MEETING

STATE OF CALIFORNIA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

BOARD OF ADMINISTRATION

PENSION & HEALTH BENEFITS COMMITTEE

ROBERT F. CARLSON AUDITORIUM

LINCOLN PLAZA NORTH

400 P STREET

SACRAMENTO, CALIFORNIA

TUESDAY, DECEMBER 15, 2015

8:02 A.M.

JAMES F. PETERS, CSR
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A P P E A R A N C E S

COMMITTEE MEMBERS:

Ms. Priya Mathur, Chairperson

Mr. Michael Bilbrey, Vice Chairperson

Mr. John Chiang, represented by Mr. Grant Boyken and Ms. Christina Elliott

Mr. Rob Feckner

Mr. Richard Gillihan, represented by Ms. Katie Hagen

Mr. J.J. Jelincic

Mr. Henry Jones

Ms. Theresa Taylor

Ms. Betty Yee, represented by Mr. Alan Lofaso

BOARD MEMBERS:

Ms. Dana Hollinger

Mr. Bill Slaton

STAFF:

Ms. Anne Stausboll, Chief Executive Officer

Ms. Cheryl Eason, Chief Financial Officer

Mr. Doug Hoffner, Deputy Executive Officer

Ms. Donna Lum, Deputy Executive Officer

Mr. Doug McKeever, Deputy Executive Officer

Mr. Brad Pacheco, Deputy Executive Officer

Mr. Matt Jacobs, General Counsel

Ms. Mary Anne Ashley, Chief, Legislative Affairs Division

A P P E A R A N C E S   C O N T I N U E D

STAFF:

Dr. Kathy Donneson, Chief, Health Plan Administration Division

Ms. Jennifer Jimenez, Committee Secretary

Mr. Anthony Suine, Chief, Benefit Services Division

ALSO PRESENT:

Mr. Chris Little, Butte County

Dr. Richard Sun, Consultant

Ms. Mai Huong Tran, Harbor Compounding Pharmacy

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1 P R O C E E D I N G S
2 CHAIRPERSON MATHUR: Good morning, everyone.
3 Welcome to the Pension and Health Benefits Committee
4 meeting. We're going to get started. It's only 8:02, so
5 we're only a couple minutes late.
6 We can start with the roll.
7 COMMITTEE SECRETARY JIMENEZ: Priya Mathur.
8 CHAIRPERSON MATHUR: Good morning.
9 COMMITTEE SECRETARY JIMENEZ: Michael Bilbrey?
10 VICE CHAIRPERSON BILBREY: Good morning.
11 COMMITTEE SECRETARY JIMENEZ: John Chiang?
12 Rob Feckner?
13 COMMITTEE MEMBER FECKNER: Good morning.
14 COMMITTEE SECRETARY JIMENEZ: Katie Hagen for
15 Richard Gillihan?
16 ACTING COMMITTEE MEMBER HAGEN: Here.
17 COMMITTEE SECRETARY JIMENEZ: J.J. Jelincic?
18 COMMITTEE MEMBER JELINCIC: Here.
19 COMMITTEE SECRETARY JIMENEZ: Henry Jones?
20 COMMITTEE MEMBER JONES: Here.
21 COMMITTEE SECRETARY JIMENEZ: Theresa Taylor?
22 CHAIRPERSON MATHUR: Excused.
23 COMMITTEE SECRETARY JIMENEZ: Alan Lofaso for
24 Betty Yee?
25 ACTING COMMITTEE MEMBER LOFASO: Here.

1 CHAIRPERSON MATHUR: All right. We have a
2 quorum, so we'll move on to Agenda Item number 2,
3 Executive Reports. Mr. McKeever.
4 DEPUTY EXECUTIVE OFFICER McKEEVER: Good morning,
5 Madam Chair, members of the Committee. Doug McKeever,
6 CalPERS staff. A couple of updates for you this month.
7 The first one is I want to provide you with an update on
8 where are - we collectively meaning those in Washington
9 D.C. - relative to the excise tax. And as we've been
10 sharing with you and our stakeholders, there has been some
11 movement back east on looking at a two-year delay for the
12 excise tax. And what they're attempting to do is put into
13 either the omnibus bill or the tax extender bill, the
14 two-year delay.
15 This was supposed to take place last week.
16 However, Congress passed an extender on the budget until
17 midnight tonight. That extender looks like it's going to
18 be again extended until Friday the 16th, or till midnight
19 at that time on the 16th. There is still hope that the
20 two-year delay will be included in that extender on the
21 omnibus bill, either one. And so what we will do is
22 continue to monitor that and certainly update everyone,
23 once we finally find out whether or not that two-year
24 delay will be included, and if it is included, whether or
25 not it's approved by Congress.

1 As a reminder, the excise tax will also be a
2 topic of discussion at the January off-site. So we have
3 Yvette Fontenot who's coming out. Yvette is one of our
4 federal representatives on the health care side.
5 She will be joining CalPERS staff on providing
6 the latest on the excise tax relative to where we're at.
7 Certainly, an update as it relates to what's going on this
8 week. We're going to provide an update on the potential
9 impacts to CalPERS on the tax. As you'll recall, we
10 provided you with an update a couple of months ago. What
11 we're going to be doing in January is providing a
12 five-year look ahead, so that you can see what will happen
13 if the tax doesn't go into place in 2018, five years out,
14 what impacts that will have on our employers, our members,
15 and our health plans.
16 And then the last thing I want to mention to you
17 is on the area of risk adjustment. So as you may recall,
18 we implemented risk adjustment back in 2014. We now have
19 three years of using the methodology in the process under
20 our belts. And we believe it's time to look at an
21 assessment as to whether or not the risk adjustment
22 methodology and process is working as we had intended it
23 to. So we're going to be contracting with a third-party
24 actuarial firm to do an objective review of that -- of the
25 risk-adjustment methodology and process that will include

1 looking internally at the process itself, the methodology
2 reaching out to our health plans, talking to them about
3 it. And then they're going to provide us with an
4 objective report early next year.
5 The findings of which we'll take a look at and
6 then determine whether or not there are any tweaks or
7 changes that may be necessary to the methodology and the
8 process for the 2017 rate year.
9 On the same topic of risk adjustment, I want to
10 mention that the Department of Finance is currently
11 drafting legislative language that would require CalPERS
12 to publicly share the unadjusted, along with the adjusted,
13 rates. And so, as you know, every June when the Board
14 approves rates for the upcoming plan year, those are the
15 adjusted rates based on the risk-adjustment process. And
16 now the Department of Finance would like for us, through
17 legislative means, to go ahead and publicly share that
18 information in the near future.
19 CalPERS has looked at this and we're okay with
20 that. We're in agreement with being able to share that
21 information, commencing with the 2017 rates process. I do
22 want to note, however, that that will require us to
23 provide some re-education to our stakeholders, and our
24 employers, our members and others, so that they become
25 very familiar with the risk-adjustment process, so that

1 when those unadjusted and adjusted rates are published,
2 there will be an awareness as to why there's a variance
3 between the two.
4 Madam Chair, that concludes my updates for this
5 morning.
6 CHAIRPERSON MATHUR: Thank you, Mr. McKeever. We
7 do have a question from the committee.
8 Mr. Jelincic.
9 COMMITTEE MEMBER JELINCIC: Doug, what's
10 Finance's interest in having that -- you know, the -- both
11 the risk and unrisk-adjusted premiums out there? You
12 know, I just see it creating massive headaches. But
13 what's their interest in it?
14 DEPUTY EXECUTIVE OFFICER McKEEVER: I think they
15 just would like for us to be able to publicly show what
16 the unadjusted rate is along with the adjusted rates, so
17 folks could understand, for example, if a particular
18 member has an adjusted rate that's maybe $50 above the
19 premium of the unadjusted rate, that that would give us
20 the opportunity to then educate members as to the health
21 status of the members that are in that plan, because
22 that's what's driving that particular change in the risk
23 adjustment methodology. So it's just another data point
24 to share with the public relative to the health status of
25 our members.

1 COMMITTEE MEMBER JELINCIC: And one of the things
2 we get a fair amount of heat about is the regional
3 adjustments. Is there any pressure to expose what that's
4 being driven by? Because, you know, everybody who's next
5 to a cheaper one wants to move into it.
6 DEPUTY EXECUTIVE OFFICER McKEEVER: Yeah. The
7 regional rates are risk adjusted as well, so -- but lit's
8 much more complicated than the State blended premium, so
9 we're focusing on the State blended premium risk-adjusted
10 rates. Although, what we will do is there will be a
11 discussion relative to regional rates as it relates to how
12 they are risk adjusted, but we're not going to revisit the
13 regions themselves, because we've had that conversation
14 over the last year and a half, and there's not been --
15 there has not been, at this point anyway, effort on your
16 part to direct staff to look at how regions are currently
17 crafted.
18 COMMITTEE MEMBER JELINCIC: So Finance is only
19 talking about the State rate.
20 DEPUTY EXECUTIVE OFFICER McKEEVER: I think they
21 want us to sunshine all of the rates relative to how
22 they're risk adjusted. And so again, we looked at it.
23 We'll be able to provide information on both the
24 unadjusted and the adjusted for State and contracting
25 agencies.

1 COMMITTEE MEMBER JELINCIC: Thank you.
2 CHAIRPERSON MATHUR: Thank you.
3 Mr. Jones.
4 COMMITTEE MEMBER JONES: Yeah. Thank you, Madam
5 Chair. Yeah, I agree with J.J. in terms of creating
6 confusion with two rates being published. So is this the
7 final rates that would be presented to everyone or is it
8 during the process you show them both, and then ultimately
9 you publish only one rate to be distributed to our
10 members? Because if you distribute two rates to our
11 members, I could see confusion.
12 DEPUTY EXECUTIVE OFFICER McKEEVER: Yeah, Mr.
13 Jones, I think the logistics haven't been worked out on
14 how we're going to facilitate that. My recommendation
15 would be that we continue to only publish the final
16 adjusted rate in all of our packages, but that we make
17 available to the public what the unadjusted rate was, as
18 we went through the process itself.
19 COMMITTEE MEMBER JONES: Thank you.
20 CHAIRPERSON MATHUR: Thank you. I see no further
21 questions. Before we move on, I just want to note for the
22 record that Ms. Elliott has joined us on behalf of the
23 Treasurer and Ms. Taylor has joined us as well.
24 Next item on the agenda is the action consent
25 times, approval of the November 17, 2015 minutes.

1 VICE CHAIRPERSON BILBREY: Move approval.
2 COMMITTEE MEMBER JONES: Second.
3 CHAIRPERSON MATHUR: Moved by Bilbrey, seconded
4 by Jones.
5 Any discussion on the motion?
6 Mr. Jelincic.
7 COMMITTEE MEMBER JELINCIC: Yeah, I would like to
8 pull E, if I may?
9 CHAIRPERSON MATHUR: We're not -- from the
10 information consent items?
11 COMMITTEE MEMBER JELINCIC: Oh, I'm sorry.
12 CHAIRPERSON MATHUR: That's okay.
13 COMMITTEE MEMBER JELINCIC: It's in the
14 information consent.
15 CHAIRPERSON MATHUR: Okay. We'll get there in
16 just a minute.
17 Any discussion on the motion?
18 Seeing none.
19 All those in favor a say aye?
20 (Ayes.)
21 CHAIRPERSON MATHUR: All opposed?
22 Motion passes.
23 So we'll take up Item 4e at the end of the
24 agenda. And we'll move on to Agenda Item 5, State
25 Legislative Proposal, Technical Amendments to the PERL.

1 Good morning.
2 LEGISLATIVE AFFAIRS DIVISION CHIEF ASHLEY: Good
3 morning, Madam Chair, and members of the Committee. Mary
4 Anne Ashley, CalPERS staff.
5 I'm presenting the legislative proposals that
6 make minor technical and clarifying changes to the Public
7 Employees' Retirement Law. And staff is recommending that
8 the Board sponsor these proposals.
9 Before I go through the proposals, I do want to
10 note that there's been a status change for one of the
11 proposals, which I believe Doug would like to address.
12 It's the proposal on your Agenda Item number 5 titled
13 Board Approval of Association Health Plan Rates.
14 DEPUTY EXECUTIVE OFFICER McKEEVER: Thank you
15 Mary Anne. Again, Doug McKeever, CalPERS staff.
16 This one we looked at. And I believe Mr. Jones
17 last year during the rate-setting process you had asked
18 the question as to why it was that CalPERS had to approve
19 the rates for the association plans. And the response was
20 that our understanding that that was based on statute that
21 was currently in place. Upon further review, what we did,
22 in fact, notice was that for whatever reason over the last
23 20 plus years, the rates have been brought to this
24 committee and the Board for final approval, but the actual
25 statute is not specific to the Board approving the rates

1 themselves.
2 What it does indicate is that the Board approved
3 the plan -- the association plan and the standards of that
4 plan. And I think the intent behind that was when you
5 have members who can choose between an association plan
6 and a CalPERS plan, we want both of those benefit designs
7 to be consistent, hence the standards.
8 And so it's our belief, at this point in time,
9 that this particular change is not required. So we're
10 going to recommend that at the end, that if you do in fact
11 choose to move forward with this agenda item, that you
12 remove this one particular item from the list of things
13 that we will move forward on the legislative side.
14 With that being said, to the degree of which you
15 all no longer need to approve those rates, as our new
16 understanding is, moving forward to 2017, we will not
17 bring forward to the Board for approval the actual
18 association plan rates themselves.
19 CHAIRPERSON MATHUR: Okay. Thank you for that.
20 Did you -- were you -- did you have more that you were
21 going to go through?
22 LEGISLATIVE AFFAIRS DIVISION CHIEF ASHLEY: I
23 did, yes.
24 CHAIRPERSON MATHUR: Okay. Please go ahead.
25 LEGISLATIVE AFFAIRS DIVISION CHIEF ASHLEY: Okay.

1 So the next proposal is titled final compensation for
2 purposes of concurrent retirement. This proposal would
3 clarify the way CalPERS calculates the final compensation
4 of members that apply for concurrent retirement with
5 CalPERS and the University of California Retirement
6 System, or 1937 Act county retirement system.
7 The change would reflect the current business
8 practice among these retirement systems, which computes
9 the final compensation of a member that retires
10 concurrently using the highest annual average compensation
11 during any consecutive 12- or 36-month period.
12 The next proposal is the member designation of
13 final compensation period. This would remove language
14 from existing law that allows a member to designate his or
15 her final compensation period for purposes of calculating
16 retirement benefits. This provision is no longer
17 necessary, because the my|CalPERS system automatically
18 searches for the highest final compensation period when
19 calculating benefits for retiring members.
20 The next proposal is conversion of sick leave to
21 service credit, which would clarify in statute that an
22 unused day of sick leave and an unused day of educational
23 leave is equivalent to an 8-hour day of sick leave or
24 educational leave, which is consistent with current
25 practice.

1 And then the last proposal is post-retirement
2 survivor allowance expanded definition of marriage. This
3 would provide a survivor allowance to same sex couples who
4 never entered into a registered domestic partnership and
5 who retired before it was legally possible to marry their
6 same sex -- same sex spouse. Providing retired members
7 that have only recently won the right to marry, the
8 ability to provide an ongoing survivor allowance to their
9 spouses under the standards that have previously applied
10 to registered domestic partners would provide benefit
11 equity to all same sex couples.
12 That concludes my presentation, and I'm happy to
13 answer any questions.
14 CHAIRPERSON MATHUR: Thank you. We do have a
15 couple questions from the Committee.
16 Mr. Jelincic.
17 COMMITTEE MEMBER JELINCIC: Doug, going back to
18 your point about the association plans. Do we approve the
19 benefit design structure now or has that been delegated to
20 the associations?
21 DEPUTY EXECUTIVE OFFICER McKEEVER: The
22 association plans, by virtue of the fact that they all
23 have their own governing boards that produce and identify
24 and approve both the benefit design and the rates. So our
25 responsibility, and my understanding, would be just to

1 ensure that we review that to ensure consistency with our
2 evidence of coverage on our plans, and that if there were
3 any issues that we saw that there might be some
4 degradation of benefits that, in a worst case scenario, an
5 association approved, we would bring that to your
6 attention.
7 And then I think under statute, you've then got
8 the authority to say, no, we're not going to approve that
9 plan, because it doesn't meet the standard.
10 COMMITTEE MEMBER JELINCIC: So if I heard you
11 correctly, we essentially have a veto over what their plan
12 design is.
13 DEPUTY EXECUTIVE OFFICER McKEEVER: I don't know
14 if I would use the term veto, but certainly you have the
15 ability to not approve the plan as it's currently written
16 in statute, if, in fact, staff brings to your attention
17 that the benefit and the standards don't meet what we
18 believe should be the minimum standards that are equal to
19 our current health benefits designs and plans.
20 COMMITTEE MEMBER JELINCIC: Okay. And then on
21 the sick leave, you know, when you do the statute, one of
22 the things I think you ought to at least consider is
23 saying that 0.0 -- that one hour of leave is equal to
24 0.005. It's the same math, but I don't think you'll ever
25 have to explain to any of the employers what an hour is.

1 DEPUTY EXECUTIVE OFFICER McKEEVER: Thank you.
2 COMMITTEE MEMBER JELINCIC: Thank you.
3 CHAIRPERSON MATHUR: Okay. Thank you.
4 Mr. Jones.
5 COMMITTEE MEMBER JONES: Yeah, thank you, Madam
6 Chair.
7 I just wanted to thank Doug for following up on
8 that issue about the approval, because approval to me
9 suggests some level of due diligence that we were not
10 really responsible for doing. We were just supposed to
11 pass through to -- on this particular item. So I just
12 wanted to thank you for following up on that. Appreciate
13 it.
14 CHAIRPERSON MATHUR: Okay. Thank you. Mr.
15 Bilbrey.
16 VICE CHAIRPERSON BILBREY: I'd like to move
17 staff's recommendation.
18 CHAIRPERSON MATHUR: With the proviso that we
19 take out the first item on the association plans?
20 VICE CHAIRPERSON BILBREY: Correct.
21 ACTING COMMITTEE MEMBER BOYKEN: Second.
22 CHAIRPERSON MATHUR: Motion has been made and
23 seconded.
24 Any further -- any discussion on the motion?
25 Seeing none.

All those in favor say aye?

(Ayes.)

CHAIRPERSON MATHUR: Thank you very much. Motion passes.

And please note the abstention from CalHR.

CHAIRPERSON MATHUR: We'll move on to Agenda Item number 6, CalPERS Strategic Measures.

DEPUTY EXECUTIVE OFFICER HOFFNER: Good morning, Madam Chair and members of the Committee.

CHAIRPERSON MATHUR: Good morning.

DEPUTY EXECUTIVE OFFICER HOFFNER: Doug Hoffner, CalPERS staff.

(Thereupon an overhead presentation was presented as follows.)

DEPUTY EXECUTIVE OFFICER HOFFNER: I'm going to be introducing this measure and then turning it over to the presenters.

As you recall, we've been working on providing updates to our strategic measures throughout the year 2015, both in May and September for the health, and then the Investment Committee items that were previously presented.

Today, we're here to talk about Items 6 and 7. And I'm joined by Donna Lum, Anthony Suine -- oh, I'm sorry, 10 and 11. I got my agenda items mixed up.

1 Mary Anne Ashley from the Legislative Office and
2 Doug McKeever. Again, this marks the final presentation
3 on strategic measures for 2015. And we'll be hearing the
4 remainder of them in the following policy committees later
5 today.
6 The items we'll be talking about today really
7 revolve around our Strategic Goal B, the part related to
8 supporting that measure, which is benefit payments,
9 timeliness, and customer satisfaction. And then goal C,
10 looking at our legislative bills supporting and opposing
11 them, and the outputs of that for the last year.
12 As previously reported, we have other measures
13 that have been identified and reported out to the
14 Committees earlier this year. And the point of this is
15 really to help you get a better handle in terms of the
16 level of -- so the level of completion, I guess, of our
17 strategic plan, as we look at these various measures
18 across the three strategic goals.
19 And the point of this is to get your, not only,
20 input but feedback as well. And we're providing again
21 today some additional information we've had in the
22 previous presentations going back to July of 2015.
23 With that, I will turn this over to Donna Lum and
24 Anthony Suine for the formal presentation.
25 Thank you.

1 DEPUTY EXECUTIVE OFFICER LUM: Thank you, Doug.
2 Good morning, Madam Chair, members of the Committee.
3 Donna Lum, CalPERS staff. Joining me this morning is
4 Anthony Suine. He is the Chief of the Benefit Services
5 Division.
6 Agenda Item number 6 is an information item. And
7 we're here today for two main purposes. The first is to
8 introduce you to our new strategic measure reporting
9 during and to highlight our overall performance for the
10 fiscal year '14-'15.
11 And then the second purpose is to hear back from
12 you and to -- feedback to validate our proposed targets,
13 measures, and weights for each of the measures that make
14 up these two metrics. We'd like to begin by turning to
15 the reporting tool. And the tool is an interactive
16 display that presents peformance and strategic measures
17 number 10 and 11.
18 Strategic Measure number 10 captures the
19 timeliness of four essential customer benefit payment
20 streams that includes service retirement, disability
21 retirement, refunds, and survivor benefits.
22 Strategic Measure number 11 combines our customer
23 service satisfaction surveys into four main categories
24 capturing the data that we collect from our various
25 customer service surveys, as well as consolidating them

1 accordingly to performance for each of the measures.
2 The tool will allow you to monitor for each of
3 our strategic measures by giving you a dynamic view of the
4 performance. The tool is very familiar to what you've
5 seen previously with the investment -- in the Investment
6 Committee and elsewhere. And Anthony is going to walk you
7 through the features of the tool, both for Strategic
8 Measures 10 and 11 and he'll also provide you with some
9 overview information about our performance. And then
10 he'll turn the presentation back to me and we'll start the
11 discussion related to validating the targets, the
12 thresholds, and the weights.
13 BENEFIT SERVICES DIVISION CHIEF SUINE: Thanks,
14 Donna. Good morning, Madam Chair, members of the
15 Committee.
16 CHAIRPERSON MATHUR: Good morning.
17 BENEFIT SERVICES DIVISION CHIEF SUINE: Anthony
18 Suine, CalPERS staff.
19 We're going to go ahead and click into the tool,
20 and I'll walk you through the features of it.
21 On the left-hand side, I'm going to start with --
22 the right-hand side has a narrative where I'll walk you
23 through and explain the factors in more detail. But the
24 left side of the tool shows three graphical images. On
25 the top graphical display, you'll see our performance for

1 our benefit payments for fiscal year '13-'14 and '14-'15.
2 This display shows we've performed extremely well
3 in making timely benefit payments over these periods. And
4 while we have not yet hit our newly proposed goal of 98
5 percent, we are certainly making strides towards that.
6 As ongoing data is accumulated, the historical
7 view of our performance will grow to show trends for
8 multiple years, which was a key request that came out when
9 we presented last December, that historical view.
10 The second graphic below our overall performance
11 displays a quarterly breakdown from the current fiscal
12 year of each of the individual benefit payment metrics.
13 So you can see more detail on where each metric stood
14 relative to the proposed targets and thresholds. As Donna
15 mentioned the four metrics are service retirement,
16 survivor benefits, disability retirement, and refunds.
17 You can see in fiscal year '14-'15, each of these
18 metrics continually exceeded the threshold, and often
19 approached our newly established goal. As we add more
20 data, you will be able to view previous fiscal years by
21 choosing the drop-down box that appears at the top of the
22 chart.
23 Moving down still on the left-hand side is the
24 third graphical view. And this displays trend lines for a
25 single benefit payment type, illustrating the individual

1 performance across multiple fiscal years. For each year
2 of data that we collect, the line is displayed for that
3 metric giving the historical view for just that benefit
4 payment. So as we add more data points here, that trend
5 line will vary or give you a more -- more data points to
6 view as we add fiscal years. And then the drop-down box
7 allows you to choose which benefit payment type you would
8 like to view the performance for across fiscal years.
9 Now, I'm going to move to the right-hand side of
10 the tool. And the right-hand side is a display of a
11 narrative section that describes the measure itself and a
12 more detailed definition and purpose of the measure.
13 Under the details and analysis section, we further explain
14 the inputs that are used in the measure. The where-we-are
15 section verbally summarizes our performance for the fiscal
16 year, and the data frequency section indicates how often
17 we collect the data internally to track our performance.
18 Under the targets, thresholds, and weights
19 section, we describe our methodology for establishing each
20 of these factors. We have set our targets for benefit
21 payments at 98 percent. This target accounts for a
22 minimum number of constraint cases, and to provide a
23 target for us to achieve based on our current resources,
24 our planned efficiencies, and our historical performance.
25 While we have yet to achieve 98 percent, we

1 believe it is a stretch goal that can be achieved as we
2 continue to develop our staff, our system efficiencies,
3 and our process improvements.
4 We have recommended a threshold of 90 percent to
5 report out when any of our benefit payments fall below
6 that threshold. This accounts for fluctuations, and our
7 staff resources, and peak inventory times. And we believe
8 we can continually achieve a success rate between 90 to 98
9 percent. And we know that from a historical perspective,
10 this success rate has resulted in a high satisfaction,
11 based on our customer feedback.
12 Any performance that falls below 90 percent could
13 result in an increased likelihood of customer complaints
14 and poor satisfaction survey results, and should require
15 an explanation of the root cause and what our corrective
16 actions are.
17 Lastly, I wanted to sneak to the weights. And I
18 wanted to point out there was an updated agenda item
19 provided to you in a hard copy, the one had some incorrect
20 weighting methodology in it previously. So in case you
21 wanted to refer to that hard copy, it has the correct
22 weighting methodology.
23 CHAIRPERSON MATHUR: I'm sorry. I don't think
24 we've received it actually.
25 COMMITTEE MEMBER TAYLOR: Here it is.

1 CHAIRPERSON MATHUR: Was, it in there? Maybe I'm
2 the only one who didn't receive it.
3 Oh, I'm sorry. That's just my mistake.
4 BENEFIT SERVICES DIVISION CHIEF SUINE: That's
5 okay. I'll speak to it.
6 CHAIRPERSON MATHUR: Thank you. It is here.
7 Sorry about that.
8 BENEFIT SERVICES DIVISION CHIEF SUINE: So in
9 speaking to the weights, I wanted to point out that when
10 we calculate an aggregate overall benefit score for this
11 measure, we do weight each of the four individual benefit
12 payment types. And while each payment we feel is
13 critical, the financial impact, the volume of
14 transactions, and the risk of not delivering timely seems
15 to warrant giving a higher importance to certain payment
16 types in our overall score to properly rate our
17 performance.
18 The weighting methodology we used is an industry
19 standard, and is -- and the criteria is in line with best
20 practices. So in looking at our weighting methodology,
21 it's really the number of transactions that's the major
22 factor in weighting service retirements slightly higher
23 than the other benefit payment types, since we process
24 three times the number of retirements monthly over any of
25 the other payment types.

1 Moving down on that right side, we have the last
2 section titled, "Exception Reporting". And as previously
3 described, when any of our benefit payments dip below the
4 reporting threshold of 90 percent, we would document in
5 this area the reason why and our mitigations or actions to
6 correct the timeliness issue.
7 While we would report to the Board in our
8 quarterly CSS performance updates, this section would
9 provide a comprehensive fiscal year view as we report out
10 on the strategic measures on an annual basis.
11 And then at the very bottom of the right-hand
12 side, there's a link titled metric description. Clicking
13 this link provides the target and the number of days to
14 achieve each metric for each benefit payment we've
15 described. Each of our four critical benefit payment
16 measures the percentage of cases completed within 45 days
17 of the benefit effective date, except for refunds which is
18 30 days.
19 We have chosen these time frames based on
20 industry standard, based on the customer feedback from our
21 surveys, and the time allowable to reduce the risk of an
22 ongoing payment interruption for our members.
23 Now, I'd like to transition to Strategic Measure
24 11.
25 CHAIRPERSON MATHUR: Can we pause maybe for a

1 questions on Strategic Measure 10? Is that all right with
2 you, or would you rather go through the whole thing?
3 DEPUTY EXECUTIVE OFFICER LUM: I think it would
4 be easier, if you don't mind, if we go through the whole
5 thing. And then at the end of Anthony's presentation,
6 it's designed for us to really have a robust discussion
7 around the measures themselves.
8 Thank you.
9 CHAIRPERSON MATHUR: Fair enough. Okay. Thank
10 you.
11 BENEFIT SERVICES DIVISION CHIEF SUINE: So moving
12 to the graphical display covering Strategic Measure 11,
13 customer satisfaction, we present data covering fiscal
14 year '14-'15. Strategic Measure 11 identifies customer
15 satisfaction, based on our extensive and increasing
16 portfolio of surveys. The first graphical box on the
17 left-hand side displays or aggregate customer satisfaction
18 performance for fiscal year '14-'15 based on the four
19 categories of surveys: Benefit payments, which displays
20 satisfaction with the Strategic Measure 10 business
21 processes; service delivery, which measures satisfaction
22 with all our other member business processes and services
23 that are not strictly tied to a benefit payment. These
24 are things such as estimates, disability determinations,
25 and beneficiary designations.

1 Third, we have employer interaction, which
2 measures our satisfaction with business partner processes
3 and functionalities. And last, we have member
4 self-service, which measures satisfaction with our on-line
5 tools.
6 As our inventory of surveys continues to grow,
7 each individual survey will be added as a component under
8 one of these four categories and will be factored into the
9 aggregate score.
10 Since the '14-'15 fiscal year is the first year
11 we have expanded our satisfaction surveys, it is the only
12 data displayed here today. However, as we add future
13 years of survey data, the historical performance would be
14 displayed in this graphic.
15 As you can see, we've attained a high
16 satisfaction rating in our first fiscal year of gathering
17 our customer satisfaction data across all domains, and we
18 have the means to strive towards our established goal of
19 95 percent through the feedback we are receiving from
20 those surveys.
21 The second graphic display again breaks down
22 these surveys into more detail. You can see we break down
23 three of the four survey categories by the results
24 achieved each quarter of the fiscal year. We do not have
25 data for the benefit payment surveys, because we just

1 implemented these surveys at the beginning of the '15-'16
2 fiscal year.
3 Again, we were able to attain a high satisfaction
4 rating in each individual survey with none dropping below
5 our threshold reporting during the fiscal year. You will
6 notice a fluctuation in the results of the employer
7 interactions survey. This is due because at the -- in the
8 first two quarters of the fiscal year, we only had one
9 survey that we were distributing. Then in the third and
10 fourth quarters, we added two now employer surveys, which
11 kind of stabilized the reporting a bit more over
12 that -- those last two quarters.
13 The additional data has leveled the reporting for
14 the satisfaction survey, and we have identified focused
15 improvements going forward.
16 That third graphical display on the bottom shows
17 the performance of each survey category in the form of
18 trend lines as opposed to the bar graph. This format is
19 helpful when monitoring quarter to quarter changes, and in
20 comparing performance between the various surveys. As we
21 obtain additional years of data going forward, we will be
22 able to show the historical trends by survey type.
23 As with Strategic Measure 10, the right-hand side
24 of the tool displays our narrative section that describes
25 the measure itself and more detailed definition and

1 purpose of the measure. The details and analysis section
2 further explains the input used in our measure, as
3 previously described, the where-we-are section verbally
4 summarizes our performance for the fiscal year, and the
5 data frequency section indicates how often we collect the
6 data internally.
7 Under the targets, thresholds, and weights
8 section, again, we describe our methodology for
9 establishing each factor. Under the targets section, you
10 can see we've set our target satisfaction percentage at 95
11 percent for our surveys, which is well above the industry
12 standards. Our exception reporting threshold for
13 Strategic Measure 11 is 85 percent. And again, we will
14 report to the Board when any individual survey falls below
15 85 percent, not just the overall grouped survey total.
16 This will allow monitoring of a single
17 underperforming business process when our overall score
18 falls below 85 percent.
19 Again, when calculating the aggregate overall
20 customer satisfaction scores for this measure, we have
21 weighted each of the four individual survey categories.
22 While each survey provides an important analysis to us,
23 the financial impacts, volumes, and risks of not
24 delivering the services in our overall score, we need to
25 factor that in to properly weight our performance.

1 As mentioned, this weighting methodology is an
2 industry standard and the criteria is in line with best
3 practices. While these weights vary slightly, the
4 financial impacts and volumes of our benefit payment
5 services again are the major factors in weighting that
6 customer feedback slightly higher than the other surveys.
7 The last section, again in line with the previous
8 benefit payment measure, is the exception reporting, where
9 we would report any individual survey dropping below 85
10 percent, and we would document the reason why, and our
11 mitigations and actions for taking corrective action to
12 address these issues.
13 And then lastly, at the bottom right-hand side,
14 is the link titled, "Metric Description". And for this
15 measure, clicking on metric description gives you all the
16 individual surveys that are accounted for in each rolled
17 up domain.
18 So now I would like to turn it back over to Donna
19 to go into more details about the agenda item and our
20 future actions.
21 DEPUTY EXECUTIVE OFFICER LUM: Thank you,
22 Anthony, and thank you for walking us through the tool and
23 our performance, and explaining each of the measures in
24 detail.
25 And sticking with the discussion, we're now

1 seeking affirmation and validation from the Committee
2 related to our targets, thresholds, and weights, and we're
3 also available to answer any questions and provide any
4 further details to information that may not have been
5 clear -- clearly presented earlier.
6 But just to reiterate, we believe that based on,
7 not only just the industry standards, but our evaluation
8 of the complexities of each of the business processes, as
9 well as our assessment of workforce, that we have
10 appropriately set the weights, targets, and thresholds for
11 both of these strategic measures. It should also be noted
12 that our performance metric methodology includes a
13 reevaluation of each of the metrics based on data and
14 information that we continue to receive throughout the
15 year.
16 In addition to that, if we find that we have not
17 set the measures, whether individual or rolled up, at the
18 correct level, we will continue to dialogue with the
19 Committee and to provide updates and additional proposed
20 changes, if those changes are necessary going forward.
21 As always, it's our primary objective to fulfill
22 our obligations to our customers and our stakeholders by
23 providing the best level of customer service that we can.
24 And we ask that in this part of the discussion that again
25 you validate and provide feedback on the measures

1 themselves, as well as the targets, the thresholds, and
2 the weights. And as we go forward and we continue to
3 report, we can adjust accordingly based on the feedback
4 that we receive from you today.
5 So that concludes our presentation, and we'd be
6 more than happy to take any questions that you may have.
7 CHAIRPERSON MATHUR: Thank you, Donna and
8 Anthony. We'll move on to questions.
9 Mr. Jelincic.
10 COMMITTEE MEMBER JELINCIC: When you showed us
11 the tool, there was an external and an internal button.
12 Does the Board have access to that survey? And the
13 follow-up question is going to be do our members have
14 access to it?
15 DEPUTY EXECUTIVE OFFICER LUM: So are you
16 referring to does the Board have access to the internal,
17 which is grayed out?
18 COMMITTEE MEMBER JELINCIC: No, actually, I was
19 more concerned with the external.
20 DEPUTY EXECUTIVE OFFICER LUM: Oh. So the way
21 that the tool is designed is this will be made available
22 to you on your iPads. And I believe it is strictly for
23 the Board and each of the individual Committee members.
24 We do not have plans to make this individual data, I
25 believe, available to the public at this time.

1 DEPUTY EXECUTIVE OFFICER McKEEVER: Well, it's in
2 the agenda item, so I think -- I think you're talking
3 about the tool itself.
4 DEPUTY EXECUTIVE OFFICER LUM: The tool itself.
5 COMMITTEE MEMBER JELINCIC: Yeah, the tool
6 itself.
7 DEPUTY EXECUTIVE OFFICER HOFFNER: The tool
8 itself is more dynamic. And so that's tied into our IT
9 system, so that's not necessarily something that's
10 publicly available, but the information that was
11 presented, and has been presented to the Board, is always
12 in the public domain. So in reference to the internal
13 versus external, the internal header there is really about
14 the internal facing measures that we're going to talk
15 about in the Performance and Comp Committee this
16 afternoon. It's not about internal. It's more about
17 inward facing sort of the talent management and
18 organizational health items. So it may be confusing a
19 little bit there.
20 COMMITTEE MEMBER JELINCIC: Okay. And then an
21 observation. We set the goals based on our resources.
22 And obviously, if you don't have resources, you've got to
23 set lower goals. But on the other hand, there is a flip
24 to that. And maybe what we need to do is look at what the
25 goals ought to be, and then make sure we have the

1 resources to do that. So, I mean, it's kind of an
2 iterative process.
3 And the other comment I would make is you set the
4 payments at a 90 percent threshold, and the survey at 85
5 percent threshold. And I'm wondering why there is a
6 difference there. And I will just observe that at least
7 for the limited set of data we've got, we set the
8 threshold at the lowest that we had received. So it could
9 be coincidental or --
10 BENEFIT SERVICES DIVISION CHIEF SUINE: It's --
11 yeah, that's just coincidental. I mean, we felt like if
12 we drop below that 85 percent, obviously -- we looked at
13 survey results in total best practices, and where those
14 levels are. Eighty-five percent -- really, 80 percent is
15 what many companies strive for to reach 80 percent to be
16 able to say, yeah, we're succeeding.
17 We felt we've well exceeded that on a consistent
18 basis, so we felt setting our bar there was not prudent.
19 So we set the bar higher to 95 percent, but set our
20 threshold that we feel like if we fall below 85 percent,
21 that's where we'll receive more customer complaints. It
22 seems to be a benchmark for when we would really see
23 negative feedback, and we'd have to make a course
24 correction.
25 CHAIRPERSON MATHUR: So what you're saying is

1 that you're setting the -- you're proposing to set the
2 threshold and the target above industry standards. And it
3 just so happens that we already exceed industry standards.
4 BENEFIT SERVICES DIVISION CHIEF SUINE: Correct.
5 Yes.
6 COMMITTEE MEMBER JELINCIC: And on the payments,
7 you talked about why you picked the weights. I don't know
8 how many disability payments we have. But it strikes me
9 that for our members who are going on disability, that's
10 really, really critical, probably more critical than the
11 others. So I'm not sure that 25 percent is the right
12 weight. But on the other hand, if it's two percent
13 transactions, it may be -- I mean, so I had some concern
14 there. And I don't know that you described really how you
15 pick the weightings in the survey.
16 BENEFIT SERVICES DIVISION CHIEF SUINE: So the --
17 just I'll speak to the disability payments. Yes, the
18 volume is much lower then our service retirements, so
19 that's why we weighted it just slightly less. The other
20 reason would be is many of our disability retirees are,
21 what we call, service pending disability retirements. So
22 they're already receiving a service retirement, pending
23 the outcome of their disability determination. So even
24 less are waiting for a payment stream to come in. So
25 again, it's weighted just slightly less.

1 On the surveys, it was the same rationale. We
2 looked at the volumes, the financial impacts and risks to
3 weight the various survey categories. So our benefit
4 payment surveys are obviously our most critical business
5 processes, and so they're slightly higher, because they
6 have more volume, more financial impact, and more risk of
7 not being up to par. So that's why we weighted that one
8 slightly higher than the others.
9 COMMITTEE MEMBER JELINCIC: Thank you.
10 CHAIRPERSON MATHUR: Thank you.
11 I'd like to note for the record that Mr. Slaton
12 and Ms. Hollinger have joined us. And I will turn now to
13 Mr. Slaton.
14 BOARD MEMBER SLATON: Thank you, Madam Chair.
15 Good body of work. You know, this is an area
16 that I tend to try to focus on. And so a couple of
17 questions. On the service delivery, and I know we talked
18 about this back at one of the off-sites at least a year
19 ago, maybe longer, about -- and this was on the survivor
20 benefits. And we had a debate about when does the 45 days
21 start, right? And so the issue was does it start when we
22 have every piece of information we need or does it start
23 when the event happens, which is when someone has passed
24 away?
25 Obviously, if you start when someone has passed

1 away, there are elements of that that are out of our
2 control. So does the 45 days, is this still when all the
3 information is obtained?
4 BENEFIT SERVICES DIVISION CHIEF SUINE: So we
5 did -- we took that feedback to heart and we did address
6 that, and we addressed it in a couple ways. The survivor
7 benefits that you're seeing today displayed, we split out
8 our survivor benefits, and we have two payment streams.
9 One is the monthly ongoing payment stream that is usually
10 that surviving spouse or domestic partner that needs that
11 ongoing income. And then the other are these lump sum
12 payments that, you know, are maybe entitled to some
13 beneficiary, family -- other family member down the road.
14 So what you're seeing here are those ongoing
15 monthly benefits. And we are measuring that from the date
16 the death was reported. So we're not measuring it from
17 any time we receive a piece of documentation, other than
18 the death being reported itself, which we need to know.
19 We are measuring those lump sum death benefit
20 payments. And in the future, you will see those added.
21 We just split them out and have just recently been
22 calculating the data on the lump sums. But in those
23 cases, we do need the documentation, because we need to
24 validate the beneficiary, and we can't pay that benefit
25 until we get that. So you will be seeing that view in the

1 future as well.
2 BOARD MEMBER SLATON: Well, good. I'm glad to
3 see that we're taking into account what the situation on
4 the ground is and not just our own internal processes.
5 But I want to come back and contrast between the
6 two measures. And I'll -- at the risk of being a broken
7 record, I would say that the time measurements, the
8 45-days, is really a -- in my view, is a management
9 measure that, for the purpose of this Committee and this
10 Board, I would suggest it's really customer satisfaction.
11 You know, whether it happens in 45 days or
12 happens in 30 days or 90 days, you know, that's your job
13 to make that delivery in a timely fashion. The question
14 is how do our constituents feel about it? Do they feel
15 they're being appropriately handled and serviced?
16 So, to me, the customer satisfaction is really
17 the measurement that we should be focusing on. And I
18 would suggest that maybe instead of 95/85 that it's 95/90.
19 That when it falls below 90, you know, we need to know
20 what's going on, what's happening, and what's the
21 corrective action to get it back above 90.
22 But I think focusing on the end result that we
23 want, which is our beneficiaries to be -- and our
24 employers to be satisfied with what CalPERS is doing, is
25 really where we should focus our attention, more so than

1 on how many days it took to get a particular task done.
2 So that's my comment.
3 DEPUTY EXECUTIVE OFFICER LUM: Just to follow up
4 on that a little bit. So in our customer surveys, we do
5 ask the question of timeliness. Did we meet your
6 satisfaction in the area of timeliness? And the vast
7 majority of the responses that we're getting from all of
8 the surveys that we're administering now is a high
9 satisfaction level of the timeliness. That's only one of
10 several questions that we ask.
11 We also ask their interaction with the agent,
12 were they pleasant, were the materials clear, did you
13 understand the process? So there's a lot of information
14 that goes into that. Certainly, as you're suggesting, Mr.
15 Slaton, if it's the Committee's desire and direction by
16 the Chair to change the weight -- or excuse me, the
17 threshold on customer surveys, to move it from a 85 to 90,
18 we can certainly take that direction and then continue to
19 report out through the exception process, which would be
20 done more on a quarterly basis during our quarterly
21 update. So you wouldn't only see it at the end of the
22 fiscal year.
23 CHAIRPERSON MATHUR: Thank you.
24 Mr. Lofaso.
25 ACTING COMMITTEE MEMBER LOFASO: Thank you,

1 Madam --
2 CHAIRPERSON MATHUR: You're on.
3 ACTING COMMITTEE MEMBER LOFASO: Thank you.
4 It's enough to figure out this system. Thank
5 you, Madam Chair. Thank you, Ms. Lum and Mr. Suine.
6 A question. I was going to observe in the intro
7 to my question that Measure 10 seems more objective than
8 Measure 11. I backed off on that from Mr. Slaton's
9 observation about the nuances. But more to Measure 11, I
10 guess I'm channeling my own discomfort with survey data as
11 being fundamentally a subjective tool. And I know it's a
12 very refined tool. Can you elaborate a little bit more on
13 how it works? And part of my question is as we refine the
14 tool, how do we account for that as we look for trends and
15 such?
16 I know things happen where response rates go up.
17 And so from period of time to period of time, the pool can
18 be a little bit different. It seems to me that the
19 measure is one of those systems that we all encounter in
20 our lives where somebody hands you a survey and says, were
21 you satisfied by that experience, which I think does a bit
22 allude to Ms. Lum's comment about 45 days might be a good
23 management measure, but I might have wanted it in 10, so I
24 might not be satisfied. I'm not sure how we even know
25 that.

1 But I'm meandering in my question, but can you
2 elaborate on exactly how the surveys work, how they've
3 evolved, and how we account for fluctuations as we look
4 for trends in the data?
5 BENEFIT SERVICES DIVISION CHIEF SUINE: Sure.
6 Let me take a stab at that one. Each of the four domains
7 operate a little bit differently. For instance, we have
8 our member self-service survey. So that's when people are
9 using our on-line tools like applying for retirement
10 on-line or designating a beneficiary on-line. At the end
11 of their process, it pops up and asks them to respond to a
12 series of five questions about the process itself, how
13 easy it was to use, that type of thing.
14 So that operates a little bit differently, and
15 allows them to give comments as well. The comments,
16 across all four of these groups of surveys, is where we
17 get our real data, right, because then we know what we can
18 address to make their experience better.
19 In other processes, like our benefit payment
20 surveys, we look at people who actually applied for
21 retirement via paper, right? And then after we complete
22 the process, it triggers a survey to go out to them and
23 ask them about their experience. That gives more
24 interaction with potentially the call center they had to
25 call with after they've received their retirement check

1 and how that full process was.
2 And so it tries to keep it simple, breaking down
3 the milestones within each of those processes to get their
4 feedback about if we didn't meet their standards, where in
5 the process could we improve? And then we can isolate
6 that it was just an anomaly or that it's a trend amongst
7 all our respondents.
8 And we have a group that collects all this data,
9 the percentage of responses, the comments that we receive
10 and how often they're repeated to see if there is
11 something we need to address, and then how it's evolved.
12 You mentioned -- we used to have basically one survey we
13 sent out from our contact center. It went to one of every
14 10 callers and asked them about their experience. And the
15 feedback we got, we couldn't tell if it was a back office
16 issue, or if it was a front-line issue, or if they just
17 didn't like one of the people they interacted with or the
18 timeliness, et cetera.
19 So we realized we needed to evolve our customer
20 satisfaction process, so we went from one survey to 20
21 surveys almost in just over the last year or so. And then
22 we've grouped these surveys into these four categories.
23 And we continue to find processes to survey and roll up
24 under each of these four categories.
25 Does that help?

1 ACTING COMMITTEE MEMBER LOFASO: It's very
2 helpful and I appreciate it. And I guess the bottom line
3 I'm just probing for is it's one thing to use these kinds
4 of devices to see how your program is doing and make
5 adjustments, another thing to establish these numbers as
6 long-range trends to show sort of global organizational
7 improvement, where -- I wasn't going to ask all the
8 follow-ups exactly how the questions work, and whether 3's
9 are satisfactory, 4's -- I get the system works as it
10 works, but when somebody says satisfaction has gone up
11 from 91 to 96 percent, my first question, is that because
12 there's a nuance in the way the tool is reflecting it or
13 because suddenly there's this ground swell of
14 satisfaction, or this significant, you know, change in the
15 program.
16 Again, I'm not asking for all these answers,
17 I'm -- we're all talking about a tool. And the more you
18 tell us about the tool, it's very helpful, and I'm very
19 much appreciate your answer.
20 Thank you.
21 And I agree with Mr. Slaton. It's good work and
22 its getting better and it's appreciated.
23 BENEFIT SERVICES DIVISION CHIEF SUINE: Thank
24 you.
25 CHAIRPERSON MATHUR: Thank you.

1 Mr. Jones.
2 COMMITTEE MEMBER JONES: Yeah. Thank you, Madam
3 Chair. Yeah, I would like to also echo good body of work
4 here. And we've had a number of opportunities to discuss
5 about the measurement factors, et cetera. And so I'm kind
6 of okay with that area. But my question goes to not the
7 payments that's being made after a person files for
8 retirement, but once you make that first payment, then are
9 we paying 100 percent? That's the more important facts to
10 me.
11 BENEFIT SERVICES DIVISION CHIEF SUINE: Yes.
12 COMMITTEE MEMBER JONES: Okay. I just wanted to
13 clarify. Thank you.
14 CHAIRPERSON MATHUR: Thank you.
15 Ms. Taylor.
16 COMMITTEE MEMBER TAYLOR: Yes. And I want to
17 echo my fellow board members its a great body of work.
18 And I'm really appreciative of the refining that you did
19 to get more surveys, to get better data. Having some
20 experience with this and my own agency, I was just
21 wondering what's the percentage -- and you mentioned that
22 you knew it, but what's the percentage of return, because
23 you know a lot of folks don't actually take the surveys,
24 or what's the percentage of return?
25 BENEFIT SERVICES DIVISION CHIEF SUINE: Yeah. It

1 varies across all the survey types. We have up to 20
2 percent respondents in some surveys, which is --
3 COMMITTEE MEMBER TAYLOR: Pretty good.
4 BENEFIT SERVICES DIVISION CHIEF SUINE:
5 -- extremely high, as you know from your
6 experience. So I think it fluctuates eight percent to 20
7 percent range, depending on the survey.
8 And we would report out on that in our exception
9 reporting. You know, if we saw something drop below a
10 threshold, we would examine it and see, oh, there was only
11 five percent of respondents, so we didn't get that broad
12 feedback this quarter and be able to kind of address that
13 in our exception reporting.
14 COMMITTEE MEMBER TAYLOR: Right, because then
15 you're not getting an appropriate amount of data to make
16 any assumptions, I think.
17 BENEFIT SERVICES DIVISION CHIEF SUINE: Exactly.
18 COMMITTEE MEMBER TAYLOR: Okay. Thank you.
19 CHAIRPERSON MATHUR: Thank you.
20 Well, we've heard from a number of Committee
21 members. You know, as a general rule, I agree with Mr.
22 Slaton that we should be focusing on sort of the results,
23 which is obviously -- you know, the customer satisfaction
24 surveys measure that, but I do think that the benefit
25 payment measure gets to sort of the heart of our business.

1 This is what we do, and it's really -- it's essential to
2 our members that they get their benefit payments in a
3 timely fashion, and it gets processed quickly. And it
4 also relates to how we allocate resources within the
5 organization to ensure that that basic business is being
6 done. So I think it's actually a good idea to keep --
7 retain Measure 10.
8 I did want to ask a question though about the
9 target, because 98 percent is a very high target. I tend
10 to be in favor of stretch targets, but, you know, as we
11 get closer to a hundred, it's sort of asymptotic, right.
12 Each marginal investment generates, you know, smaller and
13 smaller returns. And so I just want to make sure we're
14 not driving extraordinary investments, you know, in terms
15 of costs and getting a very little return for that
16 investment. So can you talk to that a little bit?
17 BENEFIT SERVICES DIVISION CHIEF SUINE: Sure.
18 Again, we want to establish that stretch target, because
19 we flirted with it. And we feel, again, the investment in
20 our staff, in our system, as you've heard through the
21 functional optimization project, and just process
22 improvements in general like we've made throughout the
23 organization and in our branch, that we feel that, you
24 know, the current resource pool that we have, with some
25 exceptions, and where we ask for more resources here or

1 there, will help us achieve that 98 percent.
2 And I don't think we'd put it there if we felt we
3 couldn't achieve it. And that we're -- it's not to the
4 point where we're diminishing our return on investments.
5 CHAIRPERSON MATHUR: Okay. So you think it's
6 achievable with moderate resource investment that's --
7 that makes sense, that's sensible.
8 BENEFIT SERVICES DIVISION CHIEF SUINE: Yes.
9 CHAIRPERSON MATHUR: Okay. That's helpful.
10 Thank you. And then also with respect to the bottom
11 threshold for the surveys -- the customer satisfaction
12 measure, Measure 11, I know Mr. Slaton threw out 90. I
13 think 90 is an extraordinarily high bottom threshold for a
14 satisfaction target. So I'm comfortable with 85. I think
15 that still exceeds industry standards, and I would stick
16 with your recommendation on that.
17 I had one last thought or note, and that is on
18 Strategic Measure number 10, metric description. For the
19 survivor benefits, it says number of benefit payments, as
20 opposed to percentage. Is there a reason why it says
21 number and not percentage? The other ones say percentage.
22 And I think it's supposed to say percentage. But I only
23 saw it when we went to it on the screen.
24 BENEFIT SERVICES DIVISION CHIEF SUINE: Yeah.
25 CHAIRPERSON MATHUR: That's just a note, but I

1 only saw it when you like clicked on the metric
2 description.
3 BENEFIT SERVICES DIVISION CHIEF SUINE: Yes, it's
4 the same
5 CHAIRPERSON MATHUR: Okay. So I would just
6 suggest that little note.
7 Mr. Boyken, you have a comment.
8 ACTING COMMITTEE MEMBER BOYKEN: Thank you.
9 Just piggybacking on your concerns, Priya, about
10 the investment and resources and -- in terms of the
11 returns we get in customer service. I was just wondering,
12 is it instructive at all to look at the CEM, the cost
13 effectiveness measures, to compare -- I don't know if
14 these Measures, 10 and 11, translate to things that CEM
15 measures, but to be --
16 BENEFIT SERVICES DIVISION CHIEF SUINE:
17 Absolutely.
18 ACTING COMMITTEE MEMBER BOYKEN: They do. So
19 where are we in comparison to our peers.
20 BENEFIT SERVICES DIVISION CHIEF SUINE: I'm not
21 sure we're -- I know that we're right in line with our
22 peers. And much of the data we use to establish the
23 targets and the thresholds were based on CEM, data and our
24 comparable peers in that area. So we use them to measure
25 ourselves and benchmark ourselves. And we are right in

1 line with them. Despite our complexities, we are on par.
2 ACTING COMMITTEE MEMBER BOYKEN: Okay.
3 DEPUTY EXECUTIVE OFFICER LUM: So there were two
4 observations that I would make from the last report that
5 we shared with the Committee. One is that in the area of
6 benefit payments, uninterrupted payments, we scored very
7 high within CEM. And then the other area in customer
8 satisfaction, our score was even higher than our peer
9 trend and between all of the pension systems that report
10 in CEM, noting that we have the highest number of surveys
11 that were being administered, as well as the outcome of
12 the survey results. So when you go back and you look at
13 our CEM reports, those were two of the three highest
14 scores that we received in the report.
15 ACTING COMMITTEE MEMBER BOYKEN: Okay. Thank
16 you.
17 CHAIRPERSON MATHUR: All right. Thank you.
18 Well, I see no further requests to speak. We've had quite
19 a broad discussion. Despite Mr. Slaton's note of wanting
20 a higher threshold on Strategic Measure 11, I haven't
21 heard that echoed across the Committee. So I think we are
22 validating and affirming what you've brought before us,
23 unless I see any hands raised.
24 Thank you very much for your hard work on this.
25 I think it's turned out really well.

1 BENEFIT SERVICES DIVISION CHIEF SUINE: Thank
2 you.
3 CHAIRPERSON MATHUR: All right. We'll move on to
4 Agenda Item number 7, more strategic measures.
5 DEPUTY EXECUTIVE OFFICER McKEEVER: Madam Chair,
6 member as of the Committee, Doug McKeever, CalPERS staff.
7 I think we'll be able to cover this one quicker than the
8 prior one, only because the subject matter is a tad bit
9 different than just focusing on customer services.
10 (Thereupon an overhead presentation was
11 presented as follows.)
12 DEPUTY EXECUTIVE OFFICER McKEEVER: Strategic
13 Goal C, which is to engage in State and national policy
14 development to enhance the long-term sustainability and
15 effectiveness of our programs. And the goal here is to
16 seek to measure the percentage of California State
17 legislation that's been enacted or defeated consistent
18 with positions that have been taken by this Board.
19 The data and analysis that Mary Anne will be
20 sharing with you will provide the Board with a sense of
21 the volume of CalPERS' legislative advocacy efforts at the
22 statewide level in recent sessions.
23 This initial presentation may provide the basis
24 for more strategic discussions on CalPERS' voice in the
25 Capitol, and how it can be further developed.

1 And with that, I'll pass it on to Marry Anne.
2 LEGISLATIVE AFFAIRS DIVISION CHIEF ASHLEY: Good
3 again. Mary Anne Ashley, CalPERS staff.
4 CHAIRPERSON MATHUR: Good morning.
5 LEGISLATIVE AFFAIRS DIVISION CHIEF ASHLEY: The
6 first graphic shows the legislative milestones for 2015.
7 And nearly 2,800 bills were introduced in that year. And
8 the Legislative Affairs Division reviewed all of those
9 bills and identified 152 that were relevant to CalPERS.
10 As so between March and June, Legislative Affairs
11 gathers information and works with CalPERS division
12 legislative representatives, and other program staff to
13 find-tune the classification and prioritization of the
14 bills and assesses the actual impact of the bills, and
15 works with the executive staff to identify which bills
16 should be brought forward to the Board.
17 Throughout the year, Legislative Affairs also
18 provides information on costs, impacts, desired
19 amendments, and other issues to author offices, committee
20 staff, and key stakeholders. And as you can see in the
21 graph, in June by the House of origin deadline, about a
22 third of the bills that Legislative Affairs had been
23 tracking and put on the list actually make it on and pass
24 that deadline -- or a third actually didn't make it out of
25 the House of origin.

1 The legislature in June also works on the budget,
2 and then goes on summer recess in July and reconvenes in
3 August. And then as you can see by the graph, by the
4 deadline to pass bills on to the Governor by
5 mid-September, only about a third of the remaining active
6 bills actually are forwarded on to the Governor's desk for
7 action.
8 And the next graphic. On the right-hand side of
9 this screen you can see the supporting narrative
10 information, which tells the story that supports the
11 strategic measure. In the interests of time, we won't
12 spend a lot of time on the content in these fields.
13 However, Attachment 2 in the agenda provides a full
14 description and content for anyone who wishes to read it.
15 After the definition and purpose, there's a short
16 glossary. And the next, there is a brief summary of where
17 the Legislative Affairs Division is and some context for
18 the tables. And then after that, you can see the
19 frequency of data reporting, which we suggest be every two
20 years to correspond with the legislative sessions.
21 And the first graph in this display indicates the
22 overall success rate for the past five sessions, or 10
23 years, which you can see ranges from 50 percent to 91
24 percent. There isn't really a discernable trend, nor is
25 it likely that there could be any projects for future

1 sessions that could be made.
2 And if you look at the first section, 2005/2006,
3 you can see that it was a particularly busy year for
4 CalPERS, as CalPERS took a position on approximately 43
5 bills. This, in part, is due to several extraordinary
6 sessions, including one specifically aimed at pension
7 reform, and the other four sessions on the graph show that
8 CalPERS took positions on a range of 18 to 26 bills.
9 Part of the drop in the number of bills that were
10 brought to the Board in the past two sessions may be
11 attributed to the passage of PEPRA, and also the launch of
12 the California Health Benefit Exchange implementing the
13 federal Affordable Care Act. There were numerous bills
14 dealing with these topics in earlier years.
15 The second graph shows the number of bills that
16 the Board actually took a support position, or sponsored
17 by session, and the number of those bills that were signed
18 into law.
19 And then the third graph shows the number of
20 bills that the Board voted to oppose with the number of
21 those that were actually defeated. And just a note for
22 2008 session, it was an unusual one. The Governor vetoed
23 much of the legislation that year due to his conflicts
24 with the legislature's leadership, and he also vetoed
25 CalPERS technical housekeeping bill, even though it was

1 very non-controversial.
2 Also, in that year, you can see that the Governor
3 did actually sign one bill that CalPERS took an oppose
4 position on. And that was AB 221 by Assembly Member
5 Anderson, which was the Iran Divestment bill.
6 For more detailed information, Attachment 3 is a
7 list of all the bills that the Board took positions on by
8 session, and it contains links to the more detailed
9 legislative summaries. What's not accounted for in this
10 measure are bills that the legislative affairs staff did
11 not ask for the Board to take a position on -- or bills
12 that CalPERS was neutral on, but that staff still spent a
13 great amount of time working on.
14 In conclusion, while it's not feasible to set any
15 technical targets for the number of bills to advocate,
16 CalPERS will always strive to be 100 percent successful on
17 bills that the Board has sponsored.
18 And then with regard to interpretation of the
19 results, it seems to be easier to stop -- oppose
20 ledge -- legislation than to pass supported legislation,
21 especially when there are real or potential costs to the
22 state. And one of the most critical factors contributing
23 to our success at the Capitol is an understanding of the
24 political structures and realities, which has contributed
25 to the decisions about which bills have been brought to

1 the Board for positions.
2 Legislative Affairs, will continue to develop
3 relationships, and seek out opportunities to be active in
4 discussions at the Capitol, and with our stakeholders, and
5 to provide quality information to policymakers.
6 And with that, Doug and I would be happy to
7 answer any questions.
8 CHAIRPERSON MATHUR: Thank you. I actually have
9 a question. What this doesn't capture, and I'm not sure
10 it can, is those bills where we might have taken a
11 position, but then we've worked hard to amend the bill to
12 make it more palatable. And that is important work that
13 is not captured by defeat or success. I don't know if
14 it's possible in a quantitative way to capture that, but
15 just thought I'd bring that up.
16 Okay. Mr. Jelincic.
17 COMMITTEE MEMBER JELINCIC: Yeah. You raised the
18 issue of a number of bills that staff works on that
19 doesn't -- either really doesn't develop or, you know,
20 doesn't come to the Board. Is there someway of capturing
21 that, because that is real workload?
22 LEGISLATIVE AFFAIRS DIVISION CHIEF ASHLEY:
23 Right. We could track that and bring that
24 information to the Board. And it kind of ties on with
25 what Priya just mentioned that, you know, we may work with

1 ties Capitol staff and have a bill amended to where it no
2 longer impacts CalPERS and would no longer need to be
3 brought to the Board for a position. So we do -- we could
4 capture that type of work and report back.
5 COMMITTEE MEMBER JELINCIC: Do you see some value
6 in capturing it, other than helping to define the
7 workload?
8 LEGISLATIVE AFFAIRS DIVISION CHIEF ASHLEY: It
9 helps to illustrate the amount of work that staff is
10 actually doing and the amount of time that's spent working
11 with Capitol staff.
12 COMMITTEE MEMBER JELINCIC: Okay. Thank you.
13 CHAIRPERSON MATHUR: Thank you.
14 Mr. Lofaso.
15 ACTING COMMITTEE MEMBER LOFASO: Thank you, Madam
16 Chair. I have never been involved in an organization that
17 was satisfied with the quantitative measures of its
18 legislative activity for observations just made.
19 (Laughter.)
20 ACTING COMMITTEE MEMBER LOFASO: I thought
21 embedded into this item was a more or less kind of
22 question. But simply put, these data help people see
23 things because it causes staff to highlight certain
24 things, although often at the exclusion of other things, à
25 la the example that the Chairwoman mentioned, notably how

1 do you measure the dynamic that Mr. McKeever discussed at
2 the beginning of our meeting regarding the excise tax. No
3 quantitative measure will ever get that, even though it is
4 important as probably anything we're doing around here.
5 So the bottom line is it seems to me that
6 whatever -- if there's a question lurking in here it's
7 what's the purpose of the measure? And if the purpose of
8 the measure is to support staff in staff explaining to the
9 Board what it needs. And if it's a workload issue, that's
10 great. The measure should support what staff needs to
11 tell the Board. That's what the measure should do.
12 Thanks.
13 CHAIRPERSON MATHUR: This is a strategic measure
14 that I think is really intended to be used by the Board to
15 assess our progress towards our overarching mission and
16 goals. And that's -- and in accordance with strategic
17 plan, which we are going to be ramping up to do a new one
18 coming up this summer.
19 I think this is a challenging -- I think this
20 pretty -- as far as I can tell, this is sort of the best
21 measure we can get to for measuring our legislative
22 achievements. Obviously, as you've have noted, it misses
23 a few things, but I think as a sort of overarching
24 management tool, it will -- or governance tool, I think it
25 works.

1 I have it -- is that acceptable to the rest of
2 the Committee? It seems like everyone is pretty much in
3 agreement, so we will affirm this one as well.
4 DEPUTY EXECUTIVE OFFICER McKEEVER: All right.
5 Thank you, Madam Chair. We'll just proceed as we have in
6 the past and continue down this path.
7 CHAIRPERSON MATHUR: Thank you.
8 DEPUTY EXECUTIVE OFFICER McKEEVER: And then any
9 further information that you could provide us to enhance
10 this as we move forward we'll certainly welcome those
11 comments. Thank you.
12 CHAIRPERSON MATHUR: Okay. Thank you.
13 Let's move on to agenda Item number 8, Population
14 Health Management Initiative.
15 Mr. McKeever.
16 DEPUTY EXECUTIVE OFFICER McKEEVER: Kathy
17 Donneson and Dr. Richard Sun will provide an update on
18 this particular agenda item.
19 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
20 DONNESON: Good morning, Madam Chair, members of the
21 Pension and Health Benefits Committee.
22 CHAIRPERSON MATHUR: Good morning.
23 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
24 DONNESON: In the 2013 to 15 business plan, CalPERS staff
25 undertook efforts to standardize our health plan's

1 approach to population health management across the
2 continuum of care for active and retired members.
3 A Population Health Management Committee was
4 formed by Dr. Richard Sun, which included staff from the
5 Health Plan Administration Division, the Center for
6 Innovation and the Health Policy and Research Division.
7 To my left is Dr. Richard Sun, CalPERS medical
8 consultant, who will present the first part of the agenda
9 item. Dr. Sun earned his medical degree with a
10 specialization in preventive medicine and holds a Master's
11 degree in public health.
12 He worked in what is now the California
13 Department of Public Health for 12 years and thus has a
14 special interest in population health.
15 Richard.
16 DR. SUN: Good morning.
17 CHAIRPERSON MATHUR: Good morning.
18 DR. SUN: The times have changed. In the past,
19 there was an emphasis on individual aspects of health
20 care, such as disease management and wellness case
21 management. Now, there's an increasing emphasis on
22 population health management. And the purpose of this
23 agenda item is to discuss CalPERS efforts in this area
24 between 2013 and the present.
25 As Kathy mentioned, we formed a committee to

1 examine population health management. And one of the
2 first jobs of the Committee was to define the term. On
3 page two, staff define population health as quote, "The
4 health outcomes of CalPERS members", unquote. There are
5 various other definitions of population health in the
6 literature. Most of them deal with geographically
7 circumscribed communities. However, our members are
8 distributed throughout the world, so we felt that this
9 particular definition would be the best for our purposes.
10 A graphical representation of the population
11 health model can be found in the attachment in figure 1.
12 Our population health model focuses on CalPERS member
13 health outcomes and we'll be discussing these outcomes
14 later on in the discussion of the dashboard.
15 We surround this core with a ring of informatics
16 or health information, because in order to measure health
17 outcomes, there must be some method of doing so in a
18 quantitative manner.
19 To affect member health outcomes, we have three
20 quadrants out of the four possible. The first quadrant on
21 the left side is what would be call primary prevention,
22 maintaining wellness and preventing disease. Then
23 detecting disease, if present is conceptualized as
24 secondary prevention, and treat detected diseases on the
25 right side is tertiary prevention.

1 With this in mind, there are aspects of health
2 that our health plans in CalPERS we find it very difficult
3 to influence, for example, genetics or environment.
4 I'd now like to turn it back to Kathy for a
5 discussion of the integrated health model.
6 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
7 DONNESON: That was concise -- that was brief and concise
8 just like the model.
9 It's difficult to generate a model of population
10 health, because it can be conceptualized in so many
11 different ways. So when I -- when they called me in to
12 see the work of the Committee, it was -- in figure 1, it
13 took me a bit by surprise, because I thought we would have
14 a lot more detail than what was presented. But I do want
15 to point out that, as Richard said, there are determinants
16 of health that we can't control, and we've identified
17 those in the agenda item. But there are determinants of
18 health that can be controlled through primary, secondary,
19 and tertiary prevention.
20 We looked at what would be an approach how to
21 conceptualize this in ways that our plans would understand
22 in order to actually come to consensus on a direction that
23 we could all agree on. So in the first year of our work,
24 it was really looking at conceptualizing how we view
25 population health on things that can be controlled through

1 the plans and ultimately through the providers, and things
2 we can't control.
3 So in figure 2, we said, okay, we need a delivery
4 system that works with our plans to deliver population
5 health. And so again, we tried to keep it simple in order
6 to say this is how we envision population health. This is
7 the structure through which we want to work with our plans
8 and work with our providers to deliver population health,
9 and we use the integrated health model as the pictorial
10 description of our approach.
11 So if you look at the center of figure 2, you'll
12 see CalPERS members are still at the center. We have
13 encircled that core with prevention, primary care, and inn
14 informatic structure that allows providers across the
15 continuum to understand the health of their particular
16 population.
17 But then we said, okay, we need to expand out.
18 If we're maintaining optimal health through health and
19 wellness, as disease gets detected through screening, and
20 as it gets treated after it is discovered, then what is
21 the delivery system doing in order to at least keep that
22 member in a healthy state, whether they're pre-chronic,
23 whether they're chronic, or whether they have a disease
24 that is not going to be reversed?
25 So you see that blue ring, which looks at the

1 pre-chronic, chronic care, and we've included behavioral
2 health and pharmacy. And so as you cross the continuum,
3 sort of in a 3-D perspective, we have patient management
4 now, once disease is detected. And we have sites of care
5 through which to deliver at least optimal health when a
6 disease state is present.
7 And finally, the outer ring is specialty care.
8 And as we move out to, what I call, the satellites, these
9 are the foundations that we discussed when we issued our
10 RFPs in 2013 of what is the structure of an integrated
11 health model. And it includes hospital and medical group
12 collaboration. It includes patient care management teams
13 that are interdisciplinary across the continuum of care.
14 And then it also includes a consolidated approach to
15 delivering care based on evidence. So this is basically
16 the structure of our model that we got to in the first
17 year.
18 So what we did was we sent this out to our plans
19 with a working paper, and said this is how we view
20 population health. Would you please critique it? Would
21 you discuss with your -- internally with your plans and
22 with your delivery system providers and give us feedback
23 on this model?
24 And they had also looked at their own models,
25 because each plan had a population health model. And in

1 some instances, they sat down with their physicians both
2 within the delivery system and within the plan under the
3 medical directors of those plans, and they came up with a
4 critique not only of our model, but also looked at
5 refashioning their models to be consistent with what they
6 believed were key components that they wanted us to
7 retain.
8 So in the second year, we got their feedback in
9 terms of our model, as they agreed that we were on
10 the -- in the right direction, our approach was sound,
11 and -- so this is where we are with the model.
12 But we didn't stop there. We said, okay, now --
13 now that we have a population health model that we agree
14 on, now that we have an integrated health model as a
15 delivery system that we agree on, can we develop a
16 dashboard that we can then start to measure -- set a
17 baseline and measure population health.
18 And so the third part of this agenda item, as an
19 attachment, is the dashboard that collectively CalPERS and
20 its health plans have designed.
21 And now I'm going to turn it back to Richard so
22 he can walk you through it.
23 DR. SUN: This is contained in the table in
24 attachment 1. As you can see, the proposed data elements
25 include summary demographics, major chronic conditions,

1 lifestyle risks, clinical quality measures and other
2 measures. We are continuing to work on this dashboard in
3 terms of the availability of data and how exactly this
4 should be displayed and presented for public consumption
5 and internal consumption.
6 In conclusion, although population health
7 management is no longer on the business plan, we'll
8 continue to track and monitor population health, and
9 integrated health activities. Meanwhile, population
10 health continues to evolve and staff will assure that
11 CalPERS follows best practices in this area.
12 Thank you.
13 CHAIRPERSON MATHUR: Thank you.
14 So I have a question or maybe it's a comment. As
15 you noted at the outset, we have quite a disaggregated
16 population. We have pockets of concentrations, but it's
17 spread all across the state, some across the country, and
18 some, as you noted, around the world.
19 And this seems to be an approach that works best
20 in sort of concentrated areas, where you can actually
21 integrate the different providers of care, and you can
22 have robust IT systems, and data management, and -- et
23 cetera. How would -- how do you anticipate -- how do you
24 see this as working in more rural areas where it might be
25 less -- might be more disaggregated.

1 DR. SUN: It will be difficult. Nevertheless, we
2 need to strive to improve health outcomes no matter where
3 our members are. And rural areas are becoming more
4 electronically health connected in terms of medical
5 records, and that will help the situation because of that
6 ring that surrounds the member health outcomes.
7 DEPUTY EXECUTIVE OFFICER McKEEVER: Madam Chair,
8 I'd also note that we've had experience in the rural areas
9 with our partner in Anthem Blue Cross specifically our
10 Priority Care Project up in Humboldt County, which would
11 directly tie to your comments relative to the
12 infrastructure that's not currently built there. And
13 although you can't maybe get to the model that's been
14 presented here this morning, many of the components of the
15 model, specifically as it relates to the concentric
16 utilization of care to a member, has proven to be useful
17 and valuable up in the Humboldt region.
18 So I think there are components of this model
19 that you can pick up and put in the rural areas, but
20 potentially not, to Richard's point, get to every single
21 component, because they just don't have currently the
22 infrastructure or the sophistication.
23 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
24 DONNESON: I have a couple of more points to build off of
25 Doug's. The Anthem PPO, which is called Enhanced Personal

1 Care, is the population health model, and it is designed
2 for the rural areas, in that perhaps you don't have this
3 integrated formal IHM structure, but there is a structure
4 associated with attributing patients to a particular
5 provider and having the provider, as we did with the
6 priority care, have that provider working with these
7 integrated teams managing a population. But certainly the
8 components we wanted to identify such that, like Anthem in
9 the rural areas through Enhanced Personal Care, they have
10 physician mentor coaches that are working with physicians
11 in particular areas. And we'll continue to work with
12 Anthem and they'll continue to work in ensuring that
13 population health is delivered, even if it's not within
14 this integrated health model structure as it's presented,
15 but something similar.
16 CHAIRPERSON MATHUR: Okay. Thank you.
17 Mr. Boyken.
18 ACTING COMMITTEE MEMBER BOYKEN: Thank you. I
19 appreciate the report and look forward to hearing updates.
20 I find it very compelling, whenever you report to us, the
21 data on how a small proportion of our members make up for
22 a very large proportion of our health spend. And to me,
23 it seems like the population health management is really
24 an effort to cast a narrow net to go after the -- you
25 know, kind of the chronic, the sickest. And so, you know,

1 however you go about that, you know, I support the
2 evidence and I look forward to hearing more updates on
3 that. So thanks.
4 CHAIRPERSON MATHUR: Thank you.
5 Ms. Hagen.
6 ACTING COMMITTEE MEMBER HAGEN: Thank you. I
7 think I know the answer to his, but I just wanted to
8 verify where you have on the table in attachment 1,
9 summary demographics, the members -- I assume that we can
10 pull from that who the employer is and whether they're
11 active or retired?
12 DR. SUN: Yes, we have information on that.
13 ACTING COMMITTEE MEMBER HAGEN: Okay. Thank you.
14 CHAIRPERSON MATHUR: Thank you.
15 DEPUTY EXECUTIVE OFFICER McKEEVER: Madam Chair,
16 if I may?
17 CHAIRPERSON MATHUR: Please.
18 DEPUTY EXECUTIVE OFFICER McKEEVER: I just want
19 to add one more point that I think is value-add for
20 CalPERS to be recognized as a leader in this area, and
21 just only mention to you that recently Covered California
22 has adopted the model contract language that we put into
23 place relative to our integrated health care models. And
24 so it's just a reflection of the good work that Kathy and
25 Dr. Sun and staff have done over the years. And now it's

1 being replicated in other environments in which they have
2 recognized that this is so important that they want to put
3 it into their contracts as well.
4 CHAIRPERSON MATHUR: Well, thank you for noting
5 that. That is an important sort of affirmation of the
6 work that our staff is so ably doing. And it's -- you
7 know, it's challenging for us to do this on our. So the
8 more other significant purchasers also are pushing for the
9 same kinds of structure and outcomes, I think the better
10 for all of us and all of our members.
11 All right. Well, thank you for this item, we'll
12 move on now to agenda item number 9, Prescription Drugs
13 Utilization and Cost Trends.
14 (Thereupon an overhead presentation was
15 presented as follows.)
16 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
17 DONNESON: Madam Chair, members of the Pension and Health
18 Committee, Dr. Richard Sun will be making this
19 presentation on behalf of Dr. Melissa Mantong, our CalPERS
20 pharmacist, as she is on leave at this time.
21 Richard.
22 --o0o--
23 DR. SUN: Good morning. I'll be discussing today
24 the trends in prescriptions and costs, the 2014 costs by
25 prescription drug type, and specialty drug trends

1 --o0o--
2 DR. SUN: First some important caveats about the
3 data. The source of these data is the CalPERS Health Care
4 Decision Support System. There is a new data warehouse, a
5 new vendor in 2014. The current and previous vendors used
6 different methodologies concerning the data, and there
7 might be variations in the data presented today compared
8 with past presentations.
9 The data include both basic and Medicare plans,
10 and include members in all plans, including the
11 association plansThere is Employer Group Waiver Plan data
12 included starting in 2013.
13 --o0o--
14 DR. SUN: The first slide is the overall
15 prescription drug costs. As you can see, there's been a
16 gradual increase to $1.86 billion in 2014.
17 --o0o--
18 DR. SUN: The increases occurred in every year,
19 except for 2012. Most recently, there has been a 7.5
20 percent increase year over year. The number of
21 prescriptions has risen, as given in the blue bars, and
22 the allowed amount per prescription has also increased.
23 This slide gives the components of change.
24 --o0o--
25 DR. SUN: In the most recent year that allows per

1 prescription increased 8 percent.
2 --o0o--
3 DR. SUN: The next two slides deal with number of
4 days supplied, which is in the blue bars, and the allowed
5 amount per day supply, which is the red line.
6 --o0o--
7 DR. SUN: And again, this slide shows the
8 components of increase over time. The allowed amount per
9 day supply increased over 5 percent in 2014. The number
10 of days supplied increased 1.6 percent.
11 --o0o--
12 DR. SUN: We'll next look at costs by
13 prescription drug type. This is generic, non-specialty
14 brand, divides multi-source and single source, specialty
15 drugs and total.
16 In total, the number of prescriptions was 19
17 million in 2014. The member cost share was -- per
18 prescription was about $10 dollars, or 10 percent. As
19 noted in the agenda item itself, this compares with the
20 cost share nationwide of about 22 percent. The cost share
21 for specialty drugs for our members was 0.9 percent.
22 Nationwide the cost share was approximately 11 percent.
23 --o0o--
24 DR. SUN: On slide number 11 are the top 10
25 non-specialty drugs used for various conditions, such as

1 ulcers, mental conditions, asthma, and so forth.
2 --o0o--
3 DR. SUN: We'll next move to a discussion of
4 specialty drugs. The number of specialty drug
5 prescriptions has increased over time. I will note there
6 is no standard definition of specialty drugs. We've used
7 in this slide and the next slide the definition used by
8 CVS Caremark.
9 The percentage of all prescriptions that are
10 specialty drugs has increased, and the allowed amount has
11 increased to 438 million.
12 --o0o--
13 DR. SUN: The top 10 specialty drugs include
14 those for rheumatoid arthritis, multiple sclerosis, and
15 cancer as has been the case in previous years. However,
16 in 2014, chronic hepatitis C drugs came into our list of
17 top 10 specialty drugs, such as Sovaldi, Harvoni and
18 Olysio.
19 --o0o--
20 DR. SUN: In conclusion, prescription drugs costs
21 continue to increase, especially specialty drug costs, and
22 staff will continue to take -- make efforts to control our
23 drug costs.
24 Thank you.
25 CHAIRPERSON MATHUR: Thank you. I see no -- I do

1 see a request from the Committee.
2 Mr. Jelincic.
3 COMMITTEE MEMBER JELINCIC: I just want to say
4 that these numbers blow me away. When you look 19 million
5 prescriptions, when you look at 937 million days, it's
6 just mind-boggling, but thank you for the report.
7 CHAIRPERSON MATHUR: Mr. Jones.
8 COMMITTEE MEMBER JONES: Yeah. Thank you, Madam
9 Chair. I was wondering whether or not the implications of
10 Medicare is reflected in this data?
11 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
12 DONNESON: Yes. If you'll recall, Mr. Jones, in 2013, we
13 adopted the Employer Group Waiver Plans, so you see some
14 dips in 2013 in terms of the spend. And that does reflect
15 the subsidies that we receive for the Centers for Medicaid
16 and Medicare Services for the Medicare members under the
17 Employer Group Waiver Plan program.
18 COMMITTEE MEMBER JONES: Thank you.
19 CHAIRPERSON MATHUR: Thank you.
20 Mr. Slaton.
21 BOARD MEMBER SLATON: Thank you, Madam Chair.
22 The one thing I don't see here, and I don't know
23 if there's a way to get there, and maybe you can enlighten
24 me, but the 19 million prescriptions, and all of this data
25 and the increasing cost of prescriptions only looks at one

1 side of medical care. It doesn't look at what the impact
2 is of these various drugs on reducing or moderating
3 medical costs. So is there anything we can do to be able
4 to put this in perspective, so that we see it in the total
5 and not just isolated as prescriptions?
6 DR. SUN: You are correct. This looks only at
7 the drug side of our spend. And it is true that use of
8 these drugs should decrease spending in hospitalizations
9 or professional services. That is a difficult thing to
10 measure though for us, because the use of drugs today may
11 prevent services in the distant future.
12 There has been an argument used for the value of
13 drugs. For example, the manufacturers of hepatitis C
14 drugs will say that their drugs reduce costs in the
15 future, and therefore their drugs should be expensive
16 today. That is still to be debated.
17 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
18 DONNESON: I did want to add to your question. Drug
19 spending, in terms of total spending, is about, if you
20 look at the whole pie that includes inpatient hospital,
21 outpatient hospital, professional ancillary, it the runs
22 in the pie about 15 percent, but it does not -- it only
23 measures the pharmaceutical component. It does not
24 measure the medical component that is being paid through
25 either -- through those sites of care.

1 We have been working with our PBM and with our
2 PPOs -- PPO to try to look at evidence based medicine on
3 the medical side, not just the pharmacy side to look at
4 sites of care. It's more expensive to infuse a member, if
5 an infusion is needed, in an outpatient hospital than it
6 is an infusion center or even at home. Home infusion is
7 now technically a possibility.
8 So we've spent about the last year and a half
9 trying to work with -- collectively with the PBM and the
10 PPO to design some value based programs that would look at
11 sites of care that might even be more convenient for the
12 member and less costly. We are continuing to look at
13 that, and that is a -- that is one of the components
14 through the procurement that we are particularly
15 interested in fleshing out for the next contract.
16 CHAIRPERSON MATHUR: Thank you. I do think that
17 is important. And I was actually going to have the exact
18 same question as Mr. Slaton around sort of the medical
19 implications of our -- of prescription drug use. It does
20 sometimes replace or eliminate the need for other more
21 intrusive interventions. Not necessarily cost saving, but
22 could potentially be.
23 So to the extent that we continue to think about
24 how we would -- might measure that. And there must be
25 studies -- and I don't know how expensive such an

1 undertaking would be, but I think it would be worthwhile
2 as the sort of the wedges on the pie shift to really
3 understand whether we're losing or gaining as those shifts
4 occur, because certainly we've always been saying that if
5 we can reduce in-hospital -- you know, inpatient care,
6 then we're going to save money. But if we're replacing
7 that with very expensive specialty drugs, perhaps that's
8 not -- that's not actually the case.
9 So if we can get -- you know, for the long term,
10 if can get a better handle on that, I think we would --
11 that would be helpful.
12 All right. We do have a few more questions from
13 the Committee. Mr. Jelincic.
14 COMMITTEE MEMBER JELINCIC: Kathy, you said that
15 prescription drugs are roughly 15 percent of the pie. Has
16 that been consistent?
17 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
18 DONNESON: Yes, that has been consistent. And to Ms.
19 Mathur's point, as we have really pushed collectively, not
20 just as this Board in running our health programs, but as
21 a society really working on the medical side to get those
22 double digit cost increase trends that we saw back in the
23 early part of this century down to what is around now CPI
24 plus 3 percent. I mean, we have collectively worked
25 together to get to that point. And now we've seen the

1 balloon on the pharmacy side really pushing us back in the
2 direction of double digits.
3 If you'll recall, the Finance and Administration
4 Committee the efficiency report last month, we pulled $63
5 million out of the pharmacy trend that's built into the
6 2016 premiums. Now, that's approximately 4 percent of
7 trend that we pulled out and it's based on the good works
8 that you did in terms of trying to manage, you know, the
9 pharmacy program here for CalPERS.
10 But again, we're under pressure, as we go into
11 the 2017 rates, to continue to look at what is the unit
12 cost trend, what is the utilization trend, and how can we
13 keep our pharmacy trend from kind of blowing through the
14 roof of our total trend as we look at 2017 premiums.
15 COMMITTEE MEMBER JELINCIC: But if the pharmacy
16 stays at 15 percent of the total spend, would that not
17 tend to undercut the argument that we are replacing other
18 costs by drug costs? I mean, otherwise, it would seem
19 that drugs is a percent of the total pie would expand if
20 there's a substitution effect going on?
21 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
22 DONNESON: That is now outside of the realm of what I've
23 looked at, but we can certainly take that back and think
24 about it. I am interested in looking at what is happening
25 for, what we call, the medical pharmacy, in terms of how

1 that may be driving the medical side of spend.
2 COMMITTEE MEMBER JELINCIC: Thank you.
3 CHAIRPERSON MATHUR: Okay. Thank you.
4 Ms. Taylor.
5 COMMITTEE MEMBER TAYLOR: I agree with Ms. Mathur
6 and Mr. Slaton about looking at the medical side and
7 seeing if -- you know, what the benefit was for using the
8 prescriptions instead, which on a commentary side doesn't
9 negate the fact that our prescription drug issue is a huge
10 issue.
11 And I appreciate the fact that you guys are
12 working really hard at figuring out a way to contain that.
13 And I assume that's also with -- you had mentioned about
14 bringing down hospital costs using other contacts or
15 whomever. And I'm assuming that's what you're doing now,
16 whether it's through legislation or other groups that
17 you're working with to bring those costs down.
18 I read about it all the time. It impacts our
19 members to such a great degree when we see these
20 increases. And then it's hard to explain that it's, you
21 know, pharmaceutical costs when it used to be medical
22 costs. And it's just difficult when our members -- it
23 impacts them so directly. So I do appreciate the work.
24 Thank you.
25 CHAIRPERSON MATHUR: Thank you, Ms. Taylor.

1 I see no further requests from the Committee, but
2 we do have one member of the public who wishes to address
3 the Committee. Ms. Mai Huong Tran, if you could please
4 come forward. We've got seats over here. We'll turn the
5 mic on for you. Please identify yourself and your
6 affiliation for the record, and you'll have three minutes
7 to speak.
8 MS. TRAN: Thank you.
9 CHAIRPERSON MATHUR: I'm sorry. We're just --
10 your mic will be turned -- now, it's on. Go ahead
11 MS. TRAN: Hello.
12 CHAIRPERSON MATHUR: Yes.
13 MS. TRAN: Thank you. My name is Mai Tran. And
14 I am a pharmacy manager at Harbor Compounding Pharmacy in
15 Orange County, California. I would like to voice my
16 concerns regarding the coverage of compounded bioidentical
17 hormones for our CalPERS patients.
18 Previously, CalPERS had allowed for coverage of
19 compounded hormones for their beneficiaries. However,
20 starting in 2015, CalPERS, and its contracted PBM, CVS
21 Caremark, had denied coverage of all compounded hormones.
22 This had left all of our CalPERS patients without a health
23 benefit that has such a positive impact on their health
24 and wellness.
25 Sorry.

1 This had impacted 100 to 200 CalPERS patients at
2 our singular pharmacy in Orange County. I can only
3 imagine the thousands of patients that this had negatively
4 impacted across the State of California. Most of our
5 patients who are on these compounded hormones need them to
6 improve their quality of life and to function in their
7 work and their relationships amongst their family and
8 friends.
9 The added benefit of having these compounded
10 hormones is that they prevent the typical chronic diseases
11 associated with age, such as high blood pressure, high
12 cholesterol, obesity, diabetes, depression, dementia, et
13 cetera.
14 As presented earlier, out of the top 10
15 non-specialty drugs utilized amongst CalPERS patients, I
16 can name five of them that could be eliminated if patients
17 were on compounded hormones, Crestor, atorvastatin,
18 duloxetine, Januvia, and Lantus.
19 Most patients would be on three out of five of
20 these drugs conjunctively, which would cost a minimum of
21 $550 per patient per month to CalPERS. Compounded
22 hormones cost, at maximum, only $250 per patient per
23 month, thus could promote a savings of $3,600 per patient
24 per year for CalPERS, if compounded hormones were covered.
25 Also, the number one cause of hospitalization in

1 men and women over 40 is due to heart disease. Compounded
2 hormones can also prevent acute disease states that
3 require hospitalization, such as heart attacks, strokes,
4 DVTs, et cetera. If you could prevent a patient from
5 having only one hospital stay per year by covering for
6 their compounded hormones, CalPERS can possibly save
7 another $10,000 per patient per year, the discussion that
8 you're currently having.
9 Overall, I would appreciate a discussion with
10 CalPERS, if possible, regarding an opportunity for change
11 where CalPERS would allow for coverage of compounded
12 medications by mandating it through the contracted PBM,
13 which is currently CVS Caremark, or whoever the new PBM
14 will be in 2017.
15 Some of our CalPERS patients have had to pay
16 fully out of pocket for their compounded hormones, and
17 others can't afford to do so and had to discontinue
18 therapy. And this distressed them greatly.
19 Thus, our patients would also appreciate someone
20 at CalPERS whom they can communicate the importance of
21 coverage for compounded hormones in their prescription
22 benefit. Thank you.
23 CHAIRPERSON MATHUR: Thank you very much for
24 sharing this with us.
25 Okay. We will move on to Agenda Item number 10,

1 which is Process for Health Carriers Interested in Joining
2 CalPERS.
3 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
4 DONNESON: Madam Chair, members of the Pension and Health
5 Committee, agenda Item 10 outlines a process by which the
6 Committee may wish to add additional health plans prior to
7 the expiration of our current health plan contracts in
8 December -- on December 31st, 2019.
9 In 2012 and 2013, CalPERS issued Request for
10 Proposal 2012-6334 to receive competitive bids from health
11 plans wishing to provide Health Maintenance Organization,
12 or HMO, services.
13 In April 2013, CalPERS awarded flex-funded HMO
14 contracts for the 2014 to 2018 contract year. Those
15 contracts were awarded to Anthem, Blue Shield, Health Net,
16 Sharp Health Plan, and UnitedHealth, which increased
17 competition among our health plans and provided more
18 choices to CalPERS members.
19 This agenda item outlines an approach equal in
20 rigor to a competitive process that brought into CalPERS
21 our additional HMO plans, should the Board wish to
22 exercise its discretion to add plans under Government Code
23 section 22850(a). I wish to be clear that the process
24 outlined in this agenda item applies the same rigor used
25 in the 2012 to '13 RFP meaning that the solicitation and

1 evaluation criteria would remain the same.
2 As this agenda item suggests, there might be a
3 compelling reason why the Board might want to think about
4 adding additional plans, such as new network coverage,
5 expanded access to HMOs and geographies where one is not
6 available, expansion of dual risk contracts and so forth.
7 If staff were to carry out such an evaluation
8 process at the request of the Board on behalf of its
9 non-contracted plan, or plans, we would need ample time to
10 solicit a competitive bid, evaluate the plan, provide the
11 evaluation to the Board and negotiate a contract
12 equivalent to those current in force to the conclusion of
13 any annual rate-setting process.
14 Based on our outlined approach in this agenda and
15 the timing of such request, health plans interested in
16 joining CalPERS, and after going through an extensive
17 review, would be brought forward as part of the annual
18 rate-setting process.
19 The decision point for adding -- for the Board
20 adding any additional HMOs would not be earlier than June
21 2017 or June 2018 depending on the timing of the request.
22 This concludes my agenda item, and I'm happy to
23 answer any questions.
24 CHAIRPERSON MATHUR: Thank you. Are there any
25 questions from the Committee?

1 Mr. Jelincic.
2 COMMITTEE MEMBER JELINCIC: Yeah. Just an
3 observation that if someone wants to bring something
4 forward that would benefit our members, we ought to at
5 least take a look at it. Since we do have a regular
6 process, I don't -- you know, I think we ought to set
7 somewhat higher standard to enter mid-year, so that it's
8 really an opportunity to our members. But I think we
9 certainly should not just flat out set you missed the time
10 frame.
11 DEPUTY EXECUTIVE OFFICER McKEEVER: Mr. Jelincic,
12 if I can just add a little clarification to that comment
13 relative to mid-year. We're not requesting in this
14 process that we would bring a health carrier in mid-year.
15 It would be --
16 CHAIRPERSON MATHUR: Mid-contract.
17 DEPUTY EXECUTIVE OFFICER McKEEVER: It would be
18 mid-contract for the upcoming plan year.
19 COMMITTEE MEMBER JELINCIC: I misspoke. I
20 understand you're on a calendar year.
21 CHAIRPERSON MATHUR: Thank you.
22 Mr. Lofaso.
23 ACTING COMMITTEE MEMBER LOFASO: Thank you, Madam
24 Chair. You said one thing, Ms. Donnelly -- Donneson.
25 Donneson. Sorry. You said in this mid-cycle process you

1 used the phrase competitive bid. And it wasn't clear to
2 me if we were talking about some potential entrant who
3 added certain value for reasons you've articulated being
4 evaluated on some standard according to that value they
5 brought, or if say rural area X has a low penetration rate
6 in terms of the health care plan offerings, and plan X
7 wants to enter that rural area that there would be a --
8 then a -- some kind of competitive solicitation where
9 anyone else who wanted to enter into that area to meet
10 that need would also get to have an opportunity?
11 When you said competitive solicitation in that
12 discreet context, I wasn't sure what you meant by
13 competitive solicitation.
14 DEPUTY EXECUTIVE OFFICER McKEEVER: Mr. Lofaso,
15 I'll clarify that. It would not include a competitive
16 bid. It would be that the plan, as Ms. Donneson
17 articulated, would have to go through the same rigor as
18 our current health plans did back in the 2013 RFP process,
19 meaning they would answer the questions that you just
20 posed relative to their value-add to CalPERS. CalPERS
21 staff then would make an assessment as to whether or not
22 that value-add made enough sense to bring it to you for
23 consideration relative to whether or not then you wanted
24 to bring them into the program in the upcoming plan year.
25 So it would not be a competitive bid per se. The

1 structure and the criteria that we would require of them
2 to provide us with the data would be similar to the
3 competitive bid process that we undertook black in
4 2012-13.
5 ACTING COMMITTEE MEMBER LOFASO: Thank you.
6 CHAIRPERSON MATHUR: Thank you.
7 Mr. Slaton.
8 BOARD MEMBER SLATON: Thank you, Madam Chair.
9 So describe to me the difference between another
10 provider saying I now can provide service to CalPERS
11 members, and so I would like to come in, AND so we would
12 have a mid-contract addition versus an existing carrier
13 who says, you know, I now have a different offering than
14 what was available on the original bid time. So would
15 they be able to do the same -- take advantage of the same
16 thing?
17 DEPUTY EXECUTIVE OFFICER McKEEVER: So our
18 current vendors, our current health carriers, by virtue of
19 them being in a five-year contract with CalPERS, during
20 every rate negotiation process, we ask specific questions
21 relative to whether or not they want to provide either
22 replacement plans and/or additional plans, and they have
23 that opportunity now.
24 BOARD MEMBER SLATON: Gotcha. Okay. Thank you.
25 CHAIRPERSON MATHUR: But they still need to

1 conform with the initial RFP criteria, et cetera.
2 DEPUTY EXECUTIVE OFFICER McKEEVER: Yes. They
3 have to articulate the value of that proposal.
4 CHAIRPERSON MATHUR: Okay. So I see no further
5 requests to speak. I think on -- this is -- this is an
6 area where you're looking for direction. And I think the
7 Committee is comfortable with this approach that you've
8 outlined. I see no objections to that, so that will be
9 the direction.
10 DEPUTY EXECUTIVE OFFICER McKEEVER: Great. Thank
11 you.
12 CHAIRPERSON MATHUR: Thank you.
13 So we'll move on to Agenda Item number 11, which
14 is a summary of committee direction.
15 DEPUTY EXECUTIVE OFFICER McKEEVER: Madam Chair,
16 I have four. Although, I believe the one was already an
17 action item for Agenda Item 5. So that item obviously was
18 approved, minus the association plan item.
19 The other three I had were for strategic
20 measures, customer service measures, they validated for
21 number 11 to remain at the current threshold of 85
22 percent. On the legislative measures is continue as is.
23 And then just as directed by the Chair, we'll move forward
24 with a process by which if a carrier requests entry, we
25 will have that process now in place to accommodate that

1 request.

2 CHAIRPERSON MATHUR: Thank you.

3 Okay. We've come to Agenda Item number 12, which
4 is public comment. Chris Little, if you would make your
5 way down, sit in front of one of these two microphones
6 that will be turned on for you. If you could identify
7 yourself and your affiliation for the record. And you
8 will have three minutes in which to speak.

9 MR. LITTLE: Good morning, Madam Chair, members
10 of the Committee. My name is Chris Little. I am here
11 again from the Butte County Human Resources Department.
12 And I thank you for the opportunity to be here today.
13 First and foremost, I would like to thank you and Mr.
14 McKeever prospectively for him coming up next month and
15 meeting with us and our employee groups to answer some
16 questions that we have. We're looking forward to his
17 feedback with regards to plan design options, to providing
18 some clarity to the regionalization process, and also some
19 other topics that we've talked about off-line.

20 We are continuing to request increased
21 flexibility with plan design options. Our employees have
22 begun paying for the January premiums. We pay a month in
23 advance, as I'm sure you're well aware. And the PERS
24 Select plan is becoming an unrealistic low dollar cost
25 option for our folks. So we're requesting some other

1 option for them in that regard.
2 We are also continuing to request additional
3 information with regards to the regionalization
4 methodology that PERS has utilized. We continue to feel
5 that Butte County is not a best fit in the NorCal group.
6 At the last meeting, we had discussed that competition and
7 utilization are factors that drive the premium rates that
8 we are experiencing. And we've looked at some of the data
9 from the other counties that are in the NorCal group. And
10 it seems to bear out that we may not be a best fit for
11 that group.
12 Just for example, the median number of hospitals
13 per county in the NorCal group is 1. And Butte County has
14 four hospitals, we feel like we have an increased access
15 to care in our county that other counties NorCal group may
16 not have. And also the median number of employees per
17 county in the entire NorCal group is about 665. And Butte
18 county has roughly 680 percent more employees. So it
19 feels almost as if we're comparing apples and oranges when
20 we are looking at our county and other counties that are
21 in the area.
22 We are -- let me back track here. We also found
23 out at the CalPERS conference that BART was given access
24 to utilization data as part of a wellness initiative. In
25 Butte County, we have requested that same utilization

1 data. We're very interested as that is one of the drivers
2 in premiums in getting that data. And to this point, we
3 have been rebuffed and would like to know how that BART
4 overcame those objections under the Government Code and
5 Evidence Code cited by CalPERS to obtain that same data
6 that we are requesting.
7 That concludes my comments for today. Thank you
8 very much for having me, and we look forward to Mr.
9 McKeever visiting us next month.
10 Thank you.
11 CHAIRPERSON MATHUR: Thank you. I'm sure he is
12 too.
13 Okay. I see no other requests for public
14 comment. Is there anyone from the public who wishes to
15 speak at this time?
16 Seeing none, that adjourns the Pension and Health
17 Benefits Committee.
18 Finance Committee will begin at 10:15.
19 DEPUTY EXECUTIVE OFFICER McKEEVER: Madam Chair,
20 I'm sorry. 4e. There was a request to bring up 4e.
21 CHAIRPERSON MATHUR: I'm so sorry. Forgive me.
22 Thank you for -- thank you for reminding me.
23 4e. Mr. Jelincic, did you want to -- could you
24 touch your --
25 COMMITTEE MEMBER JELINCIC: Yeah.

1 CHAIRPERSON MATHUR: If you could -- I'll
2 request. Yep, there we go. Mr. Jelincic.
3 COMMITTEE MEMBER JELINCIC: I got over-anxious
4 and closed my things, so I've got to open it up again. So
5 if you'll --
6 CHAIRPERSON MATHUR: Thanks for the reminder, Mr.
7 McKeever.
8 COMMITTEE MEMBER JELINCIC: I've got to reopen my
9 iPad.
10 CHAIRPERSON MATHUR: So 4e was on the Long-Term
11 Care Program Awareness Marketing Campaign Cost Evaluation.
12 COMMITTEE MEMBER JELINCIC: Right. And the --
13 one of the questions I had -- and if I could find it
14 now -- was it obviously was a very cost effective program.
15 But when you look at it compared to other program or other
16 advertising campaigns the different components, all of the
17 components were higher than our average exposure. And I'm
18 just wondering what was so different about us?
19 DEPUTY EXECUTIVE OFFICER PACHECO: Mr. Jelincic,
20 Brad Pacheco, CalPERS staff. Really what it boils down to
21 is the vendor that we used does quite a bit of advertising
22 for its clients, and we were just able to secure much
23 cheaper rates in comparison to some of the single rates
24 that you see listed there.
25 COMMITTEE MEMBER JELINCIC: So it is basically

1 driven by volume discount.
2 DEPUTY EXECUTIVE OFFICER PACHECO: Correct. And
3 that's why we used the vendor that we did, because we
4 don't have that skill set on staff. Plus, we don't do the
5 advertising that they would do for other clients.
6 COMMITTEE MEMBER JELINCIC: Okay. Thank you.
7 CHAIRPERSON MATHUR: Thank you. All right.
8 Now, we are adjourned.
9 (Thereupon the California Public Employees'
10 Retirement System, Board of Administration,
11 Pension & Health Benefits Committee open
12 session meeting adjourned at 9:59 a.m.)
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C E R T I F I C A T E   O F   R E P O R T E R

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

That I am a disinterested person herein; that the foregoing California Public Employees' Retirement System, Board of Administration, Pension & Health Benefits Committee open session meeting was reported in shorthand by me, James F. Peters, a Certified Shorthand Reporter of the State of California;

That the said proceedings was taken before me, in shorthand writing, and was thereafter transcribed, under my direction, by computer-assisted transcription.

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

IN WITNESS WHEREOF, I have hereunto set my hand this 19th day of December, 2015.

JAMES F. PETERS, CSR
Certified Shorthand Reporter
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