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

400 P STREET

SACRAMENTO, CALIFORNIA

WEDNESDAY, JUNE 21, 2023

9:21 A.M.

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

APPEARANCES

COMMITTEE MEMBERS:

Ramón Rubalcava, Chairperson

Jose Luis Pacheco, Vice Chairperson

Malia Cohen, represented by Lynn Paquin

David Miller

Kevin Palkki

Theresa Taylor

Yvonne Walker

Mullissa Willette

BOARD MEMBERS:

Fiona Ma, represented by Frank Ruffino

Lisa Middleton

STAFF:

Marcie Frost, Chief Executive Officer

Matt Jacobs, General Counsel

Kimberly Malm, Interim Deputy Executive Officer

Donald Moulds, PhD, Chief Health Director

Rob Jarzombek, Chief, Health Plan Research and Administration Division --

APPEARANCES CONTINUED

ALSO PRESENT:

David Aguinaldo

Elnora Fretwell

J.J. Jelincic

Larry Woodson, California State Retirees

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1 PROCEEDINGS
2 CHAIRPERSON RUBALCAVA: Good morning, everybody.
3 We're going to all to order the Pension and Health
4 Benefits Committee. Would you please call the roll.
5 BOARD CLERK TRAN: Ramón Rubalcava?
6 CHAIRPERSON RUBALCAVA: Present.
7 BOARD CLERK TRAN: Jose Luis Pacheco?
8 VICE CHAIRPERSON PACHECO: Present.
9 BOARD CLERK TRAN: Lynn Paquin for Malia Cohen?
10 ACTING COMMITTEE MEMBER PAQUIN: Here.
11 BOARD CLERK TRAN: David Miller?
12 COMMITTEE MEMBER MILLER: Here.
13 BOARD CLERK TRAN: Eraina Ortega?
14 Kevin Palkki?
15 COMMITTEE MEMBER PALKKI: Good morning.
16 BOARD CLERK TRAN: Theresa Taylor?
17 COMMITTEE MEMBER TAYLOR: Here.
18 BOARD CLERK TRAN: Yvonne Walker?
19 COMMITTEE MEMBER TAYLOR: Here.
20 BOARD CLERK TRAN: Mullissa Willette?
21 COMMITTEE MEMBER WILLETTE: Here.
22 CHAIRPERSON RUBALCAVA: We will now recess into
23 closed session for Items 1 through 3 on the closed session
24 agenda. And the Pension and Health Benefits Committee
25 will reconvene in open session following this closed

1 session, but the open session meeting of the Pension and
2 Health Committee will not continue until after the Risk
3 and Audit Committee meeting concludes.
4 Thank you.
5 (Off record: 9:22 a.m.)
6 (Thereupon the meeting recessed
7 into closed session.)
8 (Thereupon the meeting reconvened
9 open session.)
10 (On record: 3:30 p.m.)
11 CHAIRPERSON RUBALCAVA: Good afternoon,
12 everybody. We're going to -- we're back in open session
13 and we'll be -- reconvene the Pension and Health Benefits
14 Committee.
15 So one, if we could start with the roll call,
16 please.
17 BOARD CLERK TRAN: Ramón Rubalcava?
18 CHAIRPERSON RUBALCAVA: Present.
19 BOARD CLERK TRAN: Jose Luis Pacheco?
20 VICE CHAIRPERSON PACHECO: Present.
21 BOARD CLERK TRAN: Lynn Paquin?
22 ACTING COMMITTEE MEMBER PAQUIN: Here.
23 BOARD CLERK TRAN: David Miller?
24 COMMITTEE MEMBER MILLER: Here.
25 BOARD CLERK TRAN: Eraina Ortega?

1 Kevin Palkki?
2 COMMITTEE MEMBER PALKKI: Good afternoon
3 BOARD CLERK TRAN: Theresa Taylor?
4 COMMITTEE MEMBER TAYLOR: Here.
5 BOARD CLERK TRAN: Yvonne Walker?
6 COMMITTEE MEMBER WALKER: Here.
7 BOARD CLERK TRAN: Mullissa Willette?
8 COMMITTEE MEMBER WILLETTE: Here.
9 CHAIRPERSON RUBALCAVA: Okay. And Eraina Ortega
10 is excused.
11 BOARD CLERK TRAN: Got it.
12 CHAIRPERSON RUBALCAVA: Thank you.
13 Okay. Now, we have Item number 3, action consent
14 items. Do I have a motion to approve the items?
15 VICE CHAIRPERSON PACHECO: Motion.
16 COMMITTEE MEMBER MILLER: Second.
17 CHAIRPERSON RUBALCAVA: Motion from Jose Luis
18 Pacheco, second by Mr. David Miller.
19 Please call the vote.
20 All those in favor?
21 (Ayes.)
22 CHAIRPERSON RUBALCAVA: Thank you.
23 We now proceed to information consent items. I
24 don't think anything was pulled, so we can continue. So
25 let's continue to the information agenda item.

1 Before us, we have Item 5a, the preliminary 2024
2 Health Maintenance Organization and Preferred Provider
3 Organization plan premiums.
4 CHIEF HEALTH DIRECTOR MOULDS: Mr. Chair, sorry.
5 I think there were Executive Reports ahead of that second
6 item.
7 CHAIRPERSON RUBALCAVA: Oh. Oh, yes, they are.
8 Thank you. Thank you, Mr. Moulds. So why don't we start
9 with the Executive report. Thank you.
10 INTERIM DEPUTY EXECUTIVE OFFICER MALM: Great.
11 I'm going to go ahead and get started. Good afternoon.
12 Kim Malm, CalPERS team member. I just have a few opening
13 comments, and I'll keep them brief, as I know Don has, and
14 the team have, a lot of information to present today on
15 the health rates.
16 I thought I'd let you know that our next CBEE
17 will be this Friday and Saturday in Bakersfield, June 23rd
18 and June 4th. Luckily, the weather isn't as horrible as
19 we were expecting it to be. It's like 83 and not 90s --
20 high 90s. Currently, there's almost 1,400 registrants,
21 which is the highest registration we've ever had for a
22 Bakersfield CBEE. This surpasses our previous
23 registration high for Bakersfield of 870 back in 2018 or
24 pre-pandemic. So the team is very excited. After
25 Bakersfield, the next two CBEEs are July 28th and 29th in

1 Eureka at the Red Lion Inn, and December 5th and 6th will
2 be held virtually.
3 Secondly, I'm pleased to announce the appointment
4 of Sharon Hobbs as the new Division Chief over Disability
5 and Survivor Benefits Division effective July 3rd. Sharon
6 worked at CalPERS for 25 years -- has worked at CalPERS
7 for 25 years in many areas of the organization. For the
8 past eight years, Sharon has served as the Assistant
9 Division Chief in the Member and Account Management
10 Division in CSS leading the Service Credit Purchase and
11 Elections Program. In this role, she led her team to
12 successfully implement self-service functionality for
13 service credit costing and elections, as well as enabling
14 members to view their accumulated service credit in their
15 myCalPERS account.
16 Sharon is known for her positive attitude and
17 collaborative leadership, and always displays a strong
18 sense of commitment to the success of CalPERS and our
19 customer service environment. Please join me in
20 congratulating Sharon on this well deserved promotion.
21 (Applause).
22 INTERIM DEPUTY EXECUTIVE OFFICER MALM: So now
23 you know who to call for disability and survivor.
24 And I'll turn it over now to Mr. Moulds.
25 CHAIRPERSON RUBALCAVA: Thank you, Ms. Malm.

1 CHIEF HEALTH DIRECTOR MOULDS: Thanks. Good
2 afternoon, Mr. Chair and members of the Committee. Don
3 Moulds, Chief Health Director. Our focus today is the
4 2024 preliminary health plan premiums. So this has been a
5 challenging year for rates, as I think we all know. The
6 increasing we're going to talk -- the increases we're
7 going to talk about in just a minute are too high. And I
8 want to acknowledge that they will adversely hit the
9 wallets of our members and the budgets of our employers.
10 There are multiple underlying reasons for these
11 high rates. In general though, we are starting to
12 experience high medical inflation that we -- higher,
13 sorry, medical inflation than we've seen in recent memory.
14 This is pushing rates for all of our plans, but
15 particularly for Kaiser and our Basic PPOs.
16 On the Medicare side, some of the changes CMS
17 made this year, changes that bolster the integrity of the
18 Medicare Advantage program in particular and that we think
19 are critical to shoring up the long-term solvency of the
20 medical trust fund also have the effect of decreasing the
21 revenue our plans receive from CMS. Since our Medicare
22 plans are essentially supplemental policies and since most
23 of the cost of the Medicare plans are paid for by
24 Medicare, a decrease in Medicare revenue results in an
25 increase in our costs.

1 Rob Jarzombek is going to talk in a lot of detail
2 about what we are seeing in rates, but I also want to take
3 a couple minutes to say a little bit about our Basic PPO.
4 As you heard this morning in the Finance and
5 Administration Committee, despite the pricing and
6 surcharge you authorized last year, the PPO continues to
7 lose money and to put intense pressure on the Health Care
8 Fund's reserves.
9 Rob is going to discuss the why, but chief among
10 the reasons is that the PPO continues to lose healthy
11 members to our HMOs, and that is causing the PPO spending
12 to outpace the premiums we're collecting. Left
13 unaddressed, this trend will undermine the viability of
14 the PPO.
15 When the Board approved risk adjustment in 2020,
16 it created two distinct risk pools, one for our HMOs and a
17 single separate pool for the two PPOs. It did this to
18 minimize the disruption that comes with instituting risk
19 adjustment, and at the advice of the team as well as our
20 external consultants. But as we discussed then, this was
21 a temporary solution. We had hoped that it would be
22 longer before we needed to begin to merge the two risk
23 pools, but the losses the PPO took in 2021 and 2022 have
24 push that timeline for next steps to now.
25 Prior to implementing risk adjustment in 2020, we

1 engaged in a consultive process wherein we discussed
2 proposed changes multiple times in open session and with
3 stakeholders. The timeline we are facing now limits our
4 ability to do that. I'll say here that this is not our
5 preferred way of working. But the challenges we are
6 facing today call for immediate action.
7 Our commitment is that we will seek additional
8 change -- as we seek additional changes to improve the
9 quality and cost effectiveness of the PPO, both of which
10 are goals as we rebuild the program for 2025, we will seek
11 feedback from the public and from stakeholders early and
12 often.
13 If there's a silver lining to the picture we're
14 sharing in just a minute, it's that several of the
15 products the Board has invested in heavily, the narrow
16 network basic HMOs and some of our newer Medicare
17 advantage products are bucking the high cost trends that
18 you're going to be seeing today. That creates real
19 opportunities for our members to save money, if they're
20 willing to shop around for insurance.
21 That concludes my remarks. Happy to take any
22 questions. Otherwise, thanks and I'll turn it over to
23 Rob.
24 CHAIRPERSON RUBALCAVA: Thank you, Mr. Moulds.
25 And any questions from the Committee for Mr. Moulds?

1 Seeing none, please continue, Mr. -- who's next?
2 Rob, please continue.
3 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
4 JARZOMBEK: Okay. So we'll move on to Agenda Item 5a.
5 Can we get the slides?
6 (Thereupon a slide presentation).
7 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
8 JARZOMBEK: Great. So good afternoon, Mr. Chair and
9 members of the Committee. Rob Jarzombek, CalPERS team
10 member. This information item provides an update on the
11 progress of the rate development process and presents
12 preliminary 2024 premiums for all Basic and Medicare
13 health plans.
14 --o0o--
15 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
16 JARZOMBEK: On the agenda today, I'll go over the
17 timeline, program updates, and preliminary weighted
18 averages. We'll also cover cost influencers, discuss
19 options related to our Basic PPOs, and I'll present the
20 preliminary premiums for each of the Basic and Medicare
21 plans.
22 --o0o--
23 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
24 JARZOMBEK: Here is our timeline. In March, you approved
25 the intent to award for the next five-year contracts for

1 our HMO plans. Today, we're presenting the preliminary
2 premiums. Between now and July, the team will finalize
3 premiums and present them to you for your approval at the
4 July Board off-site.
5 --o0o--
6 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
7 JARZOMBEK: Last November and March, the Board approved
8 service area changes, benefit design changes, and the exit
9 of one plan. Those changes are detailed in the agenda
10 item.
11 --o0o--
12 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
13 JARZOMBEK: As quick a refresher, I'd like to briefly
14 share how we set health premiums. To enhance transparency
15 and significantly strengthen our negotiations with the
16 plans, we've greatly improved our process over the past
17 three years. We require the plans to present their data
18 in a way that allows us to create a baseline projection
19 for each Basic plan. We then compare it with the health
20 plan's rate proposal. This standard methodology allows us
21 to conduct an apples-to-apples comparison to our
22 projections and assumptions. It also allows us to drill
23 into significantly more detail with the plans to
24 understand what's driving trends at the plan level.
25 Finally, we risk adjust premiums for the basic

1 plans, based on the risk mitigation strategy approved in
2 2020. This methodology allows us to price the plans based
3 on the value of the network and benefit designs and not on
4 the risks -- the health risk of the members. We do not
5 risk adjust Medicare premiums as CMS already has done
6 this.

7 --o0o--

8 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
9 JARZOMBEK: Let's begin with a look at the preliminary
10 2024 Basic plan premiums. The numbers you see here and
11 throughout the presentation are the State single-party
12 premiums. I'd like to orient everyone to this table we
13 have showing the premiums for the Basic plans. As we have
14 in the past, we show the standard comparison of the
15 current year and the next year's premiums and the
16 percentage change.

17 However, this year, we have two additional
18 scenarios. These are provided here as they are a key part
19 of today's conversation and we wanted everyone to be able
20 to understand the challenges we face on the PPOs, and how
21 potential options impact the rest of our Basic plans. The
22 second and third scenarios reflect options we're
23 presenting to the Board for their consideration.

24 As we've been seeing with PPO reserve deficit,
25 the PPOs continue to experience higher unit costs and

1 utilization than what was projected. That situation
2 became very clear during the RDP process this year and
3 that some important actions need to be taken in 2024, as
4 waiting until 2025 was too risky.
5 Therefore, we started evaluating all the levers
6 we have available to us. This is working closely with
7 Anthem on ways to reduce costs and support members to the
8 right side of care, assessing additional surcharges to
9 replenish the HCF reserves, evaluating potential benefit
10 design changes, and considering network modifications to
11 reduce or eliminate high cost facilities from the PERS
12 Gold network.
13 We want to be transparent and clear about our
14 situation. The bottom line is that action must be taken
15 starting in 2024, so that we can continue to have
16 sustainable and affordable PPO plans for our members and
17 as part of the CalPERS portfolio.
18 Now, back to the table. The first set of
19 premiums in the table is our current scenario of two risk
20 pools, one for HMOs and one for PPOs. The second set of
21 premiums is transitioning to one risk pool for all Basic
22 plans with a two-year phase-in. And the third set of
23 premiums is transitioning to one risk pool with a
24 three-year phase-in in making modest benefit design
25 changes in the PPO. This last one is our recommendation

1 shown in green. For each scenario, we provide the premium
2 changes as well as the overall HMO, PPO, and Basic plan
3 weighted average increases.
4 --o0o--
5 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
6 JARZOMBEK: Next, here are the preliminary Medicare plan
7 premiums. Medicare premiums are already risk-adjusted by
8 CMS, as I mentioned, and are not impacted by the risk
9 mitigation that occurs on our Basic plans or by the
10 options we're considering for 2024. Therefor, there are
11 no additional scenarios on this table.
12 --o0o--
13 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
14 JARZOMBEK: This slide summarizes the premium changes for
15 the Basic and Medicare plans and the program overall under
16 each scenario. As I mentioned, Medicare premiums are not
17 impacted by the Basic plan risk pooling, just the Basic
18 plans are. And those potential changes are reflected
19 here. Again, this table shows the overall premium changes
20 under three scenarios and the green column is our
21 recommendation.
22 --o0o--
23 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
24 JARZOMBEK: Let's look at the cost influencers impacting
25 our program.

1 --o0o--
2 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
3 JARZOMBEK: The first is medical inflation, which while it
4 doesn't track one for one with general inflation, it is
5 driving increased costs. As prices for goods and services
6 go up, medical costs also go up. Utilization is higher
7 than anticipated. We are seeing continued high demand for
8 outpatient and professional services. In our PPO, the
9 utilization trend is up over 20 percent. We're also
10 seeing variation in projected costs across plans. Our
11 narrow network plans, UHC's Harmony, Western Health
12 Advantage, Blue Shield's Trio, and Salud y Más have lower
13 medical trend, but our larger plans and our PPO are
14 experiencing higher medical costs.
15 Pharmaceutical costs also continue to be high.
16 While we continue to get the best-in-market pricing from
17 our contract with Optum, the cost of prescription drugs
18 also continues to go up for everyone and utilization is
19 higher on pharmacy as well.
20 And for Medicare plans, premiums are increasing
21 due to receiving less revenue from CMS. CMS is
22 implementing changes to their risk-adjustment methodology
23 that are impacting plans directly.
24 --o0o--
25 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF

1 JARZOMBEK: Now, I'll walk through each of the Basic plans
2 starting with the HMOs.
3 --o0o--
4 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
5 JARZOMBEK: We'll start with Anthem Select HMO.
6 CHAIRPERSON RUBALCAVA: Excuse me.
7 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
8 JARZOMBEK: Yes.
9 CHAIRPERSON RUBALCAVA: Before you continue into
10 the individual plans, I think we have questions and
11 comments from the Committee. Thank you, Rob.
12 We'll start with President Taylor, please.
13 COMMITTEE MEMBER TAYLOR: I don't want to take up
14 too much time. I just wanted to make sure we were going
15 to talk about Kaiser, first of all. But secondly, so
16 when -- so we're showing the HMO, PPO risk-adjusted, the
17 two different ways, plans, so I just want to make sure --
18 so we've got the three-year phase-in and the two-year
19 phase-in, correct?
20 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
21 JARZOMBEK: Correct.
22 COMMITTEE MEMBER TAYLOR: And we -- we're still
23 going to discuss all the rest of it?
24 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
25 JARZOMBEK: Absolutely. Absolutely, yes.

1 COMMITTEE MEMBER TAYLOR: Okay. I just -- you
2 keep going.
3 CHAIRPERSON RUBALCAVA: Okay. Mr. Palkki.
4 COMMITTEE MEMBER PALKKI: I can wait.
5 CHAIRPERSON RUBALCAVA: You can wait.
6 Okay. Mr. Jarzombek, please continue.
7 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
8 JARZOMBEK: Okay. Thank you.
9 So we'll start by going through the plan slides
10 and we will pause whenever we need to to talk about the
11 specific plans as they come up. But for this one, I'll
12 walk through to kind of orientate us all to what is being
13 shown on the slide.
14 So the -- look at the -- at the blue table on the
15 left, it shows the 2023 premiums, so the current premium
16 of $903 and the plan's preliminary 2024 premium of $937
17 before risk mitigation. The next column shows the plan's
18 risk score. Plans with a score greater than 1 with 1
19 being the average have unhealthier lives than their --
20 have unhealthier lives and their premium is lowered with
21 the impact of risk adjustment. Plans with risk scores
22 less than 1 have healthier lives and will see risk
23 adjustment increase their premium. Anthem select has a
24 risk scour of 0.9753. This indicates that the plan has
25 healthier than average members in the basic portfolio.

1 Therefore, Select's premium is increased to $976 due to
2 risk mitigation. Overall, this is about an eight percent
3 increase from 2023.
4 Now, moving to the right, the cost drivers bar
5 chart shows a breakdown premium increase by component. So
6 Anthem's projection for medical costs contributes to four
7 and a half percent impact to their premium.
8 The next bar is pharmacy, which contributes two
9 and three-quarter's percent. Administrative plus other
10 includes overall changes on administrative costs for the
11 health plans as well as CalPERS. It also includes changes
12 to the family mix within the health plan's enrollment.
13 Last year, Select lost about 21 percent of the
14 membership -- of its membership during open enrollment.
15 This led to a 1.2 percent downward premium impact due to
16 the change in the family mix. And risk mitigation is 1.82
17 percent of the total premium increases from '23 to '24.
18 Now, let's look at Anthem Traditional.
19 --o0o--
20 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
21 JARZOMBEK: This is a broad network HMO offered in many
22 high cost, low competition areas of the state. Anthem
23 Traditional is exiting Glenn County, where there are only
24 two members enrolled in this plan. There is no impact on
25 the 2024 premium for this exit. Overall, this plan has a

1 six and a half percent increase from 2023.
2 --o0o--
3 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
4 JARZOMBEK: Blue Shield Access+ is a broad network HMO as
5 well as an EPO. In the last few years, they've been
6 working close -- closely with us to help achieve -- help
7 us achieve our goal of having lower cost -- a lower cost
8 EPO option available in rural counties. In 2023, Access+
9 EPO expanded into 11 rural counties through their EPO
10 network. And in 2024, it's expanding into Del Norte and
11 San Benito counties. The cost associated with this
12 expansion is 0.4 percent and brings the increase for next
13 year to 3 -- to four and three-quarters percent.
14 --o0o--
15 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
16 JARZOMBEK: Trio is a narrow network plan available in 19
17 counties. Trio's premium reflects not only a healthy risk
18 mix in their population, but also effective medical and
19 pharmacy management. We are pleased with their
20 performance and look forward to their continued growth in
21 our program. Their overall increase going into next year
22 is 5.3 percent.
23 --o0o--
24 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
25 JARZOMBEK: Health Net Salud y Más is a very narrow

1 network plan that provides services in six Southern
2 California counties as well as in Mexico. This plan has
3 the healthiest members in our basic portfolio and risk
4 mitigation increased their premium $131. Yet, even then,
5 Salud y Más is lowest HMO premium -- has the lowest HMO
6 premium in the basic portfolio, which is increasing by
7 less than three percent.
8 --o0o--
9 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
10 JARZOMBEK: Sharp is a closed capitated network that
11 provides services in San Diego County. Sharp's
12 preliminary premium is seven and three-quarters percent
13 from 2023.
14 --o0o--
15 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
16 JARZOMBEK: UnitedHealthcare Alliance operates in 26
17 counties. UHC is expanding Alliance to 12 Bay Area
18 counties for public agency and school members next year.
19 There is no rate impact for this expansion. UHC
20 Alliance's preliminary premium has a three and
21 three-quarter percent increase.
22 --o0o--
23 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
24 JARZOMBEK: UHC's Harmony is a narrow network currently
25 available in five Southern California counties. Harmony

1 is expanding into Santa Clara and Santa Cruz counties next
2 year providing members a low cost HMO alternative in two
3 Northern California counties. Through the HMO
4 solicitation, UHC has committed to expanding Harmony into
5 areas of the state where lower cost plans aren't
6 prevalent, while continuing to provide competitive
7 pricing. We'll work closely with them on their expansions
8 in the coming years. Harmony's preliminary premium has a
9 4.6 percent increase.
10 --o0o--
11 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
12 JARZOMBEK: Western Health Advantage provides service in
13 the Sacramento area and selected Northern California
14 counties. WHA offers a great rate for a Northern
15 California only plan and we're working with them to expand
16 into other Northern California areas. Western Health
17 Advantage's preliminary premium has a five percent
18 increase from this year.
19 --o0o--
20 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
21 JARZOMBEK: Kaiser Permanente operates in 31 counties.
22 Kaiser's preliminary premium is $953, a 12 percent
23 increase from 2023, making it the highest increase among
24 the Basic HMO plans we offer. You'll see in looking at
25 the cost drivers that most of the premium increase comes

1 from the high medical trend. While their premium is very
2 close to our projection, what's concerning is the higher
3 medical trend that they are experiencing. For example,
4 their overall increase is about double of the increases we
5 are seeing for our other HMOs. This is quite concerning
6 as Kaiser's model should be less expensive. It is an
7 integrated system that by its very structure limits the
8 choices available to members. Despite this efficient
9 model, Kaiser is projecting a very high premium in -- very
10 high premium increases across California. As we go
11 forward, we want to work with Kaiser to move them back to
12 the middle of our book over the coming years. Both
13 CalPERS and Kaiser are committed to doing this.
14 I'll pause here in case there are any questions
15 or comments about any of our HMO offerings.
16 CHAIRPERSON RUBALCAVA: Any questions from the
17 Committee members?
18 Ms. Taylor, please.
19 COMMITTEE MEMBER TAYLOR: So I just want it on
20 record - thank you, Chair Rubalcava - Kaiser is too high.
21 This is -- and I understand we're looking at this as
22 they're seeing their medical costs. Can you kind of go
23 into that a little bit for our members?
24 CHIEF HEALTH DIRECTOR MOULDS: Yeah. I mean,
25 there are -- so we don't disagree with you. In fact, I'll

1 put it more directly we agree with you they're too high.
2 We do think that this premium reflects the experience that
3 we're seeing. So, you know, we had a lot of back and
4 forth. Kaiser came to the table on that. So we don't
5 feel like this is out of line with their costs, but we are
6 deeply concerned about their costs.
7 So the trend -- you know, historically, Kaiser
8 has been in the lower part of our book, which is
9 appropriate for a plan that is half of our membership.
10 And they do that by offering high quality care that is
11 heavily managed and in a closed system, and there are
12 efficiencies that the Kaiser model offers, but we are not
13 seeing them in their prices this year.
14 So this is going to be -- it has been a
15 conversation now for a while. Kaiser thinks that part --
16 at least part of this is them seeing the effects of
17 medical inflation in much closer to real-time. So unlike
18 some of our other carriers that have multi-year contracts,
19 Kaiser, when there is medical inflation, they don't --
20 they don't see it when the next contract comes up. They
21 see it right away, because they -- you know, they are all
22 of the entities that they're contracting with.
23 We -- they also think that their labor costs have
24 gone up. We don't have the ability to see that in our
25 claims. We just say see claims. We can't unpack that,

1 but that is another thing that they have pointed to as a
2 source.
3 A third thing that they have pointed to, which we
4 will look -- which we are looking into is that they think
5 that their model is potentially disadvantaged in the risk
6 adjustment process, essentially it's a claim -- it's
7 heavily reliant on claims. And Kaiser members are managed
8 in ways where they don't generate a medical claim as
9 frequently as in some other systems, at least that is
10 the -- that's the view of Kaiser. So we're looking at
11 that to make sure that that is not an issue. If it is an
12 issue, we, of course, would be working with MARA to
13 address it.
14 So those are -- those are some of the -- of the
15 issues. I think Kaiser is also trying to get their hands
16 around all of the drivers of these increased costs, but
17 it's something that we're going to have to be working with
18 them on over the course of the next year, because we can't
19 have them where they are right now. It's highly
20 problematic given how many members they have in the Kaiser
21 system.
22 COMMITTEE MEMBER TAYLOR: Yeah. They're, yeah,
23 half their book.
24 A lot of my members would be very concerned about
25 this. All of our members will be. But here's where I'm

1 concerned, I do know that their pharmacy was relatively
2 high. And it's actually, in comparison to what it used to
3 us, because they do their own pharmacy, they do
4 everything, it's only just a little bit lower now than our
5 pharmacy benefit manager, right? So that's a problem.
6 The thing -- the -- what you were talking about
7 in terms of getting disadvantaged by the risk adjustment,
8 there was a -- there was one in here where they were risk
9 adjusted like seven percent. So Kaiser has nothing to
10 complain about. However, what I will say with Kaiser, I
11 think you said earlier to us in closed session that the
12 claims -- they're saying that their claims aren't being
13 recognizing because sometimes they don't see the person or
14 they gatekeep the patient.
15 CHIEF HEALTH DIRECTOR MOULDS: So the -- that
16 would be one way of looking at it. I'm not sure Kaiser
17 would characterize it that way.
18 COMMITTEE MEMBER TAYLOR: Sorry.
19 CHIEF HEALTH DIRECTOR MOULDS: You know, they --
20 for example, in their examples, they manage -- they work
21 with patients through email at a higher clip they think.
22 And so that wouldn't generate a claim. So telemedicine
23 visit --
24 COMMITTEE MEMBER TAYLOR: Is that a business
25 model that they've adopted is email?

1 CHIEF HEALTH DIRECTOR MOULDS: I don't know
2 whether that's formal or informal, but I think they try to
3 handle things in the -- in a combination of the most
4 accommodating in terms of scheduling for the member and
5 the lowest cost. And that's certainly what they aspire
6 to. And so, you know, email is one of the things that you
7 can use to do that. In a closed system, you can make
8 those decisions. In a fee-for-service system, it's very
9 hard to get physicians to do heavy management through
10 email, even when it's appropriate, because you can't bill
11 for email.
12 COMMITTEE MEMBER TAYLOR: Right. So but -- so
13 since they know that, then maybe they shouldn't be doing
14 that, but -- but the other issue is if they're emailing
15 them and they're not seeing them, there shouldn't be a
16 claim, right? Are they prescribing medication over email?
17 CHIEF HEALTH DIRECTOR MOULDS: I don't want to
18 speak for Kaiser on that front. I don't -- I think we
19 could certainly have a -- get a more detail explanation of
20 what transpires over email and how they use email to
21 manage claims.
22 COMMITTEE MEMBER TAYLOR: Now, as I recall, they
23 wanted to raises their prices last year as well, so we're
24 in this situation where we got them to come down a bit.
25 CHIEF HEALTH DIRECTOR MOULDS: So we did. They

1 took pretty major concessions last year, that they were
2 concerned put them at below their projected medical trend.
3 When we built up our own rate, what turned out to be the
4 case is that their projections were pretty accurate. So
5 we did -- we did -- we are proceeding this year with what
6 is probably a pretty heavily discounted rate. We think --
7 COMMITTEE MEMBER TAYLOR: Again.
8 CHIEF HEALTH DIRECTOR MOULDS: -- three percent.
9 So the -- so based on that, you know, our projections are
10 that Kaiser probably should have started about three
11 percent higher, which is another reflection on the premium
12 and where the premium actually is. So it would be -- if
13 you were starting at that higher rate, this premium
14 increase would be lower.
15 COMMITTEE MEMBER TAYLOR: Okay. So -- okay. So
16 that also is a cost driver. And do we have a way of
17 seeing the medical costs as is they -- is it through this
18 year we will see the claims?
19 CHIEF HEALTH DIRECTOR MOULDS: Yeah. We see --
20 so we have the ability to see Kaiser claims. We -- that's
21 part of our contract with Kaiser. They come into our
22 database and we're able to analyze them and look at trend.
23 That's how, you know, we work with all of our plans. We
24 get together routinely and we go over what we're seeing.
25 We compare it to what they're seeing. We ask questions

1 with what they're -- what they're doing to address some of
2 the troubling trends we're seeing. And that's certainly
3 something that we will be doing more closely with Kaiser
4 this year, both because they're so much of our membership
5 and because of the changes in their cost structure.
6 COMMITTEE MEMBER TAYLOR: Because if it -- if
7 it's true that they're saying that they get to see the
8 medical inflation and pharmacy inflation before everyone
9 else does, it would be nice if we could sort of precog
10 that a little bit for next year. But, yeah, this is still
11 awfully high. So I appreciate it. Thank you.
12 CHAIRPERSON RUBALCAVA: Thank you, President
13 Taylor.
14 Next, we have Trustee Walker.
15 There you go.
16 COMMITTEE MEMBER WALKER: Thank you, Mr. Chair.
17 And I want to echo my colleague here to say that Kaiser is
18 not just too highway, they are way too high. They are way
19 too high. And I just want to encourage you -- and I
20 realize -- and let me just say up front that I think you
21 guys have done an amazing job in working with Kaiser in
22 getting them down, but I think that they need to hear from
23 us that they have not gone down low enough, alright. I
24 think that there's a lot of factors that are involved when
25 you think about the impact of inflation that our members

1 are seeing at this moment to add these high costs on is
2 problematic for me.
3 Kaiser is not losing money. I mean, they're
4 not -- well, maybe they are, but they're not going broke.
5 They're good. They got money. It's my understanding that
6 in the past they've used reserves to try to buy this down.
7 I think that they should look at that now in the present.
8 And I'm also concerned by the fact that they have --
9 they're buying a medical group outside of California using
10 reserves that were created here in California, right? I
11 mean, I just think that that's the wrong way to go, so I
12 would encourage you to -- before we see you in July to go
13 back and have a further conversation, a demanding
14 conversation, a stern conversation, an oomph conversation
15 with Kaiser, because this is 12 percent basically. It's
16 too much. It is too much.
17 CHAIRPERSON RUBALCAVA: Thank you, Ms. Walker.
18 Mr. Pacheco, please.
19 VICE CHAIRPERSON PACHECO: Thank you. Thank you,
20 Chairman Rubalcava. And I also want to echo the same
21 sentiments with respect to President Taylor and my
22 other -- my other colleague. And I want to also mention
23 and also want to thank you guys for providing this
24 information for us. You know, I appreciate the candor you
25 are -- regarding this landscape that we are encountering

1 with respect to these high premium rates increases for
2 our -- I mean, almost half of our members are in Kaiser,
3 which is incredible. And it's interesting, because, you
4 know, throughout Kaiser's 78 year history, you know,
5 Kaiser has been known as a coastal California health care
6 provider, planting first its seeds in Northern California
7 and then later on in Southern California.
8 You know, our members our hard working members in
9 our system, you know, have -- you know, have contributed
10 to that local health care system, you know, and by serving
11 our local community. And with high quality, you know,
12 care in a closed network environment.
13 And also -- it's also helped lift not only the
14 local economy, but our State economy, the state of
15 California. This is a State. I mean, they're -- I mean,
16 we're the fourth largest -- if we were our own country,
17 we'd be the fourth largest country in the world, I mean,
18 by economics terms.
19 You know, and over the decades, CalPERS health --
20 health care -- you know, health members -- our health
21 members, which is about half as you mentioned, you know,
22 help -- have helped forge CalPERS huge market share in
23 California, and also significantly played a role in
24 increasing their reserves. I mean, that's -- that's
25 clear. That's a fact. That's incredibly factual. So I

1 am very, very frustrated with Kaiser in terms of what
2 they -- what they're doing here and what they have -- they
3 moved this with these high rates. And I would appreciate
4 them to come back, and speak to us, and collaborate with
5 us, and come back to meeting us at that lower or middle
6 market rate, so that we can move forward, and that our
7 members can have what they've done. I mean, this is very
8 important to us and it's important to our -- half of our
9 membership in the system. So thank you.
10 CHAIRPERSON RUBALCAVA: Thank you, Trustee
11 Pacheco.
12 Next, we have Mr. -- Trustee Palkki.
13 COMMITTEE MEMBER PALKKI: Thank you. I believe
14 you answered most of -- much of my question. But looking
15 at the cost influencers, I'm assuming these cost
16 influencers are equal across the board for all providers.
17 And to the point that's already been reiterated over and
18 over again, one provider comes in at roughly two percent,
19 three percent and then another provider comes in triple,
20 quadruple that amount. Are there rules in place? Because
21 it -- I hate to use the word, but it almost feels like
22 price gouging and are there rules in place that prevent
23 companies from doing things like that?
24 CHIEF HEALTH DIRECTOR MOULDS: You know, I'll say
25 that -- you know, and Rob went through the sort of how we

1 get to these rates, that we build up a rate independently
2 of our health plans based on our claims data and then --
3 and then when we go into negotiation, the health plan will
4 share the rate that they're proposing. And there is a
5 multi-month's long process where we go back and forth to
6 understand one another's assumptions, disagree about
7 assumptions.
8 In the case of the Kaiser rate, the Kaiser rate
9 is very close to what we see in our own data. So the
10 initial Kaiser rate and the second Kaiser rate were not,
11 but the Kaiser rate that you're seeing right now is quite
12 close. So I do not -- we are deeply concerned about the
13 price trend that we're seeing in Kaiser. It is
14 unsustainable and Kaiser is going to need to do something
15 different to get back to the product that they were able
16 to put on the table in the past, 'cause if they aren't,
17 then having them have half our book is going to be a
18 profound problem for CalPERS, and for CalPERS employers,
19 and for CalPERS members.
20 And so that is -- so the fact that we're able to
21 essentially verify that this rate is consistent with their
22 costs is not that encouraging. In fact, you might argue
23 that it's worse than the alternative, because in the
24 alternative, we could just say, look, you guys are coming
25 un -- in with an unreasonable rate based on what we're

1 seeing in our own data. We're not seeing that much
2 difference in our data, which means that Kaiser is going
3 to have to start doing things differently. That is the
4 conversation that we will be having with -- that we've
5 been having with Kaiser and that we will continue to have
6 with Kaiser over the course of the year, so that we're in
7 a position to come back next year with better news.
8 COMMITTEE MEMBER PALKKI: Thanks you, Chair.
9 CHAIRPERSON RUBALCAVA: Thank you, Trustee
10 Palkki.
11 We have Ms. -- Trustee Walker again, please.
12 COMMITTEE MEMBER WALKER: Thank you. I'm sorry.
13 I forgot to mention this. So you mentioned before that
14 they -- one of the reasons they cited for the high cost --
15 for the high increase was because they brought in a couple
16 of big labor contracts. And, you know, they're passing
17 that on. And I find that to be particularly offensive,
18 you know, because their labor costs are part of their
19 infrastructure, right, just like they have x-ray machines
20 and all the other things that they run. They couldn't run
21 their system without, you know, the workers in the system.
22 And to say that they're the reason for a high premium,
23 they should not be able to say that. We should not accept
24 that ever from them saying that. That's just part of
25 their infrastructure. It's their human infrastructure,

1 but it's just part of their infrastructure and they
2 should -- they should pay for that and not pass it on.
3 CHAIRPERSON RUBALCAVA: Thank you, Trustee
4 Walker.
5 Trustee -- President Taylor, please.
6 COMMITTEE MEMBER TAYLOR: Thank you so much. I
7 forget to say something. I will agree with my colleague
8 Director Walker, because, yeah, we all have to accept
9 increased labor costs, just like we have to accept
10 inflation, which they're saying we need to accept. So one
11 of the things I thought of -- and I looked back in my
12 notes. We were looking at these really high rates, the
13 first couple of rates back in May and April, and I know
14 that we -- you've had the opportunity to sort of go back
15 and forth and really see what their claims were. But I
16 really feel like are we seeing realistic costs or are
17 these costs -- are there -- is there medical inflation,
18 because they are a closed system what they're driving, you
19 know? And we won't know that till, I guess, next year.
20 So that's where I'm concerned is that they're artificially
21 driving these costs up themselves.
22 As -- and then additionally, I will reiterate
23 what Ms. Walker said earlier is that they have reserves.
24 Most of the folks at my work have Kaiser. Okay. I hear
25 this every time this goes up, and usually -- it hasn't

1 gone up double digits in years. And so when this is going
2 to go up, I'm going to hear about this. People cannot
3 afford this. With the inflation going on right now, our
4 paychecks are not covering what they used to cover.
5 People can't afford this. So maybe with the reserves that
6 they have built up, rather than spending the money out of
7 state to buy another medical facility, they should be
8 spending it here to bring down the rates in California,
9 because I'm under -- also under the understanding that
10 this is going on for Kaiser all throughout California.
11 And I really think we need to -- you know, this -- they
12 wouldn't be where they are without California. So that's
13 where I'm at for this.
14 CHAIRPERSON RUBALCAVA: Thank you, President
15 Taylor.
16 Want to continue please, Mr. Jarzombek.
17 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
18 JARZOMBEK: Okay. Sure. So we'll move on now to talk
19 about our Basic PPOs, which are, once again, experiencing
20 higher premium increases. So the PERS Gold and PERS
21 Platinum have a 19.3 percent premium increase over 2023.
22 Out of the total premium increase, roughly 13 percent of
23 this is from stubbornly high medical costs. These
24 increased costs are due to inflation, higher than expected
25 unit costs and utilization, as well as member migration.

1 Pharmacy contributed about three and a half percent to the
2 premium increase.
3 Included in the 2023 premium is a surcharge of
4 three percent for PERS Gold and two percent for PERS
5 Platinum. This surcharge is to rebuild the reserves in
6 the Health Care Fund over a five-year period. IN the 2024
7 premium, we are proposing increasing the surcharge from
8 three percent to five percent for Gold and two percent to
9 four percent for Platinum, again to replenish the required
10 reserves in the HCF. We know these increases are much too
11 high for your members and employers and they threaten the
12 long-term sustainability of the Basic PPO products. So as
13 I mentioned earlier, we are bring forwarded options to
14 stabilize the PPO program next year, which I'll go into
15 right now.
16 --o0o--
17 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
18 JARZOMBEK: So let's talk about the role the PPOs have in
19 our program. As many of you know, the PPOs provide
20 members the choice to see providers where and when they
21 want. Members don't need prior approval to see a
22 specialist and there's no requirement to see a primary
23 care doctor. The PPO has lack of care management that is
24 central in our HMOs and provide members with the most
25 choice.

1 Next is cost. Our PERS Gold plan is the lowest
2 cost plan in 32 counties, for roughly 25 percent of our
3 members. PERS Gold has the second lowest premium in 16
4 additional counties, where is for another 20 percent of
5 our members. And it is one of the four lowest cost plans
6 available to all members statewide.
7 --o0o--
8 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
9 JARZOMBEK: I want to set the stage on the challenges we
10 need to address in the PPOs starting next year. The first
11 and primary challenge is, of course, the premiums. As I
12 stated, the 19.3 percent increase the PPOs are facing is
13 unacceptable?
14 --o0o--
15 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
16 JARZOMBEK: With such an increase we anticipate that 11
17 percent of members will leave the PPO later this year
18 during open enrollment and the majority of those members
19 will be healthy members. This level of outward migration
20 is a red flag.
21 --o0o--
22 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
23 JARZOMBEK: Another challenge is the risk mix, which is
24 closely tied to enrollment. This chart shows the risk of
25 the HMOs and PPOs. The PPOs have always been sicker but

1 what we're seeing now is that the difference between them
2 is increasing more rapidly than before. If we continue to
3 risk adjust based on a two mod -- a two-pool model, we
4 will -- we forecast that the PPO risk will continue to
5 diverge from the HMO risk. Eventually, most healthy
6 members will leave the PPO for the HMO making the premiums
7 unaffordable for everyone.
8 When this happens, the HMOs will absorb the
9 high-cost members who are currently in the PPO and the HMO
10 premiums will increase 3.9 percent. This ultimately has
11 the same effect as implementing a single risk pool today,
12 but in a much more disruptive way and with the net effect
13 of no longer having a PPO offering.
14 --o0o--
15 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
16 JARZOMBEK: Here we show the progression of risk
17 adjustment in our Basic plans. In plan years 2019 through
18 2021, there was no risk adjustment. Each plan was its own
19 separate risk pool. What happened as a result was
20 unstable plan level enrollment triggered by large member
21 migration that moved healthy members to lower cost plans
22 leaving less healthy risk or sicker members in other
23 plans.
24 In 2020, the Board adopted a risk mitigation
25 strategy that created two risk pools, one for the HMO and

1 one for the PPOs. This was a transparent industry based
2 approach for risk adjustment phased in over two years to
3 reduce premium volatility. But what we're beginning to
4 see now is large migration and potentially significant
5 migration from the PPOs to HMOs, again mostly from the
6 healthier members in the PERS Gold plan.
7 We also communicated back then that the phased
8 approach included having the HMO and PPO rated as two
9 separate risk pools with ultimately moving the entire
10 basic program towards a single risk pool.
11 Now, for some additional information on risk
12 adjustment. We -- that through our research, we found
13 that many public purchasers risk adjust their PPO and HMO
14 premiums in a single risk pool. These purchasers include
15 CMS. They do this for the Medicare Advantage Part C
16 program as well as for Medicare prescription drugs Part D.
17 Also, individual and small group exchanges across the
18 country risk adjust HMOs and PPOs in one risk pool.
19 Beginning in 2014, every State has an individual
20 and small group ex -- every State has an individual and
21 small group change and every State's exchange adjusts --
22 risk adjusts the HMOs and PPOs in the same risk pool.
23 Covered California is just one example of a State exchange
24 that does this. Other purchasers, such as the -- other
25 State purchasers, such as the Washington Health Care

Authority and the Massachusetts Group Insurance Commission also do this.

Now that we know a lot of others do this, we wanted to check in to see how it's actually working. So we consulted with Covered California to learn about their experience. In speaking with Peter Lee, their former Executive Director, he shared that risk adjustment was very successful for them. He cited it as the key of being able to have plans that were willing to participate on the level playing field. Specifically, he shared that they would not have been able to have Blue Shield's PPO in their offerings. While it was the most expensive plan that they had, they were very pleased it was in their portfolio as it did appeal to some of the members who wanted that type of plan.

He added that risk adjustment also goes to the core of the Affordable Care Act, having plans compete on the care they provide and not on the risk mix of their population.

--o0o--

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: And lastly, we have the challenge of rebuilding the PPO reserves in the HCF. On this slide, we show the amount of time it will take to rebuild those reserves under each scenario. For 2023, as I mentioned,

1 we included a surcharge in the Basic PPO premiums. As was
2 shared in the Finance and Administration Committee
3 earlier, the deficit has accumulated to $437 million at
4 the end of 2022. Therefore, additional surcharges are
5 needed and for a longer period of time
6 Under the two risk pool model, the timeline for
7 recouping deficit is uncertain. This is because the high
8 premium increases will lead to two things. First, it will
9 cause large member migration from the PPOs to the HMOs,
10 and second, it will cause high uncertainties in future
11 premium projections. There's a significant risk that the
12 PPO will become unviable before we are able to rebuild the
13 reserve, unless we start to transition to one risk pool in
14 2024.
15 I'll add that our in PP -- in our PPO
16 solicitation later this summer, we will be asking for bids
17 for a fully insured model, as well as our current
18 self-insured model. We believe it's unlikely for an
19 insurer -- for an insurer to bid on a PPO as a fully
20 insured product unless it's in or transitioning to a
21 single risk pool. This is because insurers might be
22 reluctant to take on that level of risk. A note too that
23 under a fully insured arrangement, large reserves would
24 not be required.
25 --o0o--

1 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
2 JARZOMBEK: Now, let's look at the premium increases.
3 Implementing a two-year phase-in of one risk pool would
4 result in an 11.6 percent increase for the PPO premiums, a
5 significant improvement over the two risk pool model. And
6 this would be an 11.5 percent increase to the HMOs.
7 That's a little bit less than a two percent increase on
8 the HMO premiums. The three-year phase-in of one risk
9 pool with modest PPO benefit design changes would mean a
10 PPO premium increase of 12.2 percent and an increase of
11 10.8 percent to the HMOs. Either option is viable for
12 reducing the PPO increase, and either would stabilize the
13 PPOs. The three-year option has the advantage of
14 increasing the HMO premiums less in an already difficult
15 year by 1.2 percent rather than by about two percent and
16 the timeline, of course, for the two-year phase-in is done
17 one year earlier in 2026 rather than 2027.
18 --o0o--
19 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
20 JARZOMBEK: Here's the view of the enrollment or the
21 migration impact. As the premium increase for the one
22 risk pool scenarios are relatively comparable, we don't
23 expect significant differences in our migration
24 assumptions between them. For either option, only about
25 three percent of the members are expected to leave the

1 PPOs later this year during open enrollment.
2 --o0o--
3 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
4 JARZOMBEK: And here's another visual illustrating the
5 estimated risk by plan under each scenario. Just like the
6 migration assumptions we saw on the previous slide, we see
7 little difference between the two- and three-year phase-in
8 scenarios
9 However, this shows that by maintaining the
10 current model of two risk pools, we will continue to
11 struggle with the same problems we have today and it will
12 become even more difficult for us to solve them in the
13 future.
14 There are two reasons for this. First, is that
15 CalPERS carries the full risk in our self-funded
16 arrangement. Therefore, we just accrue the necessary
17 premiums to pay claims. Any mispricing in premiums is
18 ours to address in a future year, further increasing
19 rates. Second, we need to replenish the reserves. This
20 adds additional premium increases to the PPOs and also
21 contributes to the loss of healthy members. This further
22 exacerbates the situation of having sicker members in the
23 PPOs. The rates will need to continue to go up to cover
24 their costs.
25 If we don't move to one risk pool, we will very

1 likely see double digit increases for the PPOs and
2 subsequent years. This is because we will -- we will
3 continue to lose healthy members and the premiums will
4 need to continue to have an additional surcharge to
5 rebuild the HCF. As we lose members, we have to price for
6 sicker more costly members as the health status of the
7 remaining members goes down. This is not a result of the
8 PPOs being insufficient or unmanaged. It is simply
9 because the risk of the members who remain in the PPO.
10 --o0o--
11 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
12 JARZOMBEK: Transitioning to one risk pool with a two-year
13 phase-in would not require changes to the benefit design.
14 The 7.7 percent reduction to the premium increase would be
15 enough to curb outward migration of healthy members from
16 the PPOs next year as a resulting increase would be 11.6
17 percent.
18 The three-year phase-in option, which crossed all
19 scenarios minimizes the impact of the HMO premiums is not
20 enough on its own to reduce the premiums to a healthy
21 level in 2024. To do so, we propose modest benefit design
22 changes that would increase cost sharing for
23 out-of-network care. It will be from 500 to a -- and
24 $1,000 to $2,000 and $2,500 for Platinum and Gold plans
25 respectively. Making this benefit design change would

1 reduce both Platinum and Gold's premiums by 1.2 percent.
2 --o0o--
3 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
4 JARZOMBEK: Next, we propose making adjustments to the
5 PERS Gold network and are actively working with Anthem on
6 this. PERS Gold is a lower cost plan and having very high
7 cost systems in it does not make sense. Network
8 adjustments for PERS Gold involve removing high cost
9 facilities. Specifically, we are looking at high cost
10 sites of care that also have low -- lower cost alternative
11 sites of care within the same geographic area. As we
12 evaluate options, we want to ensure members will still
13 have abscess to other facilities with comparable quality.
14 Any changes made to the network will be communicated to
15 impacted members.
16 To achieve the savings needed, which is 0.6
17 percent, we will likely have to eliminate at least one
18 high cost facility from the Gold network. However, we are
19 not proposing changes to the Platinum network. This is so
20 that we can ensure members who want the greatest ability
21 to choose providers and facilities are still able to do
22 so.
23 Another item we are working with Anthem on is
24 their future contracts with facilities and physicians.
25 Anthem will use their contract renewals as an opportunity

1 to secure improved pricing where possible. If Anthem is
2 able to secure a 0.6 percent reduction through improved
3 contracts, the elimination of a high cost facility is no
4 longer necessary. The last component in this table is the
5 risk pooling impact. It reflects the difference of taking
6 a half step or a one-third step in 2024. With the three
7 year implementation to one risk pool, the proposed benefit
8 design and network changes, the PPO premium increase of
9 19.3 percent is reduced to 12.2 percent.
10 --o0o--
11 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
12 JARZOMBEK: This slide provides a summary view of all the
13 things we've talked about. Starting from the left, we
14 show the two risk pool model that we currently have. The
15 right two columns show one risk pool phased in over two
16 years and the green column is one risk pool phased in over
17 three years with modest -- with the modest benefit design
18 changes I just talked about.
19 I know there's a lot to this slide and a lot to
20 this conversation, but for CalPERS to ensure the stability
21 of our PPO program and the health -- in the Health Care
22 Fund, PPO premiums need to be adjusted to maintain the
23 PPOs as a long-term and viable product in our PPO -- in
24 our portfolio. This is vital in particular for PERS Gold,
25 which needs to remain one of the lowest cost plan options

1 available throughout the state as I mentioned earlier.
2 CHAIRPERSON RUBALCAVA: Mr. Jarzombek, let me
3 interrupt you here. This is a very sobering presentation.
4 And before we go into recommendations and next steps, I
5 would like to hear from our colleagues here on the
6 committee. So first, I'll call on Mr. -- Trustee Pacheco.
7 VICE CHAIRPERSON PACHECO: Thank you. Thank you,
8 sir, for providing this information. Again, as the Chair
9 said, this is a very sobering and very -- you know,
10 very -- yeah, it's a very sobering situation.
11 I'd like to talk about the chart on the premium
12 increases creases by the scenario. It's the one that has
13 the graphical presentation. And my interest is to learn
14 more about the -- I believe it's the one risk pool
15 three-year phase-in with modest PPO benefit design
16 changes. Can you elaborate on those -- what those modest
17 benefit design changes are? Oh, sorry, on page 30 of 47
18 and I think it's also on the slides, it's 50 of 67.
19 That's it. That's exactly it right there.
20 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
21 JARZOMBEK: So if we -- I can explain this maybe a little
22 bit better if we go to the slide that outlines the
23 percentages that has how they're broken down. So if you
24 want to go forward --
25 VICE CHAIRPERSON PACHECO: Sure.

1 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
2 JARZOMBEK: -- go forward a couple slides.
3 VICE CHAIRPERSON PACHECO: Which one would be...
4 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
5 JARZOMBEK: This one. This one. And so the difference
6 between the two- and three-year model is the time frame to
7 make that implementation. But specifically about the
8 benefit design impacts. And so here we would propose
9 changing the out-of-network deductible for PERS Platinum
10 members from $500 with the current benefits to $2,000.
11 Then on the Gold side, it would go from $1,000 to $2,500.
12 So each of the plans would have a $1,500 increase to their
13 out-of-network deductible only. It would not impact their
14 in-network deductibles.
15 VICE CHAIRPERSON PACHECO: So it would not impact
16 their in-network, only the out-of-network aspect. And how
17 many members do you project would be impacted in this --
18 in this particular scenario?
19 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
20 JARZOMBEK: So in pulling the data for -- last year in
21 2022, we only had 1.7 percent of our members go out of
22 network and go beyond the $500 or $1,000 deductible. And
23 so those numbers -- those would be the members who would
24 be impacted by that. And so that's about 5,300 members
25 though are impacted by this change -- or would be impacted

1 by this change based on 2022 data.
2 VICE CHAIRPERSON PACHECO: So 5,300 out of --
3 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
4 JARZOMBEK: Out of the 262,000 members that we have in
5 the -- in the basic PPOs.
6 VICE CHAIRPERSON PACHECO: And is it my
7 understanding that with re -- and who -- I mean, who are
8 these -- who are the demographics of these particular
9 members?
10 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
11 JARZOMBEK: And so we have it broken down a few different
12 ways here. So out of those 5,300 members who reached
13 their deductible in 2022, 74 percent of them are in urban
14 areas, so they're in metropolitan areas. And then 21
15 percent of them are in rural areas, so those basically are
16 areas that do not have -- that have one or less HMO
17 offerings. So it's really like kind of like their only
18 plan in town. And then five percent of those members are
19 out-of-state members. And so that gets at some of our
20 out-of-state members as well. So the out-of-state
21 members, there is about only 287 of them. And so the
22 out-of-state is also impacted by this, but again it's very
23 minimal who -- the members who are in this bucket.
24 VICE CHAIRPERSON PACHECO: Okay. Very good then.
25 And then there would be, if we were to moving this forward

1 in this particular situation, we would have -- we'd be
2 able to provide communication to them and understanding of
3 what options they could have -- they could take moving
4 forward, correct?
5 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
6 JARZOMBEK: Absolutely. So we would definitely be
7 communicating this benefit design -- potential benefit
8 design change to them and also helping steer them to
9 in-network care as best we can.
10 CHIEF HEALTH DIRECTOR MOULDS: The PPO members,
11 because of the size of the rate increase would essentially
12 be getting two communications. One is the high rate
13 increase, so we, as a matter of practice, send a letter to
14 any member who's going to be facing nine percent or higher
15 rate increase, both to let them know that it's going to
16 happen, to give them their options, to introduce them to
17 the tools that we have on our website to shop, and to
18 encourage them to shop. In addition to that, any member
19 who's facing a potential benefit change would receive
20 notification of that.
21 VICE CHAIRPERSON PACHECO: That is -- that is
22 very assuring and it helps, because it is, as you
23 mentioned, many of them, the majority, you said are in the
24 urban areas, so there may be other options available to
25 them.

1 CHIEF HEALTH DIRECTOR MOULDS: Yeah. I mean, in
2 fairness, you know, most of our members live in the urban
3 areas, because rural populations are less dense. You
4 know, and we don't -- you know, Rob is citing obviously
5 2022 numbers. That is not necessarily predictive of
6 future numbers, but it is a good indication. You know,
7 the other consideration is those are folks who get the
8 4500 and $1,000 deductibles. So, you know, some subset of
9 those will get the higher deductible.
10 VICE CHAIRPERSON PACHECO: Correct. Thank you
11 very much.
12 CHAIRPERSON RUBALCAVA: Thank you, Trustee
13 Pacheco.
14 We'll go now to President Taylor.
15 COMMITTEE MEMBER TAYLOR: Thank you. So as you
16 know, I don't like this. I feel like we're subsidizing --
17 I'm going to loose my iPad in a minute. I feel like we're
18 subsidizing the PPOs, and we kind of are. But I also feel
19 like it's kind of harsh to the benefit design changes, the
20 2,000 and the 2,500, that's a big jump. So I think -- and
21 I know where we're at, right? And I think we need to make
22 it very clear that it's -- if we want to bring these rates
23 down, this is the way we have to do it, whichever way we
24 choose, the two-year phase-in or the three-year phase-in.
25 I just feel that there's got to be a better way.

1 So I had asked you guys for our out-of-state
2 members for State employees. And I think we had talked at
3 cross purposes, Robert, and you gave me the members. I
4 forget what it was. I wrote it down, but I'm not sure I
5 got the right amount.
6 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
7 JARZOMBEK: So going back to the who is impacted by this.
8 So of the 1.7 percent of our members who in 2022 went over
9 their deductible amount, we do have -- that's 1.7 percent.
10 Of that 1.7 percent, there are 287 out-of-state members
11 that were in that bucket. And of that 287 members, there
12 were 40 who were either an active State subscriber or one
13 of their dependents.
14 COMMITTEE MEMBER TAYLOR: Oh, okay.
15 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
16 JARZOMBEK: So as you know, as the state -- the handful of
17 states that have State of California employees working
18 there, where they really have no other choice than to be
19 in this plan. And so that -- they are in a subset of the
20 people who are in this other -- this little bit larger
21 subset of the 1.7. They're definitely there.
22 COMMITTEE MEMBER TAYLOR: And you told me their
23 only option is the Platinum Plan, so there's is really the
24 high cost plan.
25 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF

1 JARZOMBEK: Correct.
2 COMMITTEE MEMBER TAYLOR: So this is all just
3 hard for anybody, right, whether they're, you know,
4 retirees of the state, the retirees are on a fixed income,
5 or they're active employees, counties, State, whatever,
6 this is -- these costs are just ridiculously high. And
7 the fact that we have to do this one pool risk adjusting,
8 it threw me for a loop as we started to talk about this.
9 What I would like you guys to do is kind of talk about how
10 we arrived here, why we arrived here. We have long
11 conversations. I have notes way back and why this is the
12 best course of action.
13 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
14 JARZOMBEK: So the -- just kind of sum it up, like so risk
15 adjustment is something that needs to be done slowly, and
16 over time, and not like a flip of switch type thing. And
17 so while it -- we have had our own unique relationship
18 were risk adjustment here at CalPERS, and so over -- and
19 back in '20 -- '19 and 2020, we were seeing the -- what
20 was happening with our plans, and so -- when we were not
21 risk adjusting. And so what we were seeing was that the
22 plans were actually chasing the healthier lives. So the
23 plans who actually got healthier lives were having their
24 premiums go down, while the ones that had the sicker lives
25 had their premiums going up. And so this was causing the

1 migration year over year that was just very disruptive to
2 us at the purchaser and to the plans themselves.
3 And so that's where in 2020 we brought forward to
4 the Board over multiple meetings and talking with
5 stakeholders about the need for risk adjustment. And so
6 that was just risk adjusting our HMOs and we did that over
7 a two-year period to reduce that premium volatility. In
8 that same time frame, we did the -- we started risk
9 adjusting the PPOs of the portfolio. So having them
10 together, but PERS Gold and PERS Platinum together, that
11 was also during the transition from the three PPO plans to
12 the two.
13 COMMITTEE MEMBER TAYLOR: Right.
14 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
15 JARZOMBEK: So we were doing a lot of different things
16 there to try to stabilize the program and our portfolio.
17 And so that is how we -- that was what has happened in
18 recent years. But then with moving forward to where we
19 are today, we had very bad years due to COVID and then
20 using money for buydowns also. And so this is that really
21 exacerbated and drained our savings, if you will, in the
22 Health Care Fund. And so we've gone through a lot of our
23 reserves. We're at a $437 million less in our reserves
24 that we need to have. And so having that reserve issue on
25 top of just the member migration issues between the PPOs

1 and the HMOs is adding additional pressure that's making
2 this -- that's speeding up the timeline for us to
3 transition to that one risk pool.
4 COMMITTEE MEMBER TAYLOR: You can call it a
5 deficit. It's okay.
6 CHIEF HEALTH DIRECTOR MOULDS: Yeah, it's a
7 deficit. So the other piece of this is that, you know, we
8 now have a significant -- significantly higher risk sicker
9 population in the PPO. We are losing healthy members.
10 And to stop that from happening and to stabilize the PPO,
11 there are really two options. One is -- is the single
12 risk pool, which has the effect of lowering the premium on
13 the PPO, because right now, you know, if -- if the PPO
14 went away, the rates in the HMO are going to go up four
15 percent. That's what we're looking at.
16 COMMITTEE MEMBER TAYLOR: Right.
17 CHIEF HEALTH DIRECTOR MOULDS: So we're doing
18 that over time and slowly. The other thing that we could
19 do is we could -- we could achieve those decreased costs
20 through benefit design changes. But the extent to which
21 we would have to redesign the benefit and the impact on
22 members would be deeply concerning to us. So Rob laid out
23 some of the steps that we would need to take to do that in
24 year one, and then include not just increasing cost
25 sharing for out-of-network care, but increasing

1 dramatically cost sharing for in-network care, increasing
2 the maximum out of pocket, so exposing people to much
3 higher bills if they're really sick. And that's for year
4 one.
5 And then when we get to year two, because there's
6 less value in the same increases, because there are fewer
7 people in those categories, we would have to go way up
8 here.
9 COMMITTEE MEMBER TAYLOR: Okay.
10 CHIEF HEALTH DIRECTOR MOULDS: The thing that we
11 know and we've talked about this in the past -- or I
12 should say, I talked about this in the past is that -- is
13 that cost sharing has detrimental -- some cost sharing is
14 appropriate and some cost sharing can be used to do things
15 like re -- encourage people to use the right kind of care,
16 go to high-quality, low-cost places, but just
17 indiscriminate cost sharing has negative health effects,
18 because what people do is they forgo care, because they
19 can't afford it and then they get sicker. And that is
20 something that -- in that we are looking out at the end of
21 the day for the health of our members that is something
22 that we should avoid if we can possibly do it.
23 COMMITTEE MEMBER TAYLOR: Well -- and as a
24 person, I look at it as cost shifting. You're giving --
25 you're making the employee pay for all of this, right --

1 CHIEF HEALTH DIRECTOR MOULDS: Yeah.
2 COMMITTEE MEMBER TAYLOR: -- rather than -- and I
3 get it's cost sharing. What I would like you also to
4 explain, which I don't think we -- you did earlier in open
5 session is I had asked you to come back with who else does
6 the -- both PPO and HMO risk-adjusting together. So if
7 you could go over that for us.
8 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
9 JARZOMBEK: So I cut my remarks a little bit shorter so
10 I'll --
11 COMMITTEE MEMBER TAYLOR: That's okay.
12 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
13 JARZOMBEK: -- add in the I missed. So risk adjustment
14 has been -- is widely used in the industry. So CMS does
15 it. They do it for their Part C, so Medicare Advantage
16 plans, also for our Medicare prescription drugs Part D.
17 All of the exchanges do it. So in 2014, this was -- all
18 of the exchanges were set up in the way to risk adjust
19 both their PPOs and HMOs as one risk pool. So all 50
20 states, the exchanges are doing that, including Covered
21 California.
22 We talked with Peter Lee, the former Executive
23 Director of Covered California, and it -- risk adjusting
24 there was definitely key to their success, because they
25 were able to attract other plans that would not have

1 wanted to participate in that.
2 COMMITTEE MEMBER TAYLOR: Okay.
3 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
4 JARZOMBEK: And so it was specifically Blue Shield's PPO
5 this was much higher priced. It was their highest priced
6 offering. But Peter was sharing that it was a good thing,
7 because some members do want that level of care. And so
8 had it not been a risk-adjusted environment at Covered
9 California, Blue Shield PPO would not have been there.
10 And so those numbers would have been -- would have lacked
11 a choice basically. And so that was his experience with
12 it. He also shared that it was really part of the ACA,
13 the Affordable Care Act, to make sure that the exchanges
14 are pricing on the value of the benefits in their networks
15 and not on the risk of their members. And so that's how
16 it's been working for them.
17 A couple other states that we know that have
18 done -- do this is the Washington State Health Care
19 Authority and then as well as the Massachusetts Group
20 Insurance Commission. And then also in talking with our
21 actuarial consultant, Milliman, we learned that a variety
22 of union health care purchasers also do this, but they do
23 it in a little bit different way. So they do it in a way
24 that it was described as implicit risk adjustment. And so
25 this is where the employer sets the employee's

1 contribution for the same across all of their offerings.
2 And then the employer is the one who is paying the
3 difference.
4 So to the employee, they're not worried about
5 trying to pick the lowest cost plans, because they want to
6 try to make ends meet or try to spend as -- the minimum
7 amount as possible. That is taken out of the equation.
8 And so it is a form of risk adjustment, but it's just done
9 through a different method. And so that's how larger
10 unions are doing it. They're not in the -- in the --
11 doing it the way we're doing it, but they do it really on
12 the employee facing end, so the employee doesn't have to
13 think about that premium. They just know that whatever
14 they choose, it's going to be the same amount across
15 whatever plans they offer. And so that's what we were
16 able to learn about risk adjustment and how it's -- how it
17 works in the industry, even though we have our unique
18 experiences here with our kind of evolution of it.
19 COMMITTEE MEMBER TAYLOR: Right. So we sort
20 of -- we have a history of the risk adjusting being
21 taken -- we had it. When I first got here, we started it,
22 and then we stopped it, and then we started it again in
23 2019. It was a different type, I think.
24 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
25 JARZOMBEK: A much different type, a much more

1 transparent, clear type. Before it was doing it on like a
2 back-end way. It was confusing to everyone. This is a --
3 oh, it's a industry way that is used by others. It's not
4 just unique to us. We are following the guidance from
5 Milliman. Other states use the same exact tool we did.
6 We looked at a variety of tools and methodologies back in
7 2019 and 2020, and we arrived at this one. This is the
8 one that projects future costs and doesn't look at current
9 or previous costs. So this we feel is the right one for
10 us to -- to make -- to make this assessment and to perform
11 it for our portfolio.
12 COMMITTEE MEMBER TAYLOR: I want to thank you
13 both -- or all of your team for working so hard on this,
14 because I know when you brought it to us initially, I
15 think everybody freaked out, so -- but thank you for
16 working on it, thank you for clarifying and bringing it
17 into regular language, so everybody can understand it. We
18 appreciate it.
19 Thanks.
20 CHAIRPERSON RUBALCAVA: Thank you, President
21 Taylor.
22 Trustee Palkki, please.
23 COMMITTEE MEMBER PALKKI: Yeah. Again, thank you
24 for the work that you put into this. Health Benefits is
25 not an easy subject to talk about.

1 I think you already answered it, but just for
2 clarification, it's my understanding that CalPERS is the
3 best when it comes to the services provided in their
4 plans. When we're talking about a benefit design impact,
5 does that -- would that affect any of our services that we
6 currently offer?
7 CHIEF HEALTH DIRECTOR MOULDS: So we do have --
8 we do have really, I think, exceptionally strong benefits,
9 comprehensive benefits. This would affect them by
10 increasing -- by potentially narrowing the network in our
11 Gold product, which is supposed to be a narrow network
12 product, and by increasing out-of-network cost sharing, so
13 not in-network cost sharing. We though it was important
14 just philosophically and as a practical matter to allow --
15 to keep a route where people could continue with low cost
16 sharing that exists in the plan right now, but -- so
17 putting that additional cost sharing on only the care that
18 is out of network.
19 That care -- there are two challenges with that
20 care. One is those are -- those are systems or individual
21 providers that we don't have contracts with, so we have no
22 way of controlling costs with them. They can
23 essentially -- you know, they can -- they can charge
24 anything. So that's concern number one.
25 Concern number two is that we have quality

1 requirements of the provider groups that we contract with
2 and we can't speak for the quality of providers obviously
3 that we don't have contracts with. So that seemed much
4 more in keeping with the tradition at CalPERS, which is to
5 make it easy to go -- to get the care that you need, but
6 also limits the care that is low-value care.
7 COMMITTEE MEMBER PALKKI: Thank you. Thank you,
8 Chair.
9 CHAIRPERSON RUBALCAVA: Thank you, Mr. Palkki.
10 Now, we're going to go in -- we'll hear from
11 Trustee Miller.
12 COMMITTEE MEMBER MILLER: Hi. Again, thanks. I
13 just want to recognize before my comments that I really
14 appreciate all the work that's gone into this and the
15 thought that's gone into it. It is complicated,
16 challenging stuff. And one of the things that just
17 strikes me just in my curmudgeonly way of looking at
18 decisions is that we really are faced with two very
19 different kinds of decisions at the same time here, where
20 we're kind of looking at multiple variables, you know,
21 risk pooling decision, and then we're kind of also kind of
22 tossing into the mix design changes. And, for me, it
23 would be really helpful in terms of the presentation if we
24 have current benefits, two-year phase-in, three-year
25 phase-in. And it would be -- for me it would have been

1 helpful, and still would be, to see what would the
2 two-year phase-in look like with benefit changes?
3 Three -- you know, each of the options with each of the
4 variables, so that I can see the relative contribution of
5 those variables versus what is the goal? Are there
6 nominal, numerical goals? Are we trying to match or come
7 to equivalence with costs of HMOs or whatever? What are
8 we trying to achieve and how do those two pieces each
9 contribute?
10 So, yeah, the other thing I just still want to
11 mention, I've mentioned this in the past in discussions
12 about benefit design and stuff, people aren't just
13 irrationally choosing to be in a PPO versus an HMO.
14 They're not just willy-nilly choosing out-of-network
15 services. For the most part, our members have really good
16 reasons why they are not choosing an HMO option, if they
17 even have one, and why they're not choosing to stay in
18 network. They're not just wanting to pay those additional
19 amounts of money, which can be financially devastating.
20 It's often because they want specific providers, because
21 the availability of the kind of treatment, or the kind of
22 expertise, or practitioner they're trying to reach for
23 their needs is not available within network or at a level
24 of quality that they find they have confidence in.
25 And so, for example, they may change from an HMO

1 to a PPO to be able to get higher quality, more effective,
2 more cutting edge treatment. They may choose to go
3 outside of the area where at best they can get treatment
4 options that are not available at basically a
5 community-based hospital, but they need to go to a
6 destination for treatments that are outside of the scope
7 of practice of their local hospitals or their local
8 networks.
9 And so I -- you know, even though the numbers may
10 be relatively small, the impacts of these things on
11 individuals, and their families, and their lives can be
12 huge. And so when we talk about benefit changes kind of,
13 you know, on the -- almost a very, very short time frame,
14 without looking at them in the whole picture, I feel like,
15 wow, I would like to have a much more fulsome discussion
16 on those things. And it's much bigger.
17 A few years back, people took me to task for
18 saying, you know, from just a distant view it would almost
19 look like we're trying to ultimately push everyone into an
20 HMO or in a -- or a very narrow network PPO that looks
21 like an HMO. And over the years, we've -- you know, our
22 options start looking more and more like that. And if you
23 don't have the kind of expendable income and resources to
24 afford the PPO options, you're simply going to be out of
25 luck, if your acuity, or your needs, or your family's

1 needs drive you to want the PPO option or to have to
2 choose out of network practitioners.
3 So I just -- you know, to sum it up, I think
4 it's -- these are painful decisions and they have real
5 impacts on human beings. And I feel like, you know, we're
6 kind of rushing to them a little bit sometimes without the
7 level of analysis an understanding that would make me feel
8 really more comfortable.
9 CHAIRPERSON RUBALCAVA: Thank you, Mr. Miller.
10 Now we'll go to -- Ms. Paquin hasn't spoken, yet,
11 so we'll go to you next.
12 ACTING COMMITTEE MEMBER PAQUIN: Thank you.
13 Thank you, Mr. Chair. I wanted to thank you both and your
14 team for such a great presentation. This is a very
15 complex issue that we're talking about. And I think what
16 really resonated with me was when you said that we don't
17 move to the one risk pool now, then eventually it's going
18 to drive up the HMO rates. And so it's a matter of do you
19 shore everything up now and address also the Health Care
20 Funding deficit or do you wait a year or two? And it
21 seems best to attack it now. I think you have better
22 outcomes.
23 But I do share some of Mr. Miller's concerns
24 about the out-of-network, and in particular for those
25 folks who don't have any HMO choices and are in PPOs. And

1 maybe they have to go out of network, not because they're
2 choosing to, but because there is such a lack of medical
3 providers and a shortage that in order to have their
4 issues addressed in a timely manner, they have to choose
5 that.
6 So, you know, I think it's hard. And I think
7 that staff has done a great job with this. But if we had
8 more information about that, like what is -- what is the
9 impact of medical provider shortages as well and not just
10 an individual choosing to go to a different place, that
11 would be helpful.
12 CHIEF HEALTH DIRECTOR MOULDS: Medical providers
13 are an issue. Medical provider supply is an issue,
14 particularly in some areas that we've talked about in the
15 past. Behavioral care right now there are extreme
16 shortages on the provider side. Primary care and some --
17 and some specialists. The -- on the question of having to
18 go out of network, the networks in both the Gold and
19 particularly the Platinum PPOs are broad networks, Gold
20 less so. Platinum very broad. So some of the -- some of
21 the providers that are excluded are excluded because they
22 are -- have completely unreasonable price structures, but
23 some of them are also excluded based on quality concerns.
24 And if there is ever an instance where you need
25 to go out of network because you need a specialist who is

1 not in network, that -- that is covered as an in-network
2 benefit. So we have a -- we have a process wherein you
3 can say I need rare cancer specialist X, because I have
4 rare cancer specialist -- rare cancer X, and there is a
5 process for getting there. That is not going to be
6 satisfying for the person who wants to go to -- who wants
7 to go to a particular specialist when there's another
8 specialist within network that they don't want to go.
9 That is not a path for those folks. But I will say that
10 again for the network, for both networks, they're broad.
11 For the Platinum network, it is particularly broad.
12 And those protections, by the way, for being able
13 to see a specialist to the specific condition that
14 you're -- that you're dealing with not -- are not just on
15 the PPO side. They're also on the HMO side, because it
16 can always be the case that the net -- any network doesn't
17 have that particular type of person.
18 Those are real concerns. And I also -- to Mr.
19 Miller's point, you know, I spoke to this a little bit in
20 my opening comments. We like to do things like benefit
21 design changes over time in consultation with our
22 stakeholders and over multiple conversations with you all.
23 That is our preferred way of working. It always has been.
24 I hope that we've stayed fairly true to that.
25 This is one of -- this is one of those cases

1 where we do need to do something this year. We do not
2 need to do benefit design changes this year, but we do
3 need to take this step towards a single risk pool this
4 year in order to protect the viability of the PPO. So,
5 you know, I -- we certainly understand if there is not a
6 lot of comfort in making those kinds of decisions quickly
7 for many of the very articulate reasons both of you
8 raised. Our primary concern is making sure that we are
9 going to have a PPO in the coming years, and that's why
10 we're bringing this to you this year on an expedited time
11 frame.
12 STRATEGIC MANAGEMENT SERVICES DIVISION CHIEF
13 QUINLAN: Thank you.
14 CHAIRPERSON RUBALCAVA: Thank you, both.
15 Mr. Pacheco, why don't you sum it up for us.
16 VICE CHAIRPERSON PACHECO: Thank you.
17 CHAIRPERSON RUBALCAVA: Oh, Ms. Walker, okay,
18 after this.
19 VICE CHAIRPERSON PACHECO: Thank you. First of
20 all, I want to thank you, gentlemen, for this very, very
21 difficult presentation. I think you've done a great job
22 in presenting it. My question is, and I -- you actually
23 alluded to this, Don, with respect to the solution. I
24 think in our Finance and Administration Committee meeting
25 this morning, it was mentioned in the very last slide that

1 there's a long-term solution in place. The 2025-2029 PPO
2 solicitation as a -- as a path forward in these PP -- this
3 PPO.
4 I think right now the PPO is -- you know, we're
5 kind of putting a Band-Aid on it and we're also
6 maintaining the foundation. You know, and hopefully if we
7 move toward the one -- the one risk pool with the
8 three-year phase-in, which is the -- and then bring up --
9 build up the reserves, you know, that will be -- and that
10 will also be compatible in the future when we -- if we
11 move into the -- into a -- into a system, a plan that's a
12 solicitation. I just wanted to know if that's a viable
13 long-term process. And can you -- either of you can
14 elaborate at little bit more on that.
15 CHIEF HEALTH DIRECTOR MOULDS: Yeah, I -- so
16 we're looking at -- obviously, you know, we see
17 reprocurement as an opportunity to improve the product.
18 The PPO right now is in need of a number of improvements.
19 We're actively -- we've been talking to -- we've had a
20 process in place for close to a year now, where we've been
21 talking to pretty much all of the really good, large,
22 purchasers who run their own PPOs to talk through what
23 they're -- what they'e doing by way of benefit design.
24 We've talked to a number of groups that are venturing into
25 some interesting models, both on the quality improvement

1 side -- so we should always be talking at least a little
2 bit about quality. We've talked very little about quality
3 today.
4 But the other big challenge of the PPO is that --
5 is that the PPO does not score nearly as well as -- as our
6 HMOs do on our quality metrics. And so one of the things
7 that we're trying to think about, that we are thinking
8 about for the coming procurement is how to improve on
9 that. How to bring care management, for example, into an
10 environment that is not sort of, you know, built for
11 management of anything, right? How you promote primary
12 care, which all of the evidence suggests is hugely
13 improving on the cost side, but even more so on the
14 quality side. When you have a quarterback behind the
15 care, you have coordination, you have the right kinds of
16 care delivered in the right environment and so forth.
17 So there are a lot of technique that exist out in
18 the market, ranging from tiering to provide incentives for
19 people to go to the right sites of care, to start with the
20 right types of care, and to discourage the opposite, that
21 we will be coming and talking to you all, and talking to
22 the stakeholders over the course of the next year as we
23 move forward with the RFP process. And we are hopeful
24 that those will address what we think are really two major
25 concerns, the quality concern and then also, of course,

1 the cost concern in the PPO.
2 So we're optimistic. It is -- there are no magic
3 pills out there. It is very hard to do some of this in
4 rural areas, because you don't have the depth of network
5 in rural areas, which makes it -- can make it much more
6 challenging to use site of care to improve care, and to
7 lower costs. But we're talking through at the moment
8 about -- you know, we're beginning to talk internally at
9 least about how you do that in many of the parts of
10 California and even how you would do that in some of the
11 rural areas where the PPO, even though there are fewer
12 members, it plays a much more predominant role in
13 people's lives -- in our members lives.
14 VICE CHAIRPERSON PACHECO: Thank you very much
15 for that comment.
16 CHAIRPERSON RUBALCAVA: Thank you, Mr. Pacheco.
17 Thank you, Mr. Moulds.
18 We have two more speakers.
19 Trustee walker, please.
20 COMMITTEE MEMBER WALKER: Thank you. This is not
21 the topic to end the day on, boy, let me tell you.
22 So I just want to put out there I heard you say
23 earlier that the thing that's most important out of this
24 presentation is the going to one risk pool, right? And I
25 can get behind that and see that.

1 I don't think that we should do the benefit
2 changes. I don't think that we have enough information to
3 really understand the impact. I mean, if we're just
4 talking members, it's easy to say, oh, it's easy to do
5 this. But it has real world impact on someone, the
6 difference between -- a $1,500 difference, right, is huge.
7 It's life changing. And I'd like to know more about why
8 they're doing that.
9 I'd also like to be able to have an opportunity
10 to not only work with the stakeholder groups, but figure
11 out and intensive education program, you know, with our
12 members in those programs, right, so that -- I mean,
13 because if they're not understanding, you know, that this
14 will then equal this, you know -- and just to figure out a
15 way to make it a lot -- I don't know, I just -- it's just
16 hard to go that high on the design changes without knowing
17 all the impacts. So I think that there's other work that
18 we need to do, but I am in favor of the two-year phase-in
19 on the risk pool. I think that's something that we have
20 to do. And the other we have just a little bit more time
21 that we can figure out what to do and how to do it.
22 CHAIRPERSON RUBALCAVA: Thank you, Ms. Walker.
23 Mr. Palkki.
24 COMMITTEE MEMBER PALKKI: Yeah, just really
25 quickly. I completely agree with sentiments Ms. Walker

1 stated just now. But for clarification when we're talking
2 about three-year phase-in, what we're seeing is the
3 initial impact, the first year, and then we will expect
4 that similar impact year after year for three years or is
5 that the impact phased in?
6 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
7 JARZOMBEK: So it would -- there would be -- this is -- so
8 year one would be one-third of a step. And so the
9 one-third of a step is 1.3 percent because we need to get
10 to 3.9 percent, so it would be a 1.3 versus 1.9, splitting
11 that 3.9 into two versus splitting it into three. And so
12 we would see a bump next year for the two -- the second
13 half of the two-step. That's the direction of the
14 Committee today. But we would see -- regardless though,
15 you will see something in subsequent years.
16 COMMITTEE MEMBER PALKKI: Thank you
17 CHAIRPERSON RUBALCAVA: Thank you, Mr. Palkki.
18 President Taylor, please.
19 COMMITTEE MEMBER TAYLOR: I'm talking about --
20 CHAIRPERSON RUBALCAVA: Oh, hold on. We're going
21 to -- there you go.
22 COMMITTEE MEMBER TAYLOR: There I am. Ms. Walker
23 talking about the deductible. It reminded me when we
24 initially put these in didn't we have a path for one or
25 both of the PPOs for the folks in those PPOs to knock $500

1 off, wasn't that correct?
2 CHIEF HEALTH DIRECTOR MOULDS: Yeah, that would
3 be staying in network is the path.
4 COMMITTEE MEMBER TAYLOR: I was testing for
5 stuff.
6 CHIEF HEALTH DIRECTOR MOULDS: Oh, you mean -- go
7 ahead.
8 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
9 JARZOMBEK: So it's the -- so for PERS Gold, that is what
10 we have. And so it's the VBID, the Value-Based Insurance
11 Design. So even though the deductible for current
12 benefits is $1,000 right there, a member can do five
13 things and reduce that deductible from 1,000 to 500.
14 COMMITTEE MEMBER TAYLOR: Yeah.
15 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
16 JARZOMBEK: And so that is -- so in reality what it is
17 is --
18 COMMITTEE MEMBER TAYLOR: Five hundred.
19 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
20 JARZOMBEK: -- almost 500, because the things are -- we
21 have quite bit of uptake from them.
22 COMMITTEE MEMBER TAYLOR: So then that would
23 apply for -- I'm sorry, I walk -- I got away from my
24 thing. That would apply to the $2,000 still, the 500, or
25 no?

1 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
2 JARZOMBEK: It would not apply to the out-of-network
3 deductible. It would apply to the in-network deductible.
4 And so that out-of-network deductible --
5 COMMITTEE MEMBER TAYLOR: Oh, these are out of
6 network. That's right. I'm sorry. Sorry.
7 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
8 JARZOMBEK: So that's the difference, but -- so that's the
9 difference. So we still have those five VBID elements in
10 play here, but there are on the Gold plan only. They're
11 not on the Platinum plan.
12 COMMITTEE MEMBER TAYLOR: Okay. So if we were to
13 not -- I guess I'm hearing -- and, Mr. Chair, if you want
14 to look at this, you can, but what I'm hearing is people
15 don't want to do the benefit changes yet, but I don't know
16 what that does to the premium, so we would have to see
17 that before we vote on it in July.
18 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
19 JARZOMBEK: So are you asking about the three-year
20 phase-in with no benefit changes?
21 COMMITTEE MEMBER TAYLOR: Right, that's what I'm
22 hearing from like three people.
23 CHIEF HEALTH DIRECTOR MOULDS: That would not --
24 that would not get us where we need to get to stabilize
25 the plan. It would have to -- you would have to be

1 choosing the two-year phase-in, which -- so the two-year
2 phase-in --
3 COMMITTEE MEMBER TAYLOR: Oh, two-year phase-in
4 with no --
5 HEALTH DIRECTOR MOULDS: The two year phase in
6 and the three-year phase-in with the -- with the benefit
7 design changes are -- both get you where you need to get
8 to stabilize the PPO. The three-year proposal without the
9 benefit that -- we're bringing the benefit design changes
10 as part of the three-year proposal because we have to as
11 part of a three-year proposal. We don't have to with the
12 two-year proposal.
13 COMMITTEE MEMBER TAYLOR: I see what you're
14 saying. So I'm not -- I'm a little lost as to why you
15 don't have to with the two-year proposal, but you do with
16 a three-year proposal. I guess because the cost of
17 putting it out for three years costs more.
18 CHIEF HEALTH DIRECTOR MOULDS: The -- because the
19 two-year proposal decreases the PPO rates more than the
20 three-year proposal and increases the different -- de --
21 increases the different -- differential between the HMO
22 and the PPO in such a way that we're going -- it will stem
23 the migration issues that we will face if we don't do it.
24 COMMITTEE MEMBER TAYLOR: That's what you --
25 well, ultimately, that's what we want is to stem the

1 migration issues.
2 CHIEF HEALTH DIRECTOR MOULDS: Right.
3 COMMITTEE MEMBER TAYLOR: Okay. So never mind
4 then. I was a little confused.
5 CHAIRPERSON RUBALCAVA: Yeah. And I just want
6 to -- thank you, Ms. Taylor. I want to remind the body
7 here that Trustee Miller already asked for some sort of
8 matrix that shows the decrements, meaning, you know, what
9 the two-year option would be with benefit changes, but
10 that -- that's one of the options. It may not be needed.
11 I mean, the goal here is to bring stability to the risk --
12 to the risk pool for th PPO. And then the variable is
13 what impact would it be on the HMO rates? So I think
14 that's the other thing that's -- you can see not on this
15 chart.
16 COMMITTEE MEMBER TAYLOR: I think I asked that
17 and you guys told me it wouldn't make that much of a
18 difference.
19 CHIEF HEALTH DIRECTOR MOULDS: So I want to be
20 clear on the question. The question is -- is the question
21 the value of the benefit design changes as a premium
22 reducer?
23 COMMITTEE MEMBER TAYLOR: In the two-year.
24 CHIEF HEALTH DIRECTOR MOULDS: So it's a -- it's
25 the -- it's the same value in three and in two. It's just

1 not necessary in two, but would be necessary in three, but
2 the value is about 1.8 percent.
3 COMMITTEE MEMBER TAYLOR: And as I recall, when
4 you told me this, then what we locked at is it lowers the
5 premium for the PPOs lower than the HMOs when you risk
6 adjust.
7 CHIEF HEALTH DIRECTOR MOULDS: It -- so there are
8 marginal differences between the two scenarios. The
9 actuarial analysis is that both of those numbers have the
10 stabilizing effect. We couldn't do less benefit design
11 change on the three-year and be in a safe margin on the
12 migration issue, if that makes any sense.
13 COMMITTEE MEMBER TAYLOR: Not really.
14 CHIEF HEALTH DIRECTOR: Sorry.
15 COMMITTEE MEMBER TAYLOR: I'm not a math person,
16 so I'm not grasping this.
17 CHIEF HEALTH DIRECTOR MOULDS: So the actuarial
18 analysis that looks at my -- so there are price points
19 that are largely related to the price diff -- the relation
20 between the cost of the HMO and the cost of the Gold PPO.
21 COMMITTEE MEMBER TAYLOR: Okay.
22 CHIEF HEALTH DIRECTOR MOULDS: So in order to not
23 have the additional migration that we would be looking at,
24 if we didn't start this transition, they need to be pretty
25 similar.

1 COMMITTEE MEMBER TAYLOR: Okay.
2 CHIEF HEALTH DIRECTOR MOULDS: Within a range,
3 but pretty similar. So there are price sensitivities that
4 actuaries use to kind of make these predictions about
5 migration. And both of these scenarios are sufficient to
6 not instigate the risk migration.
7 COMMITTEE MEMBER TAYLOR: YOu may want to move
8 your --
9 CHAIRPERSON RUBALCAVA: Perhaps -- yeah, perhaps
10 we could go to the page 30 -- slide 34 --
11 COMMITTEE MEMBER TAYLOR: Four, yeah.
12 CHAIRPERSON RUBALCAVA: -- that has the impact of
13 the -- of the enrollment change.
14 COMMITTEE MEMBER TAYLOR: Slide 34. There you
15 go.
16 CHAIRPERSON RUBALCAVA: Thank you.
17 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
18 JARZOMBEK: And so this walks through the different -- the
19 impacts to the HMOs and to the PPOs, so the middle column.
20 So with the two-year phase-in with no benefit design
21 changes, the PPOs are 11.6 compared to HMOs at 11.5. And
22 then with those additional benefit design changes and the
23 three-year phase-in, it changes. And so this is where the
24 HMOs take less of a hit. It's only 1.2 percent compared
25 to 1.9 percent.

1 COMMITTEE MEMBER TAYLOR: Yeah, just under two.
2 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
3 JARZOMBEK: And so -- and then you see what happens to the
4 PPOs. The PPOs are -- don't go down as much, but they're
5 still at a level that we are comfortable where won't see
6 that outward migration. And so that's why we added in the
7 benefit design changes to get it a little bit closer to
8 that 11.6.
9 COMMITTEE MEMBER TAYLOR: Okay. Those were my
10 questions. I appreciate it.
11 CHAIRPERSON RUBALCAVA: Thank you. Those are
12 very important clarifying questions. We need it.
13 Trustee Miller, please?
14 COMMITTEE MEMBER MILLER: Yeah, I think you've,
15 in a roundabout way, kind of answered my question,
16 because, you know, when say, you know, this one gets us to
17 where we need and this one doesn't get us to where -- it's
18 what is that place we need to get to. And it seems like
19 it's a combination of a couple things, but defining that
20 in a pretty clear objective way that is what we're trying
21 to get to is estimated change of enrollment that are
22 within this range for both of them, or is it that we want
23 to get the -- out of -- the total premium within this much
24 or so much range of these two products, or is it -- so
25 what is that target that we're trying to get to that

1 these -- in at shell? And so I think we've kind of
2 answered that, but I still don't see it like here it is.
3 Here's --
4 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
5 JARZOMBEK: So the targets is 12.2 percent. The target is
6 12.2 percent, however you get there. If you get there
7 with benefit design changes or just with a two-year
8 phase-in. And so that is why we were able to do an
9 additional -- the three-year phase-in scenario with
10 change -- benefit design changes, because it still will
11 get us there to keep the premium in line with the HMOs and
12 prevent the migration out. And so that is our number. So
13 that's why we can't not do benefit design changes with the
14 three-year proposal, but it needs to have something more.
15 So it's at -- so -- because 12.2 percent is the number.
16 COMMITTEE MEMBER MILLER: Thank you.
17 CHAIRPERSON RUBALCAVA: Thank you for another
18 clarifying question that we heeded.
19 Did you want to continue or you want me to make
20 my comments now?
21 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
22 JARZOMBEK: I think we'll welcome your comments or --
23 CHAIRPERSON RUBALCAVA: I'll do my comments now.
24 We've heard from the Committee here, the
25 colleagues. And I think the one message is -- there's two

1 messages, but one is the premiums -- the premiums are too
2 high, especially Kaiser. And it is disappointing as a
3 couple of the colleagues have stated that Kaiser would
4 sort of use labor cost as a reason. I recall an earlier
5 CIO making a pledge to try to make Kaiser the lowest
6 priced plan -- a lower price plan and still embracing --
7 it's a labor plan. And I know that a lot of labor unions
8 have promoted Kaiser because of that. I know my union has
9 for -- that was the only option for many, many years to
10 our staff. That's one.
11 The other one is the -- it is a tough spot to get
12 to changes -- plan design changes, but we clearly need to
13 stabilize the risk pool, and make the PPO a viable option
14 for us to continue and have -- offer that. And so one
15 thing that -- that had -- that Rob had mention is it's
16 CalPERS practice to always have a letter go out to
17 whenever the premiums going to be nine percent or more to
18 the impacted members. And I think we need to continue
19 that tradition and remind them that there are other
20 quality value networks that have -- in the same -- similar
21 jurisdictions, but have lower premiums.
22 So I think we should do that and we should -- we
23 should compliment the Board for having the foresight to
24 start bringing in these -- I know people keep calling them
25 narrow networks. I prefer another word. But there are

1 quality value there and so we need to see that as it
2 brings in better quality. And I know that's one thing
3 we're going to have to look in the future on the PPO some
4 things that you've talked about, Rob, is how do we get
5 them to have better delivery, better outcomes? And so
6 people understand that the goal here is to get -- use
7 choice, but also make sure you don't have to keep going
8 back to the same doctrine. And if it can be coordinated
9 and there could be primary care that definitely would
10 help. So I think this is the time we go into public
11 comment, correct, unless -- no, nothing else to report?
12 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
13 JARZOMBEK: So we -- we're at the -- kind of at the spot
14 right now where --
15 CHAIRPERSON RUBALCAVA: Okay.
16 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
17 JARZOMBEK: -- we have our PPO recommendation. And then
18 after that, I have --
19 CHIEF HEALTH DIRECTOR MOULDS: I think they've
20 heard the recommendation.
21 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
22 JARZOMBEK: Right.
23 CHIEF HEALTH DIRECTOR MOULDS: Just one thing
24 that would be helpful, because one of -- so this is --
25 this is a little bit of a weird space that we're in right

1 now, because even though you're not making a decision
2 today consistent with regulations, we send a letter to the
3 Legislature, Department of Finance, CalHR, et cetera to --
4 so that they can start the process of calculating the
5 contribution rates. So what we do -- we don't -- we don't
6 need an action here, but we need a sense of how we're
7 calculating. So a little bit more of an indication. I
8 got the distinct impression from the speakers who spoke to
9 it, that the inclination was to -- was in favor of the
10 two-year phase-in without benefit design changes, rather
11 than the three-year phase-in with benefit design changes.
12 But if I have misread things, it would be helpful to know
13 that now.
14 CHAIRPERSON RUBALCAVA: Well, I know we had
15 speakers on both options. Mr. Pacheco favored the
16 three-year phase. Ms. Walker favored the two-year phase.
17 Not everybody has spoken, so I don't know if the people
18 who have not spoken want to speak. I guess -- I'll say
19 that I favor the three-year -- this is a tough road,
20 because there has to be adjustments for both the PPO and
21 the HMO. And I know the HMO may -- people may see it
22 as -- I don't want to use the word sub -- it may seem --
23 it's an impact.
24 So I see the three-year phase-in as having a less
25 impact on the HMO and the people that we're trying to

1 address, so they can have access to enough, as best we
2 can, quality and affordable are the PPO population. And
3 so they will have minor modest, I think is the -- moderate
4 is the word that we used plan design changes on the -- for
5 the out-of-network only. And so some may see it as an
6 incentive to go -- to go in network, sobeit. But I
7 would -- unless -- okay. So unless somebody wants to
8 speak against that, I think that's the direction.
9 COMMITTEE MEMBER TAYLOR: (Inaudible).
10 CHAIRPERSON RUBALCAVA: Well, I know Ms. Walker
11 had a concern about three-year.
12 COMMITTEE MEMBER WALKER: (Inaudible.) because I
13 don't think we know -- we don't know enough about why
14 they're going out of network, right. And so, I mean --
15 and for the people -- oh, I'm sorry. I apologize. We
16 don't know enough about why the people are going out of
17 network. And while it might see like, you know, a small
18 thing that we're doing, it is a huge thing for the people
19 that it impacts. And I feel like if we're going to make
20 that decision, we should know -- we should be intentional
21 about making it and know what impact it's going to have,
22 and we don't. We don't have that information right now.
23 We don't -- so it just -- that's why I'm opposed to it. I
24 don't that you should -- it's -- it is easy sitting back
25 and it's not my pocket to say, okay, we should do this and

1 that's going to be better for everybody.
2 And then you run you up on the person who says
3 how could you do this to me. This is the impact that this
4 has had on me and my family. And I've heard too many
5 stories like that to travel that road. We had a big
6 project at Local 1000, where our members told their
7 stories, and they -- and these were primarily the members
8 that were in the rural areas and out of state. And the
9 impact of the health care, and what it did, and how the
10 impact that it had on your life. And I just don't think
11 that we should -- unless we know, it is too significant a
12 decision that we're making when we're talking about the
13 design changes. It's not a small thing. It's a big thing
14 for the people that it impacts.
15 CHAIRPERSON RUBALCAVA: Ms. Walker, you speak
16 truthfully. It is a big impact. It is big decision and
17 it is a very short runway, but we do have time frame we
18 have to follow. We have open enrollment that needs to
19 happen and it is a tough one. And everybody will be
20 impacted, whether you're in the HMO or in the PPO. And
21 the goal -- I think the broader goal here is to sustain
22 the PPO so it can be an option, a viable option. And
23 unfortunately, everybody is going to have to pay a price,
24 whether it's a higher premium, whether it's a plan design,
25 on whether it's a higher HMO premium -- or PPO premium.

1 COMMITTEE MEMBER WALKER: But it's a double
2 impact for those folks --
3 CHAIRPERSON RUBALCAVA: Yes.
4 COMMITTEE MEMBER WALKER: -- not just a single
5 one. We're asking them to make a double and triple
6 impact, because everybody is going to have a higher -- a
7 higher premium, right. Everybody is going to have that.
8 COMMITTEE MEMBER TAYLOR: Yeah, but otherwise
9 their premiums will go way high.
10 COMMITTEE MEMBER WALKER: Right.
11 CHAIRPERSON RUBALCAVA: So we're asking --
12 COMMITTEE MEMBER WALKER: Still, but everybody is
13 having a higher premium though. Everybody is having a
14 higher premium. And you're right -- you're right. I know
15 that some people are looking at it as the HMO people are
16 subsidizing the PPO people. But the reality is if we're
17 honest with ourselves, the whole nature of health care is
18 about subsidizing. Our young members subsidize people my
19 age, right? And, you know, I mean, the healthy members
20 subsidize members who get sick. So it is all about
21 subsidization.
22 And so -- you know, and I get it and I get why
23 you guys are saying it, but I just -- I would ask you to
24 think about this, right, because again, I'm just telling
25 you guys this is -- has the potential to be life changing

1 for folks and it's not a decision we have to make today.
2 We can make the decision to just change the risk pool and
3 then, you know, once we have more information and really
4 understand what it is, we still have the opportunity to go
5 back and change next year or the year after. But to make
6 that level of impact without knowing that that impact is,
7 it's not a good thing.
8 CHAIRPERSON RUBALCAVA: Thank you, Ms. Walker.
9 We have -- now, everybody wants -- my board has lighted
10 up, so I think everybody wants to speak to it and rightly
11 so.
12 Ms. Taylor, did you take off you -- did you mean
13 to speak?
14 COMMITTEE MEMBER TAYLOR: I think I was trying to
15 second --
16 CHAIRPERSON RUBALCAVA: Oh, okay. Okay. Now, we
17 have Trustee Palkki.
18 COMMITTEE MEMBER PALKKI: Thank you, Chair. You
19 know, it's my belief that we need to do the best thing for
20 the greater of the community. And trying to justify
21 changes in designs without having a full understanding of
22 what that means and the impact on the members, I can't
23 justify that being the greater good for all. And so I'd
24 have to agree with Ms. Walker where the -- I believe that
25 we need to do something in sustainability by going to the

1 one risk pool. But I think we need further discussion
2 when it comes to the benefit design. So thank you, Chair
3 CHAIRPERSON RUBALCAVA: Thank you, Trustee
4 Palkki.
5 Next, we have Trustee Pacheco.
6 VICE CHAIRPERSON PACHECO: Thank you. I want to
7 add a little bit more commentary to this. You know, I
8 feel for these 5,000 folks. You know, there -- as many of
9 them -- some of the live in the rural areas. Some of them
10 may -- a lot of them in the urban areas. But as Don and
11 Rob have mentioned, there is a mechanism to take care of
12 the ones that out of -- let's say for the ones that have
13 to find a specialist in cancer or something like that,
14 there's a mechanism that they go out of network, they
15 would still be in network, and it would still take care of
16 that. You know, it's still -- there is mechanisms in
17 place, systems in place to ensure that they are taken care
18 of. And in the -- in the -- and what we're looking at in
19 this particular case is we're looking at trying to sustain
20 the fund over the long run, and we need to build it out,
21 because right now the actuarial reserves are very, very
22 low.
23 So that I think that we need to -- we need to
24 look at in that way and it's a tough decision, but I feel
25 that that is -- that's the -- that's the appropriate

1 avenue, so that we can support all 300,000 persons in the
2 system. Thank you.
3 CHAIRPERSON RUBALCAVA: Thank you, Mr. Pacheco.
4 Mr. Miller, please.
5 COMMITTEE MEMBER MILLER: Yeah. You know, I
6 don't want to speak for my colleagues, but I think -- I
7 think it seems pretty safe to me to say that everyone
8 understands and is on board with addressing the risk
9 pooling and moving to one pool, if I'm not mistaken. I
10 think, you know, some of us still have some concerns about
11 understanding the benefit changes and this kind of, you
12 know, what seems like on a fairly short fuse jumping into
13 benefit changes. But ultimately, I think, you know, we're
14 going to have to make benefit changes in the long run.
15 And so I can probably live with -- with that, if we go
16 that way, you know, sooner with some of this stuff.
17 The one thing I would point out though is again,
18 people are sometimes -- they're not even choosing to go
19 out of network. If you're in the hospital -- I'll speak
20 from personal experience, and you don't know if you're
21 going to make out of the hospital, and the hospitalist the
22 multiple doctors they trot in and out of your room say,
23 oh, this here is Dr. So-and-So, here is Dr. So-and-So.
24 You need this. You need that. You need the other thing.
25 And then a month or so later when what you finally get

1 happily at home, and you get the bill, and you find out,
2 oh, this doctor wasn't in network, oh that thing wasn't in
3 network, oh they don't want to pay for this. Oh, now, I'm
4 going to have to pay for this. So it's not even that
5 people are choosing to go out of network for things. And
6 it's not surprising that it's relatively few that ever do,
7 because it's very costly.
8 So -- and you can very quickly end up well over
9 your deductibles, so -- and then, you know, your benefits
10 do kick in, but when your -- if your deductible is going
11 to be, you know, more than doubling, that can be quite a
12 hit. I even look back at when we were so thrilled to have
13 a rural subsidy towards premiums, it was only like a
14 thousand bucks. You know, just this change in deductible
15 is potentially more than that for anyone who runs afoul of
16 it, so...
17 CHAIRPERSON RUBALCAVA: Thank you, Mr. Miller.
18 Ms. -- President Taylor, please.
19 COMMITTEE MEMBER TAYLOR: I didn't know you had
20 turned my mic on. Sorry about that.
21 So I will say I feel this from both ends. First
22 of all, I think addressing Trustee Miller's thoughts
23 there, we're not supposed to be getting surprise billings,
24 so that's -- that should take care of that. That's a law
25 now and I remember signing it for the last six months

1 every time I go into the doctor.
2 Could you -- and I just heard a horrifying story
3 about somebody I know who's husband had cancer, had to go
4 out of network for a specialist to Stanford. When they
5 finally got approval, the appointment was set, but it was
6 set so far head, he died of his cancer. So I see where
7 these kinds of impacts have real life horrifying impacts,
8 right?
9 But you guys explained the 5,300 members and then
10 how many of those actually reached over, I think, was it?
11 CHIEF HEALTH DIRECTOR MOULDS: Those are -- those
12 are the ones who all --
13 COMMITTEE MEMBER TAYLOR: All 5,300 hit the --
14 CHIEF HEALTH DIRECTOR MOULDS: Yeah, so there is
15 a higher percentage that use out-of-network care. Those
16 are the people who hit the deductible for out-of-network
17 care. So it's a much smaller percentage who hit that, but
18 use of -- use of out of network care, so the -- is
19 significantly higher percentage than that. It's in the
20 double digits -- low double digits.
21 COMMITTEE MEMBER TAYLOR: So this would --
22 CHIEF HEALTH DIRECTOR MOULDS: I think 11 to 14
23 percent.
24 COMMITTEE MEMBER TAYLOR: So basically most
25 people don't even hit their deductible, which is pretty

1 low right now.
2 CHIEF HEALTH DIRECTOR MOULDS: That's right.
3 COMMITTEE MEMBER TAYLOR: Out of 300,00 you said,
4 313,000, most people don't even hit their deductible.
5 CHIEF HEALTH DIRECTOR MOULDS: Correct.
6 COMMITTEE MEMBER TAYLOR: And I see what Ms.
7 Walker is saying. And when we come back in July before we
8 finalize the vote, let's -- can we have a look at are
9 these people -- I know you can't say, right, but are there
10 reasons for their going out of network?
11 CHIEF HEALTH DIRECTOR MOULDS: Yeah. So that --
12 that would be the kind of thing that we would talk through
13 in the stakeholder engagement. The other way of doing
14 that is through focus groups. I'm a fan of stakeholder
15 engagement, because this is about our stakeholders -- our
16 members, and we want to hear from them about their
17 experiences. Focus group are -- focus groups are a way of
18 sort of getting a juiced up version of that, where you're
19 focused on the question at hand and you can ask second and
20 third versions, because, you know, somebody's there for a
21 reason.
22 COMMITTEE MEMBER TAYLOR: So, Don, are you saying
23 that you want us to go ahead and do this --
24 CHIEF HEALTH DIRECTOR MOULDS: I'm not --
25 COMMITTEE MEMBER TAYLOR: -- and then move

1 towards stakeholder engagement.
2 CHIEF HEALTH DIRECTOR MOULDS: So honestly,
3 I'm -- we had a -- we had a recommendation here. It was
4 three years with modest benefit design changes, because on
5 principle we are for people staying in network, and we are
6 for keeping cost sharing as low as possible. And that
7 seemed like the route that it came -- that came closest to
8 meeting that objective.
9 The other concern is that we have eye-poppingly
10 high rates in particularly with Kaiser that we are trying
11 to not have affect our members anymore than they already
12 are, which is the reason that we brought the additional
13 option. So that is a consideration as well.
14 Certainly -- you know, I think it's important to
15 remember that at the end of this whole process, we have --
16 we will have made exactly the same change. It's just a
17 matter of how long it takes, two years versus three years.
18 We -- if we went through a year-long process
19 where we were reaching out to stakeholders and doing focus
20 groups to talk about their experiences with out-of-network
21 care, we might make different choices than we're
22 advocating for right now. The data that we are looking at
23 right now suggests that those are the -- clearly the right
24 ones to be making. I will add that as we start talking
25 about how to reduce the costs in the PPO, what we're

1 talking about today unfortunately is probably pretty
2 low-hanging fruit.
3 COMMITTEE MEMBER TAYLOR: Right.
4 CHIEF HEALTH DIRECTOR MOULDS: So that's just out
5 there for consideration.
6 COMMITTEE MEMBER TAYLOR: I appreciate it. I
7 think I'm still on board with - I hate to do this - with
8 the three years with the modest benefit changes.
9 CHAIRPERSON RUBALCAVA: Thank you, President
10 Taylor.
11 Ms. Paquin.
12 ACTING COMMITTEE MEMBER PAQUIN: Thank you, Mr.
13 Chair. I also agree with the staff recommendation for the
14 three-year phase-in. And many of my colleagues made some
15 very great comments, great points, and it's a difficult
16 decision, but I think that we are supportive of the
17 recommendation.
18 CHAIRPERSON RUBALCAVA: Do you want to. You're
19 the only one that hasn't spoken, Ms. Willette, so I want
20 to. I'll afford you that opportunity.
21 COMMITTEE MEMBER WILLETTE: Thank you so much. I
22 really appreciate the discussion, and the presentation,
23 and the information, and the thoughtfulness behind it. I
24 think if -- as you just said, if you're -- if we're
25 looking at the same result at the end of three years, then

1 I'd be in favor of doing the two-year pool adjustment and
2 waiting on the benefit plan change.
3 CHAIRPERSON RUBALCAVA: Now, you have it. It's
4 pretty evenly split. I wouldn't want to force a vote.
5 CHIEF HEALTH DIRECTOR MOULDS: Yeah.
6 CHAIRPERSON RUBALCAVA: So --
7 CHIEF HEALTH DIRECTOR MOULDS: Well, we
8 appreciate the direction.
9 (Laughter).
10 CHIEF HEALTH DIRECTOR MOULDS: In all
11 seriousness, it's helpful to hear it and I think we
12 have --
13 CHAIRPERSON RUBALCAVA: Okay. Thank you. I do
14 want to -- I was going to save one more comment till
15 later, but I think maybe I should say it now. One thing
16 that my predecessor would always say is tell the carriers
17 to -- we have one month before we come back with final
18 rates. And I do want to honor Rob Feckner and his legacy
19 and his work by using his statement and telling Kaiser
20 specifically to please go back and sharpen your pencil.
21 Thank you.
22 So we want to hear from the people who have
23 signed up to speak in public comment, so let's go to the
24 phone first. David, we have somebody on the phone.
25 STAKEHOLDER RELATIONS ASSISTANT DIVISION CHIEF

1 TEYKAERTS: Yes. Thank you Chair Rubalcava. First up, we
2 have David Aguinaldo. Go ahead, David.
3 DAVID AGUINALDO: Hi. Yes. My name is David
4 Aguinaldo. I am a CDTFA employee in out of state Chicago.
5 So Theresa knows me well, so -- and thank you so much for
6 all of you for your thoughtful comments today.
7 I just wanted to share just some of the human
8 impacts that these rates have been having on us. And this
9 is even more of an unprecedented situation than it was
10 last year. But as of this year, we have folks in our
11 office who are coming in as insured tax auditors and
12 they're making around $50,000 a year, and they are paying
13 $12,000 is their employee share of their premiums before
14 they even go to the doctor. For me, as my myself plus my
15 partner, we're at about $10,000 a year in premiums before
16 we ever go to the doctor. And then on top of that, we
17 have higher co-pays than the HMOs have. We have higher
18 out-of-pocket maxes than the HMOs have. So we are getting
19 hit on every end.
20 And at this point, looking at the --
21 unfortunately, I don't have access to my computer right
22 now. I'm -- I just landed in LA. I'm here for a union
23 rally, but I was listening to you guys on my plane. But
24 we have people who are not able to get their health care,
25 because they have spent so much on their premiums. We

1 have an office tech in my office who's been there for 13
2 years. It's her and her daughter on the plan and she is
3 paying north of I believe it's 21 percent of her gross pay
4 on her health care premiums. That is -- that is
5 terrifying. How does somebody make ends meet? I don't
6 know how she makes ends meet.
7 And again as out of state, we only have the
8 option of the PERS Platinum PPO. We have no other option.
9 Please, please do everything you can to equalize us with,
10 you know, that risk pool. Do the two year. Do the most
11 you can possibly do to bring the HMO risk in line with the
12 PPO risk, because we are just being left out to dry. I
13 don't know how to -- how to explain the severity of what
14 people are feeling in our office.
15 To explain the fact that every single person who
16 can change to a spouse's health insurance has done so at
17 this point. There -- if I had a choice, believe me, I
18 would change, but I don't have a choice. This is my
19 health care. I have one choice for my partner and I. And
20 it's not sustainable. It's not affordable. And I don't
21 care how it gets done to be honest. I've been talking to
22 everybody who will listen for the last two years saying
23 what's been happening. And ultimate --
24 CHAIRPERSON RUBALCAVA: David, could you wrap it
25 up, please.

1 DAVID AGUINALDO: Absolutely. Yes. Thank you
2 all for listening. Do everything in your power, whether
3 that's working with CalHR, whether that's working with the
4 health care plans to figure it out, because this is the
5 number one point, CalHR covers 80 percent of the average
6 cost of plans. That is Kaiser. That means that for the
7 PPO, even though it's the same percentage going up, we are
8 bearing even more of the brunt, because ultimately the
9 State pays for 80 percent of Kaiser and so we pay 100
10 percent of the difference between Kaiser and the PERS
11 Platinum PPO.
12 Thank you for your time, everyone.
13 CHAIRPERSON RUBALCAVA: Thank you, David. Your
14 time is up here.
15 Okay. Next, we have for public comment Larry
16 Woodson. And you have three minutes when you start.
17 LARRY WOODSON: I was going to say good
18 afternoon, but I'll say good evening.
19 CHAIRPERSON RUBALCAVA: Good evening.
20 LARRY WOODSON: Larry Woodson, California State
21 Retirees. Chairman Rubalcava and Board members, thank you
22 for the opportunity to comment. We also thank the staff
23 for the early briefing that we received several hours ago
24 on the preliminary rates the stakeholders heard, and they
25 answered our questions.

1 My main conclusion is, as all of you have said,
2 that the rate increases are much too high overall,
3 especially Kaiser. There are a few exceptions. Glad to
4 see those. We've climbed back into double digit percent
5 increases. I understand, by the way, the logic for the
6 single risk pool, a three-year phase-in to moderate the
7 PPO premiums, and understand Board Member Walker's
8 concerns as well.
9 But there -- the increase -- all these increases
10 are against a backdrop of higher revenues and profits for
11 the most part. And fortuitously, your preliminary rates
12 are released in the same month as fortune releases its
13 Fortune 500. I do this every year. This year, eight of
14 the top 25 Fortune 500 companies with largest revenues are
15 for-profit health care companies. They're led by United
16 Health Group, ranked it fifth. Their 2022 profits are
17 over $20 billion, which ranks them 11th in profits. They
18 had a 16 percent increase in profits over the previous
19 year. By my thinking, they should be lowering their
20 premiums instead of raising almost six percent and 14
21 percent.
22 Elevance Health, which is Anthem Blue Cross is
23 22nd in '22 revenues. They are had -- they're 68th in
24 profits with $6 billion dollar plus level I think with
25 their profits in 2021 just about.

1 And in conclusion, really the high rates, the
2 lack of good solutions to mitigate them represent what I
3 think is a broken health care system. And I'm not
4 speaking here on behalf of CSR, but my own personal
5 opinion is that we would have much lower rates, much lower
6 costs with better outcomes under a universal single payer
7 health care system, or some hybrid at least, as some 38
8 industrialized countries have with much lower costs and
9 many measures that are much better than ours.
10 So as I say, that's my personal opinion.
11 CHAIRPERSON RUBALCAVA: Thank you.
12 LARRY WOODSON: And it would make your job easier
13 too, so thank you.
14 CHAIRPERSON RUBALCAVA: Thank you for your
15 comments.
16 Next, we have J.J. Jelincic.
17 J.J. JELINCIC: J.J. Jelincic. And from a
18 personal viewpoint, I'm glad I'm a retiree without 100/90
19 formula.
20 Risk adjustment means an actuarial tool used to
21 calculate premiums paid to health plan benefits -- or
22 health benefit plans and it's based on geographical
23 differences, and the costs of health care, and the
24 relative difference in the health characteristics of
25 employees, annuitants, and family members enrolled in each

1 plan.
2 Risk adjustment establishes premiums in part by
3 assuming an equal distribution of health risks among plans
4 in order to avoid penalizing employees, annuitants, and
5 family members enrolled in health plan with higher average
6 health risks.
7 This Board changed that definition in 2020. The
8 new definition is risk adjustment means that -- the
9 process by which relative risk factors are assigned to
10 individuals or groups based on expected resource use and
11 by which those factors are taken into consideration.
12 Notice this Board chose to eliminate geographical
13 differences and differences in health characteristics. We
14 have made a decision we're going to protect the PPO. The
15 90/10 PPO, the ability to pick any provider you want is
16 sacrosanct. We're going to protect that.
17 Combining the PPOs and the HMOs into a single
18 health risk pool is like combining auto and homeowners
19 insurance into the same pool. They're very different
20 products, but they -- we want to treat them as the same
21 risk pool. I think you need to think about that. I agree
22 that the Kaiser rates are way too high, but one of the
23 things you have to remember about that is part of the
24 reason it's as high as it is, is you have decided to add
25 $68 per member per month to the premium for risk

1 adjustment.
2 You know, last year, you added $45 per member per
3 month, and then wonder why Kaiser's pencil wasn't as
4 sharp. They were too low, so you jacked up the premium.
5 That does not induce sharp pencils.
6 And one other suggestion you may want to consider
7 with Kaiser is something I advocated a number of times
8 when I was on the Board. You can't cut them out. They're
9 too big a part of your group. If you do, none of you will
10 get reelected, but you may want to give some thought to
11 saying Kaiser you cannot enroll any new members. We tried
12 the once and it got their attention. I suggest you give
13 it some thought. Thank you
14 CHAIRPERSON RUBALCAVA: Thank you very much.
15 Can we have Elondra[SIC] Fretwell please next.
16 Elnora, excuse me. Thank you.
17 ELNORA FRETWELL: Elnora Fretwell, and I'm
18 representing myself, because I'm a little passionate, so I
19 don't want to represent and do something wrong.
20 But the panel here, you may not realize, but you
21 sounded kind of heartless, and maybe you didn't mean to,
22 when you let the Board know that because you have other
23 things to do as far as telling the Legislature they need
24 to make a decision kind of right now what you give. When
25 heard Yvonne speaking and saying more information -- other

1 people asked for more information. When people ask for
2 more information to make a decision, it shouldn't come up
3 and say, well, you know what, we've got other deadlines so
4 make a decision now. I didn't appreciate that and I'm
5 sure other people this is affecting don't appreciate that.
6 It doesn't really affect you all, so it's easy to
7 come and say, you know, do this and do that. But as some
8 of the Board members spoke up and said, we need more
9 information. We need know more to make a sound decision.
10 These are human beings lives that you are affecting. So
11 you cannot just make a decision like that, because you're
12 on a time frame. You still have time.
13 And I'm going to say this. It may sound crazy.
14 Write up two proposals, so if they say yes, you've got
15 one. If they say no, you've got another. Then you're
16 ahead of the time. Do some extra work, because we are
17 paying you all good money to do things. But like I said,
18 this is high. They're making money. But the Board needs
19 information back to you to make a sound decision. And
20 that's what they're saying. So you have to wait to July
21 and hear what they got to say, but do your job, bring some
22 stuff back like they said. And to me, do not pressure the
23 Board, because you have other things to do than make a
24 decision now.
25 Thank you.

1 CHAIRPERSON RUBALCAVA: Thank you very much.
2 That concludes the public comment on Item number
3 5a.
4 Summary of Committee direction.
5 CHIEF HEALTH DIRECTOR MOULDS: So I have -- I
6 have two things from you, Mr. Chair. I'll just confirm
7 that they are Committee direction. One is to enhance the
8 letter that we do for members who are facing a nine
9 percent or greater increase in their rates to include
10 additional information, potentially even regional
11 information about alternative pricing and options. And,
12 of course, also to make them aware of the tools on the --
13 on the myCalPERS website, which allow you to see which
14 plans cover which doctors and so forth. So that was one.
15 The other was to deliver the message initially to
16 Kaiser, but then I think later to all of our plans, that
17 they need to sharpen their pencils between now and July.
18 CHAIRPERSON RUBALCAVA: Thank you. And I would
19 add, based on what a lot of colleagues here have said,
20 starting with Ms. Walker and everybody else, we -- the
21 Board would really appreciate any additional information
22 you can get us for the July meeting, so that we can make
23 an informed decision as to how to sustain these PPOs and
24 keep the HMO rates as low as possible.
25 CHIEF HEALTH DIRECTOR MOULDS: Sure.

1 CHAIRPERSON RUBALCAVA: Mr. Miller, did you --
2 you had sort of another request. Are you okay with it?
3 COMMITTEE MEMBER MILLER: Yes.
4 CHAIRPERSON RUBALCAVA: Okay. So we will leave
5 it at that. Thank you, Mr. Moulds and thank you Mr.
6 Rob -- Rob. It was a very good presentation. Sobering is
7 the term I used.
8 Now, we will go into public comment.
9 And I only have one name, Larry Woodson.
10 LARRY WOODSON: Okay. Thank you for the
11 opportunity to comment again. My comments are on another
12 health benefits related topic. California State Retirees
13 continuing opposition to ACO REACH. And I want to offer
14 you further cause for this Board to join over 250 health
15 care advocacy groups, local governments, and more in
16 petitioning President Biden to halt this ill-conceived
17 program immediately.
18 As you know, it moves beneficiaries, without
19 their knowledge until after the fact, including thousands
20 of CalPERS retirees who chose traditional Medicare for
21 their health coverage, into an experimental plan managed
22 by for-profit middlemen, many with no -- little or no
23 experience managing Medicare. And even worse, it allows
24 private equity companies whose sole mission, as you know,
25 is to maximize profit for its limited partners and

1 investors. It allows them to manage our health care.
2 As you may know, or may not, California Assembly
3 Member Schiavo and Senator McGuire introduced Assembly
4 Joint Resolution 4, which calls on President Biden to
5 immediately halt ACO REACH. CSR and -- has endorsed that
6 AGR 4. It passed the Assembly floor 63 to 15 on May 31st.
7 It's now in the Senate Community on Health. I expect it
8 will easily be adopted.
9 We hope this resolution by our State Legislature
10 will compel this Board to at least agendize this topic,
11 which it hasn't done yet, for a discussion. And of
12 course, you don't have the authority to stop it, but like
13 many others throughout the country, you have the
14 opportunity to voice objection and your voice can be
15 powerful. It could be done at your July off-site.
16 And in conclusion, I've been researching the
17 newest approved REACH ACOs for 2023 focused on the 27 in
18 California. I'm finding some appalling shortcomings and
19 noncompliance with CMS requirements for this program. In
20 spite of Liz Folwer's assurance to you that the approved
21 ACOs were carefully screened. And I hope to share this
22 information soon with you in a written report as I've done
23 in the past. Thank you for your attention
24 CHAIRPERSON RUBALCAVA: Thank you, sir.
25 Having heard public comment and the presentations

1 from staff, I think we'll adjourn the meeting.
2 Thank you very much. See you in July.
3 (Thereupon California Public Employees'
4 Retirement System, Pension and Health Benefits
5 Committee open session meeting adjourned
6 at 5:55 p.m.)
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1 CERTIFICATE OF REPORTER

2 I, JAMES F. PETERS, a Certified Shorthand
3 Reporter of the State of California, do hereby certify:
4 That I am a disinterested person herein; that the
5 foregoing California Public Employees' Retirement System,
6 Board of Administration, Pension and Health Benefits
7 Committee open session meeting was reported in shorthand
8 by me, James F. Peters, a Certified Shorthand Reporter of
9 the State of California, and was thereafter transcribed,
10 under my direction, by computer-assisted transcription;
11 I further certify that I am not of counsel or
12 attorney for any of the parties to said meeting nor in any
13 way interested in the outcome of said meeting.
14 IN WITNESS WHEREOF, I have hereunto set my hand
15 this 27th day of June, 2023.
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