reasonable, and is a value to our

1 members and the health program based upon CalPERS
2 evaluation.
3 We'll start with Anthem Blue Cross.
4 Next slide.
5 --o0o--
6 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
7 DIVISION CHIEF PÁLES: Anthem submitted two benefit design
8 change proposals both for their Medicare Advantage plan.
9 The first proposal is a change to the copay amounts for
10 their acupuncture and chiropractic benefits. These copays
11 would change from the CalPERS standard copay of $15 to the
12 Medicare covered standard copay of $10.
13 The rationale for this change is to create parity
14 between Anthem's Medicare copays for acupuncture,
15 chiropractic, and office visits. The projected premium
16 impact would be $0.39 per subscriber, per month, or a 0.11
17 percent impact on the projected premium. Per subscriber
18 per month, or PSPM is the monthly premium impact on the
19 single-party rate.
20 We recommend approval of this proposal.
21 Next slide.
22 --o0o--
23 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
24 DIVISION CHIEF PÁLES: The second proposal is an
25 enhancement to the routine vision benefit to include a

1 $100 eyewear allowance every two years. The projected
2 premium impact would be $1.24, or a 0.34 percent impact on
3 the premium.
4 The CalPERS team does not recommend approval of
5 this proposal, because, in general, our Medicare members
6 already have access to vision benefits through an employer
7 benefit or a policy rider. So this would be a relatively
8 expensive benefit change at a dollar twenty-four for a
9 duplicate benefit that most of our members receive
10 elsewhere.
11 Next slide.
12 --o0o--
13 CHAIRPERSON FECKNER: Before you go any further,
14 Ms. Páles --
15 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
16 DIVISION CHIEF PÁLES: Yes.
17 CHAIRPERSON FECKNER: -- we do have a request to
18 speak on a question for Anthem Blue Cross. Ms. Brown.
19 COMMITTEE MEMBER BROWN: Can we go back to page
20 seven, or whatever that one -- back one more. I was
21 looking at the bottom of the -- yeah, this one. So what
22 Anthem Blue Cross is proposing is that everybody pay for
23 acupuncture and chiropractic, because you're going to
24 bring the -- you're going to bring the cost down by $5.
25 So if I never use acupuncture, which I don't, or

1 chiropractic, which I don't, I will be paying more.
2 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
3 DIVISION CHIEF PÁLES: Well, much like all of our
4 benefits, the cost is applied across the population and
5 the plan, so yes, there would be $0.39.
6 COMMITTEE MEMBER BROWN: Per month, per member.
7 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
8 DIVISION CHIEF PÁLES: Per month. Per subscriber, so that
9 would be the single-party impact to premiums, so times two
10 for the two party, and times 2.6 for the family. So
11 basically, less than a dollar per month.
12 COMMITTEE MEMBER BROWN: And how many members do
13 we have in this plan?
14 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
15 DIVISION CHIEF PÁLES: Off the top of my head, I don't
16 know.
17 COMMITTEE MEMBER BROWN: Hundred thousand,
18 50,000, just curious.
19 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
20 DIVISION CHIEF PÁLES: Just one second.
21 CHIEF HEALTH DIRECTOR MOULDS: We'll get you a
22 number.
23 COMMITTEE MEMBER BROWN: Yeah, I'm just -- I'm
24 just -- I'm just curious, but are you saying that all our
25 other plans charge about $10 for this copay?

1 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
2 DIVISION CHIEF PÁLES: Most of the Medicare plans charge
3 15 for the acupuncture, I believe, if they have it.
4 COMMITTEE MEMBER BROWN: Yeah.
5 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
6 DIVISION CHIEF PÁLES: And they tend to shift over time as
7 they align with one another.
8 COMMITTEE MEMBER BROWN: So -- okay. So all I'm
9 saying is that it looks like my premium is going to go up
10 if I never use acu -- even though I never use acupuncture
11 or chiropractic.
12 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
13 DIVISION CHIEF PÁLES: That's a true statement. You are
14 already paying for it if you didn't use it, to be honest,
15 right?
16 COMMITTEE MEMBER BROWN: I just want to make sure
17 we're not shifting costs to the -- to the members, right?
18 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
19 DIVISION CHIEF PÁLES: Um-hmm.
20 COMMITTEE MEMBER BROWN: That's what this one
21 looks like it's doing. I know it's a little tiny bit, but
22 you know, it's --
23 CHIEF HEALTH DIRECTOR MOULDS: It is a -- it is
24 not -- it is not a --
25 CHAIRPERSON FECKNER: Microphone.

1 COMMITTEE MEMBER BROWN: Microphone.
2 CHIEF HEALTH DIRECTOR MOULDS: Sorry. It is not
3 a -- to your point, I'll say because we have a robust
4 discussion of everyone of these with the team when we
5 review them, and one of the reasons that we decided to
6 recommend moving forward with this is increasingly
7 acupuncture and chiropractic are seen as alternative pain
8 therapies, and so are replacements for opioids. One of
9 the goals that -- long-standing we've -- goal we've had is
10 to reduce the use of those drugs, which as you know can be
11 addictive and lead to other problems. So our clinical
12 team was supportive of this move, because it's a far
13 superior alternative to that.
14 COMMITTEE MEMBER BROWN: So did we do the
15 analysis that shows that based on the number of members
16 who use acupuncture and chiropractic at $5 more times
17 whatever visits versus what they're going to collect in
18 premiums, that it's a wash or are they going to be -- you
19 know, are they going to be increasing their -- are they
20 going to be increasing their income?
21 CHIEF HEALTH DIRECTOR MOULDS: The --
22 COMMITTEE MEMBER BROWN: Or did we do that
23 analysis?
24 CHIEF HEALTH DIRECTOR MOULDS: The analysis is
25 that overall -- so the -- so some -- some of these -- some

1 of these effects are unknowable. We only model things
2 that are knowable. The knowable costs associated with the
3 these are the $0.39 per member per month charge. The
4 unknowable is offsets for pain therapy. But beyond the
5 dollar offsets that are potentially out there, there
6 are -- you know, there are health benefits if you're
7 getting non-addictive treatment for pain.
8 COMMITTEE MEMBER BROWN: But aren't they already
9 getting non-addictive treatment, they're just paying $5
10 more, right?
11 CHIEF HEALTH DIRECTOR MOULDS: Correct.
12 COMMITTEE MEMBER BROWN: We don't expect that
13 this would cause anybody -- do we really think that $5 is
14 going to stop people from going to acupuncture and go get
15 and opioid? I don't think so.
16 CHIEF HEALTH DIRECTOR MOULDS: I'll let you
17 speculate about that.
18 COMMITTEE MEMBER BROWN: All right. Thank you.
19 CHAIRPERSON FECKNER: Probably about the same as
20 costing $0.39 to have the care, so...
21 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
22 DIVISION CHIEF PÁLES: To your point there's 4,300 members
23 in this Medicare plan.
24 COMMITTEE MEMBER BROWN: Thank you.
25 CHAIRPERSON FECKNER: Go ahead, Ms. Páles.

1 Oh, just a second. Mr. Miller.
2 COMMITTEE MEMBER MILLER: Kind of a follow-up on
3 Ms. Brown's question. Do we know even roughly what
4 percentage of our members are current -- in that group of
5 four thousand or so are currently availing themselves of
6 acupuncture?
7 CHIEF HEALTH DIRECTOR MOULDS: We can
8 certainly -- we don't -- we can certainly look that up and
9 bring it back as a deliverable.
10 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
11 DIVISION CHIEF PÁLES: Yeah, we can bring that back.
12 CHAIRPERSON FECKNER: Ms. Taylor.
13 COMMITTEE MEMBER TAYLOR: Sorry, I just had to
14 jump in on this. You know, having the choice that it's
15 there I think is what we're looking at here. It's --
16 yeah, by the time the rates are figured out, I'm sure we
17 won't even see that $0.39, but I think having the option
18 to have it -- hey, if I had the option I'd add massage
19 therapy, but -- I think it's a great option, so...
20 CHAIRPERSON FECKNER: Okay. Ms. Páles
21 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
22 DIVISION CHIEF PÁLES: Yes. So I think we're back to
23 slide seven, was where we stopped.
24 CHAIRPERSON FECKNER: Yes.
25 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING

1 DIVISION CHIEF PÁLES: Blue Shield submitted proposals for
2 two service area expansions and a benefit design change.
3 First is an 11-county service area expansion for Blue
4 Shield's Exclusive Provider Organization, or EPO, Plan.
5 And EPO is a hybrid of HMO and PPO characteristics. The
6 EPO plan utilizes the PPO network, but like an HMO,
7 members must use in-network providers and hospitals and
8 they have set copays rather than deductibles and
9 coinsurance. EPO plans are an effective tool in counties
10 where it's challenging to put together and HMO network.
11 The EPO is DMHC regulated. And we work with plans to make
12 sure our EPOs can take advantage of the coordinated
13 benefits typical of an HMO.
14 In our conversations with Blue Shield, we've
15 expressed our desire for the EPO to be as similar to an
16 HMO as can be reasonably achieved.
17 We're current -- we currently have two EPO plans
18 in our portfolio, the Anthem EPO in Del Norte County and
19 the Blue Shield EPO is currently in Butte, Colusa,
20 Mendocino, Monterey, and Sierra counties. Additionally,
21 the Blue Shield EPO will be in Lassen and Shasta counties
22 beginning in 2022. I want to note here that the map on
23 the original attachment and on your Board books did not
24 show the Lassen and Shasta counties in blue. The EPO is
25 available in both Lassen and Shasta counties in 2022. You

1 can see that we updated the PowerPoint here on this
2 screen. You have updated maps in your folders and we've
3 had copies placed at the back of the room with the updated
4 map.
5 The 2023 expansion is all rural counties that
6 currently do not have an HMO option. The expansion would
7 provide an HMO-like option in these rural counties using a
8 mix of Blue Shield's PPO network and additional contracted
9 providers. Because the EPO plan will have much lower
10 out-of-pocket costs than current PPO plans, it will reduce
11 member's cost exposure.
12 The competition model also shows this proposal
13 will benefit rural members overall. It's expected that
14 the proposal will not have a premium impact, because the
15 number of potential members for this plan is relatively
16 small.
17 The CalPERS team recommends approval with the
18 acknowledgement that the proposal is contingent on DMHC
19 approval.
20 Next slide.
21 --o0o--
22 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
23 DIVISION CHIEF PÁLES: Blue Shield is proposing a pharmacy
24 shared patient savings program for its Trio members only.
25 It offers Trio members a one-time per drug class, per

1 lifetime incentive, if they switch to a clinically
2 equivalent lower cost drug alternative. Trio members will
3 receive one month of plan savings in the form of a visa
4 gift card. This program will have nominal projected
5 savings for CalPERS and members with no premium impact.
6 The CalPERS team recommends approval.
7 CHAIRPERSON FECKNER: Ms. Taylor, on this item?
8 COMMITTEE MEMBER TAYLOR: Yeah.
9 CHAIRPERSON FECKNER: Okay. Ms. Taylor.
10 Can you go back one slide, please?
11 COMMITTEE MEMBER TAYLOR: Sorry about that.
12 Yeah, I just wanted to make sure, the Blue Shield Access+
13 EPO expanding for 2023 into these counties up here. Now,
14 does that include doctors groups or a doctor that goes
15 with it?
16 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
17 DIVISION CHIEF PÁLES: Well, they use the PPO network. So
18 yeah, there are doctors and doctor groups in that network.
19 COMMITTEE MEMBER TAYLOR: Okay. So they've used
20 the network. They're going to have like a primary care
21 physician they'll have to report to and they'll have
22 copays, but no deductibles, correct?
23 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
24 DIVISION CHIEF PÁLES: Right. It's set up more like an
25 HMO.

1 COMMITTEE MEMBER TAYLOR: Okay. So -- and in
2 most of these places there's like one hospital. Is that
3 it, that's what they're going to have to deal with, even
4 if it's like a bad hospital?
5 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
6 DIVISION CHIEF PÁLES: Yeah. That's, of course, the
7 challenge in the rural counties, which is why we have
8 trouble getting an HMO in there, getting a network that's
9 sufficient. And so the EPO is the current solve for that,
10 because they utilize the PPO network. So unfortunately,
11 you know, it is what it is in some of these counties, and
12 what exists is what would be utilized.
13 COMMITTEE MEMBER TAYLOR: And it won't impact
14 premiums?
15 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
16 DIVISION CHIEF PÁLES: It's such a small number of people
17 is why.
18 COMMITTEE MEMBER TAYLOR: Right. So -- for
19 Access+, because that was kind of one of the highest
20 priced plans we have, I believe. So if somebody has
21 access -- well, the other thing is though will it be
22 comparable to our PPO plans in price, so that switching
23 over to the -- will save somebody money and avail them
24 better service and -- et cetera, I guess is what I'm
25 trying to figure out.

1 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
2 DIVISION CHIEF PÁLES: Well, the PPO -- or, I'm sorry, the
3 Access+ already has sort of a spot within the portfolio.
4 And it's -- this is not going to change that spot, so it's
5 not going to be significantly different from where it
6 normally lands against the PPOs, although we do have quite
7 a few changes happening to the PPOs. So next year is
8 going to be generally interesting to see how everything
9 falls out.
10 COMMITTEE MEMBER TAYLOR: Right, because it's
11 going up quite a bit, but I can't remember -- I'll have to
12 look again. I can't remember if the PPOs this coming year
13 with the increase --
14 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
15 DIVISION CHIEF PÁLES: The PPOs switched to a two-plan
16 model --
17 COMMITTEE MEMBER TAYLOR: Right
18 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
19 DIVISION CHIEF PÁLES: -- in 2022 with the first half of
20 risk mitigation implementation. And then this is for
21 2023, so this would be the next year.
22 COMMITTEE MEMBER TAYLOR: Oh, so we're not even
23 there yet. Never mind.
24 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
25 DIVISION CHIEF PÁLES: Right. Right.

1 COMMITTEE MEMBER TAYLOR: Yeah. Okay. Great.
2 Thank you.
3 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
4 DIVISION CHIEF PÁLES: Sure.
5 CHAIRPERSON FECKNER: Thank you.
6 Ms. Brown?
7 COMMITTEE MEMBER BROWN: Thank you. On this same
8 slide, you said that these changes would benefit rural
9 members.
10 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
11 DIVISION CHIEF PÁLES: Um-hmm.
12 COMMITTEE MEMBER BROWN: How does this impact
13 urban members in -- that participate in HMOs, like Kaiser.
14 And my concern is is whether or not when we do these
15 expansions, do we expect that the people in Kaiser HMOs
16 will be paying a surcharge to help offset the cost of
17 expansion into these new counties?
18 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
19 DIVISION CHIEF PÁLES: No. The -- so the way that the
20 health plans develop their health plan premiums are
21 individual. So what Kaiser would be developing for their
22 premium is related to Kaiser membership and Kaiser costs.
23 And the --
24 COMMITTEE MEMBER BROWN: I'm not talking about --
25 I'm not talking about the premiums. I'm talking about

1 what we do, what CalPERS does in terms of the rate
2 surcharge. People get money, give you money -- like
3 everybody at Kaiser has to pay $24 more, and then
4 everybody else in the more expensive plans gets offset.
5 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
6 DIVISION CHIEF PÁLES: So are you talking about risk
7 mitigation and portfolio rating?
8 COMMITTEE MEMBER BROWN: Yes. So do we think
9 this expanding into these, I'll call them, pseudo HMOs is
10 going to cause more cost to come out of the people who are
11 in the, what I call, suburban or --
12 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
13 DIVISION CHIEF PÁLES: Right. So again, it's such a small
14 number of people, it's difficult to say exactly what their
15 risk profile would be and how it would potentially impact
16 the aggregate risk number for the Access+ EPO. But it's
17 such a small number of individuals, we don't expect that
18 it will have an impact.
19 CHIEF HEALTH DIRECTOR MOULDS: Yeah. Ms. Brown,
20 this is -- this was why we engaged the Bates White team
21 and used their model. They ran these numbers, including
22 with risk adjustment built in. They are such small
23 numbers compared to the overall pool in Access+ that they
24 are not projected to affect premiums.
25 COMMITTEE MEMBER BROWN: So not even -- not even

1 a dollar out of the Kaiser people or the low cost? And
2 it's not just Kaiser. It's the other ones.
3 CHIEF HEALTH DIRECTOR MOULDS: I cannot tell you
4 that it will not be a dollar, I can't tell you that it
5 wouldn't save a dollar, but the project was that it would
6 be close to zero.
7 COMMITTEE MEMBER BROWN: Thank you.
8 CHAIRPERSON FECKNER: Thank you.
9 Ms. Páles, continue.
10 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
11 DIVISION CHIEF PÁLES: I believe we're on slide nine.
12 Next slide.
13 --o0o--
14 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
15 DIVISION CHIEF PÁLES: Blue Shield is proposing to expand
16 its Trio product to bring an alternative low-cost HMO
17 option into seven counties, Butte, Kern, Kings, Monterey,
18 Riverside, San Bernardino, and Tulare. It's a mix of
19 rural, central, and Southern California counties that have
20 varying levels of plan concentration. That Trio plan is
21 offered in 12 counties for the 2022 plan year.
22 And again here, I want to note that on the
23 original attachment and your Board books, the counties of
24 Orange, Santa Cruz, and Stanislaus should be blue because
25 they're offered in 2022, but they are not. But again, the

1 PowerPoint here that we're showing is updated. You have
2 updated maps in your folders and there are updated copies
3 in the back of the room.
4 This proposal would have a favorable premium
5 impact of $3.41 or a savings of 0.46 percent off the
6 projected premium. The competition model suggests that
7 the expansion would create modest down white -- downward
8 pressure in the expansion counties.
9 And the CalPERS team recommends approval with the
10 acknowledgement that the proposal is contingent on DMHC
11 approval.
12 Next slide.
13 CHAIRPERSON FECKNER: Just a second, please.
14 Mr. Rubalcava.
15 VICE CHAIRPERSON RUBALCAVA: Thank you.
16 I was going to say something earlier, but I think
17 this is a good explanation of how area action has been
18 recommended in staying with our strategic plan which is to
19 provide access and quality care. We've always talked
20 about how we need to expand to get competition and get
21 pricing that relates to the quality of care -- the cost of
22 care versus trying to grab the low risk populations. So I
23 commend you on all these proposals -- getting the carriers
24 to submit these proposals.
25 Thank you.

1 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
2 DIVISION CHIEF PÁLES: Thank you.
3 CHAIRPERSON FECKNER: Thank you.
4 Ms. Páles.
5 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
6 DIVISION CHIEF PÁLES: Next slide, please.
7 --o0o--
8 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
9 DIVISION CHIEF PÁLES: Next, let's move to Kaiser. They
10 submitted proposals for a service area expansion, an
11 additional Senior Advantage product and a benefit design
12 change.
13 First, Kaiser is proposing to expand their Basic
14 and Medicare service area into Monterey County. The
15 providers, specialists, and hospital network will be a
16 combination of Kaiser Medical Group providers, contracted
17 inpatient facilities, and contracted community providers
18 and specialists. This expansion provides an alternative
19 low cost HMO option with favorable premiums in Monterey
20 County and nominal impact statewide.
21 The competition model suggests that this
22 expansion would be beneficial to the members in Monterey
23 County. CalPERS team recommends approval with the
24 acknowledgement that the proposal is contingent upon both
25 DMHC and CMS approvals.

1 Next slide.

2 --o0o--

3 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
4 DIVISION CHIEF PÁLES: Next, Kaiser is proposing to add a
5 brand new Senior Advantage plan with $0 copays for most
6 services, except for emergency room, prescription drugs,
7 and our acupuncture and chiropractic benefits. The new
8 Kaiser Permanente Senior Advantage $0 copay plan would be
9 a new plan in addition to the existing Senior Advantage
10 plan, and would be made available out of state. The only
11 difference is the $0 copays for most services. Kaiser
12 projects the premium to be about 13.1 percent more than
13 their current Senior Advantage plan. The chart on the
14 next slide illustrates the 2022 premiums for all CalPERS
15 Medicare plans.

16 Next slide.

17 --o0o--

18 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
19 DIVISION CHIEF PÁLES: The chart shown here illustrates
20 the 2022 Medicare premiums and where the Kaiser zero copay
21 Senior Advantage premium would likely fall comparatively.

22 The CalPERS team recommends approval of this
23 proposal.

24 Next slide.

25 --o0o--

1 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
2 DIVISION CHIEF PÁLES: Lastly, Kaiser proposed a benefit
3 design change for the existing Senior Advantage plan that
4 would also apply to the new Medicare Advantage plan if
5 approved. This proposal adds a quarterly $70
6 over-the-counter allowance for members to purchase certain
7 over-the-counter items. Purchases can only be made
8 through a designated website or mail order catalogue using
9 a third-party vendor not affiliated with Kaiser. Any
10 unused portion cannot be rolled over to future quarters.
11 This benefit is similar to what's offered by other MA
12 plans and has a projected premium impact of $1.45, which
13 is a 0.48 percent increase.
14 The CalPERS team recommends approval of this
15 proposal.
16 Next slide.
17 --o0o--
18 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
19 DIVISION CHIEF PÁLES: Next, we have a proposal from
20 Western Health Advantage. They propose adding a
21 post-discharge meal delivery benefit to their MyCare
22 Select HMO Medicare Advantage plan. The benefit includes
23 up to 56 meals four times per year following a hospital
24 stay. There are a range of meal options consistent with
25 the hospital's recommendations and meal delivery

1 coordination would occur prior to discharge. Other
2 CalPERS plans -- other MA plans, sorry, have similar
3 benefits beginning in 2022. The projected premium impact
4 would be $1.37, which is a 0.44 percent increase. The
5 proposed changes enhance Medicare Advantage benefits to
6 help keep our Medicare members healthy.
7 The CalPERS team recommends approval.
8 CHAIRPERSON FECKNER: If you could go back to
9 slide 13, please, Ms. Karen Greene-Ross has a question.
10 ACTING COMMITTEE MEMBER GREENE-ROSS: It wasn't
11 specific to that slide. It was just in general about the
12 DMHC approval process and what the timeline is on that and
13 what you can tell us about that? That was all. And
14 obviously --
15 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
16 DIVISION CHIEF PÁLES: Unfortunately, we don't have a
17 definitive timeline on DMHC. We hope to know prior to the
18 rate approval process obviously. So we'll obviously share
19 that out as soon as we got it. But I know that the plans
20 have submitted all their information. I know they're all
21 very hopeful, but there's not a set timeline on how long
22 it takes.
23 CHIEF HEALTH DIRECTOR MOULDS: What I -- what we
24 can tell you is that we were able to move the Santa
25 Barbara expansion in a shorter timeline than the one we're

1 talking about now for these plans, but it is -- it will be
2 a heavy lift. We have a good relationship with DMHC, so,
3 you know, communication right now is excellent between our
4 organization and that department. And we will do what we
5 can to aid in answering any questions that they have.
6 ACTING COMMITTEE MEMBER GREENE-ROSS: I
7 appreciate that. I just also -- when you say heavy lift,
8 is it -- is it what we were hoping to get is unprecedented
9 for them?
10 CHIEF HEALTH DIRECTOR MOULDS: It's -- so it's
11 more -- it's more expansions. It's -- so EPOs are -- my
12 understanding is EPOs are easier, because of -- because
13 the expectations -- they're smaller networks. The
14 expectations are lower. A lot of the network, as Ms.
15 Páles pointed out, are built off of the PPO networks, so
16 they've been -- they're networks that have been in front
17 of DMHC before. Blue Shield is optimistic that they'll be
18 able to move these through DMHC. And we are optimistic as
19 well or we wouldn't be bringing them forward.
20 ACTING COMMITTEE MEMBER GREENE-ROSS: Okay.
21 Thank you.
22 CHAIRPERSON FECKNER: Mr. Miller.
23 COMMITTEE MEMBER MILLER: Yeah. I really
24 appreciate everything that went into these and I really
25 appreciate the -- you know, providing more value for our

1 members and features that they'll like. One of the things
2 that would help me in assessing these is to have a sense
3 of what our expectations are in terms of just the pure
4 quantitative numbers in terms of our expectations of
5 utilization of say we're providing a new benefit. Is it a
6 benefit that 15 percent of the people in the plan will
7 utilize at some point during the year or five years, or is
8 it something that 0.005 percent of the members are likely
9 to utilize, just in terms of having a sense of -- you
10 know, because the numbers -- I mean, I looked at the
11 numbers and go, oh, X cents a month.
12 CHIEF HEALTH DIRECTOR MOULDS: Yeah.
13 COMMITTEE MEMBER MILLER: Well, obviously, very,
14 very few people are going to be using this, because if
15 very many of them were using it, it would cost $2 a month
16 or something.
17 CHIEF HEALTH DIRECTOR MOULDS: Yeah.
18 COMMITTEE MEMBER MILLER: So it would be helpful
19 in future presentations.
20 Thank you.
21 CHIEF HEALTH DIRECTOR MOULDS: So we're happy --
22 we're happy to do that. I can tell you -- and this may be
23 too much information, so you can stop me if I'm providing
24 too much information, but on a number of the supp -- the
25 Medicare supplemental benefits, so this is a new -- this

1 is new territory. As we've talked about in this Committee
2 before, CMS approved these proposals as part of the
3 CHRONIC Care Act. And the theory behind them is that
4 these benefits - so the great example is the
5 post-discharge meal benefit - are designed to keep people
6 healthy in very vulnerable times and keep them from being
7 readmitted to hospitals.
8 So we expect over time that we will see returns
9 on some of these investments. We will be monitoring that
10 with our own data. You know, I look at sort of critical
11 time to be making initial evaluation as the upcoming cycle
12 when we're looking at the five-year renewal for the -- for
13 the next HMO contract, when we will make decisions based
14 on our data about recommendations to you all, you know,
15 about which ones should be moving forward and which ones
16 not. And that will largely be based on what we see in
17 that data in terms of secondary effects, as well as
18 utilization.
19 You know, the utilization, the less -- the less
20 these get used, the lower that per member per month cost
21 is going to be. So if they're not heavily utilized, those
22 numbers go down. As I said before, we can't model some of
23 the secondary effects that we anticipate, so some of the
24 health advantages that we see or even long-term cost
25 savings. You know, if we can't put a hard number on it,

1 it doesn't work into our -- into our math. But as we're
2 able to capture that in our data, we'll bring that forward
3 as well.
4 CHAIRPERSON FECKNER: Thank you.
5 Ms. Páles.
6 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
7 DIVISION CHIEF PÁLES: I believe that brings us to slide
8 15.
9 --o0o--
10 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
11 DIVISION CHIEF PÁLES: So that's actually the summary of
12 the health plan proposals. And that will do it for the
13 2023 health plan proposals.
14 Now, I'll turn it over to Dr. Julia Logan to
15 discuss the CalPERS team proposals.
16 CHAIRPERSON FECKNER: Thank you.
17 Dr. Logan.
18 CHIEF MEDICAL OFFICER LOGAN: Thank you, Karen.
19 Can you hear me okay?
20 CHAIRPERSON FECKNER: Yes, ma'am.
21 CHIEF MEDICAL OFFICER LOGAN: Okay. Goo
22 afternoon, Mr. Chair, members of the Committee. Julia
23 Logan, CalPERS team member. I am pleased to share CalPERS
24 team proposals that we feel align with our strategic plan,
25 promote improved health outcomes and demonstrate our

1 commitment to health equity. We believe these proposals
2 will drive long-term cost effectiveness and are the right
3 thing to do for our members.
4 --o0o--
5 CHIEF MEDICAL OFFICER LOGAN: This first proposal
6 is a change to the benefit language as it relates to
7 reproductive health equity. This benefit change will
8 improve quality of care and timely access to
9 time-sensitive services, such as cervical and breast
10 cancer screening, abortion care, and sexual-transmitted
11 infections screening and treatment. The new language
12 ensures that all members will have timely access and
13 equitable care without undue barriers or delays,
14 regardless of biologic sex, sexual orientation, or gender
15 identity. There's no premium impact with this change.
16 And the CalPERS team recommends approval.
17 Next slide, please.
18 --o0o--
19 CHIEF MEDICAL OFFICER LOGAN: This next proposal
20 updates the definition of infertility to create a more
21 equitable benefit structure for all members seeking these
22 services. The current definition of infertility excludes
23 most LGBTQ+ couples, single adults, and anyone pursuing
24 parenthood outside of a heterosexual relationship. The
25 new proposed infertility definition would expand the

1 availability of fertility benefits irrespective of a
2 member's sexual orientation, gender identity, or
3 relationship status. We anticipate this will have a
4 nominal premium impact, if at all.
5 The CalPERS team recommends approval.
6 Next slide, please.
7 --o0o--
8 CHIEF MEDICAL OFFICER LOGAN: Next, we're
9 proposing coverage of medically necessary and clinically
10 appropriate hearing aids in both ears for members under
11 the age of 26 at 100 percent coverage every 36 months.
12 Children with hearing loss and deafness often face trouble
13 developing speech, language, and social skills, and are at
14 risk for developing depression and anxiety.
15 Studies show that early hearing loss intervention
16 has helped children develop communication and social
17 skills, which in turn promotes academic performance. We
18 bring this proposal to you after a comprehensive review of
19 our current hearing aid benefit. You may be aware hearing
20 aid benefits are part of the discussion at the federal
21 level, including pending FDA authorization of
22 over-the-counter hearing aids for adults with mild to
23 moderate hearing loss, and legislation that includes
24 hearing aid benefits for Medicare recipients.
25 Until this regulatory landscape is clarified at

1 the federal level, CalPERS recommends that we focus the
2 benefit change for 2023 on our youngest members, because
3 this benefit change could have a really dramatic impact on
4 this group, and because this group of members would not be
5 included in the proposed federal hearing aid regulation
6 and legislation changes. There is a minimal associated
7 premium impact with this change and we recommend approval.
8 Next slide, please.
9 --o0o--
10 CHIEF MEDICAL OFFICER LOGAN: Finally, the
11 CalPERS team proposes that PPO members are matched with a
12 primary care provider, also known as a PCP, such as a
13 family physician, a general internist, or pediatrician for
14 themselves and their dependents. This benefit change
15 would not limit choice for our PPO members. If members
16 seek an alternate PCP other than the one they are matched
17 to, they would be free to choose a different PCP. PPO
18 members would still have the flexibility to see any doctor
19 they want and wouldn't need a referral from a PCP -- their
20 PCP to see a specialist. If a member already has a
21 primary care provider that they're comfortable with, they
22 would be matched to that clinician.
23 We bring you this proposal, because of our
24 commitment to primary care and after a thorough review of
25 the evidence that consistently demonstrates its

1 effectiveness. Primary care providers are the foundation
2 to patient-centered care. They and their care teams focus
3 on the early detection and treatment of disease, chronic
4 care management, and preventive care. Patients with a
5 usual source of primary care are more likely to receive
6 recommended preventive services, like flu shots and other
7 vaccines, blood pressure screenings, and cancer
8 screenings. Research shows that matching to a primary
9 clinician is associated with positive health outcomes and
10 mitigates overall health care costs over the long term.
11 This proposal also aligns with the work we're
12 doing to promote primary care, including our advanced
13 primary care measures pilot and our alignment work with
14 Covered California and the Department of Health Care
15 Services.
16 There's no premium impact with this change and
17 the CalPERS team recommends approval.
18 Next slide, please.
19 --o0o--
20 CHIEF MEDICAL OFFICER LOGAN: That concludes my
21 presentation of the CalPERS team proposals we submit to
22 you for approval. I'll hand it back to Karen to talk
23 about next steps.
24 CHAIRPERSON FECKNER: We have a couple of
25 questions. Mr. Rubalcava.

1 VICE CHAIRPERSON RUBALCAVA: Thank you. Dr.
2 Logan, this is very exciting actually, to try to match
3 with a PCP. How would the match be done? Is it by -- I
4 mean, is it by address or, I mean, how -- acts -- how
5 would you match them I guess is my question? I know you
6 under -- they can change at any time and they don't have
7 to. They can still go to the PPO, because that's what
8 they signed up for. But if you can get them a PCP, it
9 would be great, but how do you match them? Is it based on
10 address?
11 CHIEF MEDICAL OFFICER LOGAN: Yes, exactly. It's
12 based on location or address, primary language, and
13 whether or not a member has seen that primary provider in
14 the past. So one thing that's -- three things that are
15 really important about primary care are that primary care
16 is comprehensive, it's continuous, and it's coordinated.
17 So it's really important that members continue to see the
18 same primary care provider and we do not want to disrupt
19 that relationship.
20 VICE CHAIRPERSON RUBALCAVA: Thank you. And
21 thank you for thinking also making it cultural sensitive.
22 You said something about you look at that, too, right or
23 something.
24 CHAIRPERSON FECKNER: Their language.
25 VICE CHAIRPERSON RUBALCAVA: Language.

1 CHIEF MEDICAL OFFICER LOGAN: Yes. Yes.
2 VICE CHAIRPERSON RUBALCAVA: That's very
3 important. Thank you very much.
4 CHIEF MEDICAL OFFICER LOGAN: Um-hmm.
5 CHAIRPERSON FECKNER: Thank you.
6 Ms. Middleton.
7 BOARD MEMBER MIDDLETON: Thank you, Mr. Chair.
8 CHAIRPERSON FECKNER: Wait. You turned it off.
9 Hold on.
10 BOARD MEMBER MIDDLETON: ....but very heartfelt.
11 I can't tell you how much it means to me to see CalPERS
12 moving forward on fertility care language and the
13 inclusion of LGBTQ members fully.
14 Thank you.
15 CHAIRPERSON FECKNER: Thank you.
16 Ms. Brown.
17 COMMITTEE MEMBER BROWN: Thank you.
18 Doctor, sorry, how often can you -- with respect
19 to saying that you have to -- that you're going to assign
20 a primary care physician. So how often could they change?
21 How easy will it be to change? I really have concerns
22 about that.
23 CHIEF MEDICAL OFFICER LOGAN: Yes. That is very
24 important to us too, to make sure that members feel that
25 they -- that they do have choice and they continue to have

1 choice. And so members will be able to change their PCP
2 as often as they choose to do so.
3 COMMITTEE MEMBER BROWN: So do they have to go
4 online to do it? Can they call up and do it?
5 CHIEF MEDICAL OFFICER LOGAN: Yes. They'll be
6 able to go online or to call. And we're working with
7 Anthem to make that transition as seamless as possible.
8 COMMITTEE MEMBER BROWN: I have Anthem PPO and I
9 have to tell you the website is terrible, even in terms of
10 to just get my -- just to get my medications, let alone to
11 try and get a doctor, or change my primary care physician,
12 because I've moved, or I don't want to keep seeing my
13 doctor in Orange County, or whatever. So it's not that
14 simple and I really don't think our members with the PPO
15 are going to want that. So, Mr. Chair, I want to know, if
16 I don't support that one, but I support the other changes,
17 how is that going to work? Will I just have to vote no on
18 all of 6a, because it's just one item, is that correct?
19 CHAIRPERSON FECKNER: Yes.
20 COMMITTEE MEMBER BROWN: Okay. Thank you.
21 CHAIRPERSON FECKNER: Thank you.
22 Ms. Páles.
23 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
24 DIVISION CHIEF PÁLES: Sorry. Reactivate. For next
25 steps, any approved proposals will be incorporated into

1 the 2023 rate development process. Approved changes will
2 be communicated with the health plans, our members, and
3 stakeholders via the appropriate channels. And final 2023
4 premiums will be presented for approval in summer of 2022.
5 That concludes our presentation and we're happy to take
6 any additional questions at this time.
7 CHAIRPERSON FECKNER: Thank you and thank you
8 both for a great presentation. Very concise. A lot of
9 good improvements. We really appreciate that and all the
10 hard work.
11 Seeing no requests to speak.
12 It's an action item. What's the pleasure of the
13 Committee?
14 COMMITTEE MEMBER TAYLOR: Move approval.
15 COMMITTEE MEMBER MILLER: Second.
16 CHAIRPERSON FECKNER: Moved by Taylor, seconded
17 by Miller. We have three requests to speak from the
18 audience. Mr. Jelincic, while you're on your way down,
19 I'm going to take Ms. Hueg and Mr. Woodson on the phone.
20 Mr. Fox.
21 STAKEHOLDER RELATIONS CHIEF FOX: Yes. Mr.
22 Chair, we have Stephanie Hueg to go first and Larry
23 Woodson after.
24 MS. HUEG: Ho. I am Stephanie Hueg, the
25 President of California State Retirees. Chairman Feckner

1 and Board members, thank you for the opportunity to
2 comment. CSR is in general support of the Health Benefits
3 Program proposals for to 2023 plan year. We also
4 appreciate staff's earlier public airing of new plans,
5 coverage area changes, and benefit design changes as
6 opposed to the previous practice of presenting them in
7 June at the same time as the preliminary premium increases
8 are released. This improved scheduling gives stakeholders
9 a much better opportunity to review and comment on them,
10 apart from the premium-setting process.
11 We also thank the staff for discussing these with
12 us at the stakeholders briefing last week. There were
13 some needed points of clarification on a couple of items,
14 which staff was able to clarify. Mr. Larry Woodson, our
15 Health Benefits Committee Chair, will speak to those in
16 his comments, specifically the matching of PPO members
17 with primary care providers.
18 CSR supports the expansion of plans
19 geographically. Although, we would like to see better
20 expansion to the 17 rural counties identified in the
21 annual report as having no HMO availability. We also
22 support the positive benefit design changes. And thank
23 you very much.
24 CHAIRPERSON FECKNER: Thank you.
25 STAKEHOLDER RELATIONS CHIEF FOX: Mr. Chair, we

1 have Mr. Larry Woodson.
2 MR. WOODSON: Good afternoon. Larry Woodson,
3 California State Retirees. Chairman Feckner, Board
4 members, thank you for the opportunity to comment.
5 As CSR President Hueg stated, we are supportive
6 of all the Health Benefit Program proposals for 2023.
7 That will give more choices geographically and offer some
8 improvements in benefit design.
9 I would note that while Kaiser, Blue Shield,
10 Anthem, and Western Health Advantage all offer
11 improvements, UnitedHealthcare, while offering some in
12 2022, are offering none in 2023, yet, as the Chairman will
13 recall, increased their premiums by 8.26 percent for
14 '23 -- '22. So enough said.
15 Regarding the staff-initiated proposals, we
16 support them, but we do have concerns about the
17 implementation challenge of the PCP match for the PPO
18 plans. The wording of the 6a memo is a little vague on
19 several points. And at stakeholder briefings last week, I
20 was able to get clarification on most of those issues,
21 namely that the matching applies to the Basic plans,
22 Platinum, and Gold, and not Medicare supplements, that
23 they apply to both new sign-ups and existing members,
24 those plans. The PCP assigned will be in close proximity
25 to the member's residences, as Dr. Logan mentioned.

1 A couple -- that's important. A Couple years ago
2 when Anthem Traditional was first made available to
3 members in Chico, a couple of our members there who signed
4 up and were excited to have another choice got their cards
5 and found they'd been assigned to a PCP in Grass Valley 75
6 miles away, so -- and that was a hassle for them to get it
7 straightened out So hopefully, Anthem won't make those
8 kind of errors.
9 Since neither Anthem nor CalPERS have an accurate
10 estimate, and I learned this in the stakeholders, of which
11 PPO members actually have PCPs, it appears there may be
12 shall confusion there. Even though Dr. Logan said those
13 that have them will not be getting a match, and that's
14 good, but it sounds like there may be some that do have
15 them that will get a match and that will be cumbersome.
16 So the other thing that we learned is that
17 members and their dependents will be matched with the same
18 PCP for those that are matched. That may cause a burden
19 for some members to have to change because covered members
20 may prefer a PCP of the same gender.
21 Another issue, I raised to staff was that
22 ensuring PCP assigned by matching was indeed accepting new
23 patients, because there have been some examples in the
24 past of assignments to doctors with closed practices.
25 So lastly, we are in full support of having

1 primary care providers as a first line of service and
2 treatment, both as a cost savings and reinforcement for
3 quality care. We do have concerns about some undue
4 burdens to some members.
5 Thank you.
6 CHAIRPERSON FECKNER: Thank you.
7 Mr. Jelincic.
8 MR. JELINCIC: J.J. Jelincic.
9 CHAIRPERSON FECKNER: Microphone, sir.
10 MR. JELINCIC: Hello.
11 CHAIRPERSON FECKNER: There you go.
12 MR. JELINCIC: Okay. J.J. Jelincic, RPEA.
13 If you choose to live in the beauty and serenity
14 of the forest, you accept the risk of forest fires, and
15 should not complain that your homeowners insurance is
16 higher than it would be in Fresno.
17 If you choose to move near an airport, you should
18 not expect much sympathy when you complain about aircraft
19 noise, unless you're the State Controller.
20 I would like to build a ski resort in Sacramento.
21 Unfortunately, the city lacks the essential elements of
22 mountains and snow. I share Don Moulds desire for an HMO
23 in every county. However, the HMO model, like a ski
24 resort, has certain necessary conditions. The HMO model
25 depends on a critical density of population of medical

1 providers.
2 Among other proposals before you is a proposal to
3 expand Blue Shield Access+ into some very rural areas. No
4 one else has figured out how to make this work. As I said
5 last week, it would be easier to create an HMO for cows
6 than for people in Modoc. It's just a question of
7 critical mass.
8 The system has advocated risk mitigation to
9 protect insurance companies from adverse action -- or
10 adverse selection, that is getting stuck with a
11 disproportionately unhealthy population.
12 Last month, the Board decided that the focus
13 would be on the cost structure of plans and the health
14 characteristics of the insured would not be a factor.
15 Several Board member expressed surprise, even though it
16 was at least the third time they were voting on the
17 language.
18 Because of the high costs incurred by Blue Shield
19 Access+, much of it driven by its willingness to go into
20 rural areas, in 2022 Access+ will receive $117 per member
21 per month subsidy. Since you were only half way through
22 the mitigation process, the expectation is that in 2023,
23 the subsidy will be about $230. These subsidies are being
24 paid by members subscribing to more cost controlled plans.
25 RPEA acknowledges that the proposals are for the basic

1 plans and directly impact very few of our members.
2 However, policies that reward higher medical costs and
3 punish low cost structures and cost controls will
4 eventually flow through the entire system and impact all
5 our members.
6 Blue Shield has said that these added counties --
7 it can add these counties with no additional increase in
8 premium. I am, and you should be, skeptical.
9 If you accept the expansion, I would encourage
10 you to add a condition that the higher costs in the
11 expansion area will not be included in the risk mitigation
12 calculation.
13 CHAIRPERSON FECKNER: Your time is up, Mr.
14 Jelincic.
15 MR. JELINCIC: Blue Shield should have no
16 objection, since it says the premiums will not increase.
17 You may want to consider the same conditions for Blue
18 Shield Trio.
19 Thank you.
20 CHAIRPERSON FECKNER: Thank you.
21 All right. No other requests to speak.
22 We have a motion before us. I want to remind the
23 members you're voting for the betterment of all the
24 members of the health system
25 All in favor of the motion say aye?

1 (Ayes.)
2 CHAIRPERSON FECKNER: Opposed, no?
3 (No.)
4 CHAIRPERSON FECKNER: Motion carries.
5 Anything else on this item, Ms. Páles, Dr. Logan?
6 HEALTH PLAN RESEARCH & ADMINISTRATION ACTING
7 DIVISION CHIEF PÁLES: No.
8 CHAIRPERSON FECKNER: Thank you both very much
9 for the presentation.
10 It brings us to item 7a, the Summary of Committee
11 Direction. Mr. Moulds?
12 CHIEF HEALTH DIRECTOR MOULDS: I have --
13 CHAIRPERSON FECKNER: Microphone, sir.
14 There you go. You're on now.
15 CHIEF HEALTH DIRECTOR MOULDS: Oh, I'm sorry. My
16 book is covering it.
17 (Laughter.)
18 CHIEF HEALTH DIRECTOR MOULDS: You know, it's
19 been a long time. I'm sorry. So I have two item -- I
20 have two directional items. The first is to look at the
21 percentage of members who are using the acupuncture and
22 chiropractic benefit in the -- and I believe it's in the
23 Anthem Medicare plan where the changes are being made.
24 And the second is to bring projected utilization where
25 it's available to future discussion when we're talking

1 about benefit enhancement.
2 CHAIRPERSON FECKNER: Yes.
3 CHIEF HEALTH DIRECTOR MOULDS: Yeah. Great.
4 CHAIRPERSON FECKNER: All right. Item 7b, public
5 comment. I have a request from David Haxton.
6 Mr. Fox, is that someone on the Chair.
7 STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair,
8 we have David Haxton representing himself.
9 MR. HAXTON: Good afternoon. My name is David
10 Haxton. I'm a CalPERS member, having retired two years
11 ago after 31 years of State service a Deputy Attorney
12 General in Los Angeles.
13 My comment is about Medicare Part B premiums,
14 which many retirees pay, but PERS does not reimburse. I
15 just discovered this on the eve of my 65th birthday. With
16 Medicare now contributing to the cost of my health care, I
17 had expected my premium cost to go down, but instead I
18 will be paying more while the State and PERS will be
19 paying less, much less. That's not right.
20 Medicare Part B is doctor visits and Part D is
21 drugs. Part B has always charged a premium, which
22 recipients pay to Medicare or have it deducted from their
23 social security. PERS reimburses these premiums for State
24 and Cal State retirees by adding money to their pension
25 checks up to the retiree's maximum State contribution.

1 Part D didn't become part of Medicare until 2006.
2 And the only premium recipients pay was to the Part B
3 provider with nothing paid to Medicare. But soon after,
4 to increase Medicare's revenue, Congress began charging
5 higher premiums to recipients with higher incomes. Higher
6 Part B premiums started in 2007, followed in 2011 by
7 higher Part D premiums that were for the first time paid
8 to Medicare. Higher premiums next year start at annual
9 incomes above $91,000.
10 Medicare reports that about eight percent of
11 Medicare recipients pay these higher premiums. When the
12 higher premiums were added, PERS reimbursed the higher
13 Part B premiums, but has never reimbursed the Part D
14 premium. Since both these premiums are for health care
15 and the State is legally obligated to pay health care
16 costs up to the maximum State contribution, it makes no
17 sense for PERS to be reimbursing Part B premium but not
18 Part D premiums.
19 Most of the State and Cal State retirees who pay
20 the higher Medicare premiums will be paying nearly $150 in
21 unreimbursed Part D premiums next year and some will pay
22 double and triple that amount. The State, on the other
23 hand, saves over $3,000 when a retiree is on Medicare.
24 That $3,000 is what is unused from the maximum State
25 contribution and therefore is available to reimburse the

1 $150 in Part D premium.
2 I ask you to direct staff to look at this issue
3 and prepare a report for a presentation at a future
4 meeting. And at that meeting, I ask that you sponsor
5 legislation to amend Government Code section 22879 to
6 authorize PERS to reimburse Part D premiums. This will
7 allow the many retirees who Part D premiums to finally get
8 all the health care costs paid that they are entitled to
9 have paid.
10 Thank you.
11 CHAIRPERSON FECKNER: Thank you.
12 So that ends our public comment. I do want to
13 take a moment of personal privilege and since this is Mr.
14 Brown's last PHBC meeting to thank her for her service on
15 this Committee and for offering her input into many of the
16 discussion that we have throughout the year.
17 I also want to remind everyone that this is the
18 Holiday season and especially in these last 18 months,
19 this is a tough time for a lot of families and a lot of
20 people that no longer have families. So think about that
21 when you're out there shopping or seeing people that
22 are -- that you interact with on the streets that they
23 might need a little smile or a little helping hand. So
24 give them that thought and that time during this time of
25 the season, because people need that.

1 With that, the Committee is adjourned. We'll see
2 you in March.
3 (Thereupon California Public Employees'
4 Retirement System, Pension and Health Benefits
5 Committee meeting adjourned at 3:51 p.m.)
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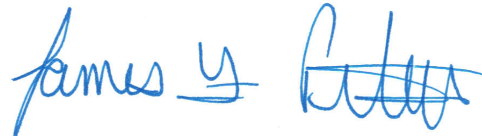
CERTIFICATE OF REPORTER

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 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 23rd day of November, 2021.



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Certified Shorthand Reporter
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