MEETING

STATE OF CALIFORNIA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

BOARD OF ADMINISTRATION

PENSION & HEALTH BENEFITS COMMITTEE

OPEN SESSION

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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. Steve Juarez

Mr. Rob Feckner

Mr. Richard Gillihan

Ms. Dana Hollinger

Mr. Henry Jones

Ms. Theresa Taylor

Ms. Betty Yee, represented by Mr. Alan Lofaso

BOARD MEMBERS:

Mr. Richard Costigan

Mr. J.J. Jelincic

Mr. Ron Lind

STAFF:

Ms. Marcie Frost, Chief Executive Officer

Mr. Matt Jacobs, General Counsel

Ms. Liana Baily-Crimmins, Interim Deputy Executive Officer

Ms. Donna Lum, Deputy Executive Officer

Ms. Mary Anne Ashley, Chief, Legislative Affairs Division

Dr. Kathy Donneson, Chief, Health Plan Administration Division

Ms. Flora Hu, Senior Life Actuary

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

STAFF:

Ms. Anita Jones, Committee Secretary

Ms. Renee Ostrander, Chief, Employer Account Management Division

Ms. Gretchen Zeagler, Assistant Chief, Legislative Affairs Division

ALSO PRESENT:

Mr. James Anderson, Retired Public Employees Association

Mr. Tim Behrens, California State Retirees

Mr. Al Darby, Retired Public Employees Association

Ms. Yvette Fontenot, Avenue Solutions
(via teleconference)

Mr. Jerry Fountain, California State Retirees

Mr. Chris Jennings, Jennings Policy Strategies
(via teleconference)

Mr. Tom Lussier, The Lussier Group
(via teleconference)

Dr. Tobias Moeller-Bertram, Desert Clinic Pain & Wellness Group

Mr. James Prigoff

Mr. Tony Roda, Williams and Jensen
(via teleconference)

Dr. Richard Sun, CalPERS Physician Consultant

Mr. Larry Woodson, California State Retirees

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1 P R O C E E D I N G S
2 CHAIRPERSON MATHUR: Good morning, everyone. I'm
3 going to call to order the Pension and Health Benefits
4 Committee. First order of business is roll call.
5 COMMITTEE SECRETARY JONES: Good morning.
6 Priya Mathur.
7 CHAIRPERSON MATHUR: Good morning.
8 COMMITTEE SECRETARY JONES: Michael Bilbrey?
9 VICE CHAIRPERSON BILBREY: Good morning.
10 COMMITTEE SECRETARY JONES: Steve Juarez for John
11 Chiang?
12 ACTING COMMITTEE MEMBER JUAREZ: Here.
13 COMMITTEE SECRETARY JONES: Rob Feckner?
14 COMMITTEE MEMBER FECKNER: Good morning.
15 COMMITTEE SECRETARY JONES: Richard Gillihan?
16 COMMITTEE MEMBER GILLIHAN: Here.
17 COMMITTEE SECRETARY JONES: Dana Hollinger?
18 COMMITTEE MEMBER HOLLINGER: Here.
19 COMMITTEE SECRETARY JONES: Henry Jones?
20 COMMITTEE MEMBER JONES: Here.
21 COMMITTEE SECRETARY JONES: Theresa Taylor?
22 COMMITTEE MEMBER TAYLOR: Here.
23 COMMITTEE SECRETARY JONES: Alan Lofaso for Betty
24 Yee.
25 ACTING COMMITTEE MEMBER LOFASO: Here.

1 CHAIRPERSON MATHUR: And please also note for the
2 record that Mr. Lind, Mr. Jelincic, and Mr. Slaton are all
3 also in attendance.
4 Next order of business is the executive reports.
5 Ms. Lum.
6 DEPUTY EXECUTIVE OFFICER LUM: Good morning,
7 Madam Chair, members of the Committee. Donna Lum, CalPERS
8 team member. I have 2 very brief updates to share with
9 you this morning. And the first is related to our CalPERS
10 benefit education event, which was held in Millbrae,
11 California on March 2nd -- or 3 and 4th. This CBEE was
12 considered to be our second highest crowd in the Bay Area,
13 and we had quite a bit of good attendance.
14 And one of the things that we noticed
15 particularly at this CBEE as well is that we had a lot of
16 our members engaging in our kiosk coming with their
17 personal information and getting personalized assistance
18 from the staff that were at the CBEE. So we're starting
19 to see a little bit of an evolution into how we're
20 presenting our education materials, and the different
21 items that our members are coming to the CBEEs to be
22 educated on.
23 I did want to say that again the team is very
24 excited to be out going through the State, and hosting
25 these CBEEs. The members continually express their

1 appreciation for the work that is being done there. And
2 again, we're starting to -- we're continually seeing
3 record attendance at almost all of the ones that we've
4 held this year.
5 Planning is underway for next year. It looks
6 like we've got quite a nice venue that we are looking for
7 in terms options throughout the State. As always, we do
8 go to the larger metropolitan areas, but we also alternate
9 going to some of the smaller rural urban sores. So we
10 have some plans underway to make sure that we're reaching
11 far up in the Northern California area as well.
12 The next CBEE is going to be in Santa Barbara,
13 and it's on March 17th and 18th. And then it will be
14 followed by Fresno, which is in April -- on April 28th and
15 29th.
16 The second item that I wanted to provide you an
17 update on is a follow up to one that I provided last
18 month. In your folder, you should have a document it
19 looks like this. And it's titled, "Going Paperless With
20 Your CalPERS Direct Deposit Statements".
21 If you recall last month, I shared with you an
22 initiative that we are undertaking to go paperless with
23 the retiree direct deposit advices. And this month, we've
24 continued to work through the project implementation, and
25 continued to have discussions with our stakeholders. I

1 just wanted to emphasize that the ability to view and
2 access the retiree direct deposits is currently available.
3 It's functionality that we added after the launch of
4 my|CalPERS as part of member self-service. And so as we
5 evolve to all direct deposits on-line, I just wanted to
6 emphasize that there is no added cost in doing this. This
7 was something that we had considered quite some time ago.
8 And through the opportunity, it seems to have availed
9 itself to do this now the right -- and this is the right
10 time.
11 I also want to emphasize that members, retirees
12 who wish to continue to receive their paper warrant will
13 still have that opportunity. They -- we are doing quite a
14 broad outreach in terms of notifying the membership about
15 this option. We will be providing information as to when
16 the opt-out capability is going to be available, and how
17 our retirees will be able to do that.
18 In addition to that, as noted on the fact sheet
19 that you have, not only are we expecting an anticipated $1
20 million in savings, which is really the postage and
21 printing of these statements, but there are also many
22 other benefits that we are also, you know, communicating
23 to the retirees about going paperless and going on-line.
24 And as you can see, those are listed there on the fact
25 sheet.

1 I think it's another -- another important point
2 to make is that this is one of many efforts that we are
3 undertaking going paperless. If you recall, we did it
4 with the health statements, but it's also an opportunity
5 for us to really look throughout CalPERS internally and
6 externally, and really focus on operational efficiencies.
7 And this is kind of the premise for what we're seeing
8 here.
9 As you know, we focus a lot on reducing -- on
10 communicating with all of our investor companies as we
11 apply pressure to reduce carbon environmental footprint.
12 And this organization really must do its part in
13 continuing to make efforts, whether they're large or
14 small, in order to be successful.
15 So again, I wanted to emphasize that again this
16 is one of several measures that we're taking. It is an
17 opportunity for us to look at cost savings and
18 efficiencies without significantly impacting the
19 opportunity to continue to serve our members and provide
20 the information timely, and as they need it.
21 So that concludes my update. And I'm happy to
22 answer any questions that you may have.
23 CHAIRPERSON MATHUR: Thank you.
24 Any questions from the Committee?
25 Mr. Bilbrey.

1 VICE CHAIRPERSON BILBREY: Ms. Lum, so how do
2 they -- if they still want to get a paper statement, how
3 does that process work? I was trying to read it here, and
4 I was not clear.
5 DEPUTY EXECUTIVE OFFICER LUM: So I believe it's
6 going to be in the April time frame, we are going to be
7 sending out information that will identify how members can
8 opt in to it. There will be a postcard that they can
9 complete and return to us that would identify that they
10 would want to continue to get their -- their paper advice.
11 If by the time we have a dead -- if the deadline
12 passes, if a member decides that they want to continue and
13 they didn't opt in during that opt-in period time -- or
14 opt-out time, they can still call the CalPERS call center,
15 and the call center agents can make the necessary
16 adjustments for them to continue to receive mail.
17 So they can do inside of this period of time, and
18 they can do it outside. Again, we're hoping that they can
19 see the added benefits of staying with electronic, but
20 certainly its's on option that will be provided.
21 VICE CHAIRPERSON BILBREY: Okay. Thank you.
22 CHAIRPERSON MATHUR: Thank you. I see no further
23 questions. Thank you.
24 Ms. Bailey-Crimmins.
25 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:

1 Good morning, Madam Chair and members of
2 Committee. Liana Bailey-Crimmins, CalPERS team member.
3 For my opening remarks, I would like to provide two
4 updates. One is based on a discussion we had in February
5 regarding OptumRx. I want to discuss what successes we've
6 had, and then the opportunities that still are presented
7 in relation to their corrective action memo.
8 And then also because of what's going on in D.C.,
9 I'd also like to provide you an update on what's going on
10 with the repeal and replace regarding the Affordable Care
11 Act.
12 So for OptumRx, in February, the exec -- we
13 had -- held an executive briefing with the OptumRx senior
14 leaders. And one of those discussions was about improving
15 customer service and really focusing on the details
16 related to the corrective action memo.
17 As a result of the meeting, February 27th, we
18 conducted and were -- we were invited and we conducted an
19 on-site review of their contact center in Southern
20 California. We felt it was important to see the
21 improvements firsthand. And then on March 8th, we also
22 received a letter -- Marcie Frost our Chief Executive
23 Officer received a letter from OptumRx. And they wanted
24 to share their continued commitment to recognize us as a
25 very valuable customer of theirs, and they also apologized

1 that they had not met our customer service expectations.
2 In the span of 90 days, OptumRx has hired over
3 100 new agents to take on the calls that our members are
4 calling in with. And they've also enhanced their
5 continuing education program. Now, some of the things
6 that they've done is they've established a secret shopper
7 program. So basically the agents do not know if it is a
8 real member, CalPERS member, or not to keep agents on
9 their toes.
10 They're also doing pop quizzes to make sure that
11 accurate information is being given on -- to our members
12 related to their coverage. And then enhanced scripting,
13 we feel that it's very important that before the agent
14 gets off the phone, that they ensure that our members have
15 the medication that's necessary, which is most -- first
16 and foremost important to all of us.
17 And then also to make sure that they -- before
18 they conclude the call, that they ask the member if they
19 have answered all of their questions satisfactorily.
20 But OptumRx has been focusing on customer
21 service, but member concerns continue to come in related
22 to prior authorizations. And as such, we have a meeting
23 in the next few weeks to laser focus on the prior
24 authorization, both the approval and the denial criteria.
25 And we're going through a comprehensive discussion to see

1 if there's things that need to be changed.
2 And then also, lastly, because of, again, member
3 concerns, we are looking at having a specific discussion
4 about Walgreens, and specifically certain pharmacy
5 locations to ensure that there's coverage, and that our
6 members are not standing in line for an undo amount of --
7 period of time.
8 So with OptumRx, I'd like to then transition to
9 what's going in D.C. right now. The American Health Care
10 Act, which is basically the repeal and replace of the
11 Affordable Care Act, as we know on March 6th, the House
12 Republicans submitted 2 bills. And they constitute the
13 first attempt to replace and repeal again the Affordable
14 Care Act. Even though that that is what is stated, it
15 does seem like it's more of Medicare reform.
16 And over the past 7 days, CalPERS has attended --
17 we actually went to D.C. and attended a board meeting for
18 the National Coalition of Health Care, and had a very -- a
19 robust discussion about that. And we've also received
20 one-on-one debriefs from our federal reps. We've analyzed
21 several of the analyst reports -- latest set of analyst
22 reports, and we have also spoke with State experts on
23 discussing the impacts to California specifically.
24 Yesterday, as we saw, the Congressional Budget
25 Office issued their scores. And it indicates that almost

1 14 million individuals will go unassure[sic] if the bill
2 stays as is. The legislation does not repeal all of the
3 insurance reforms, which is something that we are
4 concerned about. It will continue to cover preexisting
5 conditions, which was something that was very much in play
6 when ACA was being developed - it was important to CalPERS
7 - and also covered adults up to 26 is still in the bill.
8 But even though CalPERS does not necessarily have
9 a direct impact in relation to the AHCA, there are 3 areas
10 that we are paying close attention to. One is the taxes
11 related to what is going to stay in place and what is not.
12 The Cadillac Tax was not -- is not going to be
13 elimited[sic][phon.]. They're pushed it out another 5
14 years and it will reappear in 2025. It does not -- the
15 bill does not impose a tax on employer-sponsored plans,
16 which is something that's important to us. And it also
17 repeals the employee and individual mandates.
18 But in addition to the ACA taxes, indirectly we
19 are keeping an eye on two things. One is when we shift
20 cost to the State, specifically related to Medicaid, and
21 there's less federal subsidies, what that does is that
22 puts an undue pressure potentially on our players. So
23 it's something that we are keeping a close eye on.
24 And then there is this equilibrium that happens
25 in the market when you are looking at commercial Medicare

1 and Medicaid. And when that starts to shift, it creates
2 potential issues in the commercial market. And then we
3 have to be very conscious as we're going in through rate
4 development to ensure that things are not going to be
5 showing up in our rates that we do not want on behalf of
6 our members.
7 So please know that we promise that we will
8 continue to monitor the possible impacts. Things are
9 changing day by day. The Senate has basically said that
10 they probably will not, without changes, approve as is.
11 So there's a lot of discussion going on with the
12 governors. And we will continue to make sure that we are
13 staying apprised of what is necessary to protect CalPERS
14 and the members that we serve.
15 So, Madam Chair, that concludes my opening
16 remarks, and I am available for any questions.
17 CHAIRPERSON MATHUR: Thank you.
18 We do have some questions. Mr. Jones.
19 COMMITTEE MEMBER JONES: Yeah. Thank you, Madam
20 Chair. Yeah. Thank you for the update. I would just
21 like to add that the 14 million members that would be
22 uninsured as a result of this bill is for 2018, but in 10
23 years it grows to 24 million people. So that's a huge
24 number that people will lose their coverage.
25 CHAIRPERSON MATHUR: Mr. Feckner.

1 COMMITTEE MEMBER FECKNER: Thank you, Madam
2 Chair. Liana, I want to talk about the OptumRx piece.
3 Every time we switch vendors we go through a period of
4 time where we hear from our members, et cetera. This one
5 seems to be a lot larger concentration of folks that we're
6 hearing from. Why -- somebody that's in this business,
7 why are we such a scope that they can't seem to understand
8 prior to taking on this contract? It's not like we have
9 hidden numbers. They can see everything out there, the
10 number of people we have in the plan, et cetera.
11 Why have these -- are these people cannot come up
12 to speed to be able to handle the job that they've
13 applied? Any clue?
14 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
15 Well, you're absolutely right, President Feckner.
16 As any transition, there are obstacles, or things --
17 transition opportunities that we must face. They had
18 technical difficulties the first 30 days. They
19 immediately turned those around. We do still believe that
20 the prior authorizations is really the heart of the
21 matter, where -- that the criteria for approval or denial
22 is creating concerns for our members. And so that is why
23 we are doing a concentrated effort to look at that
24 specifically.
25 We believe that the percentage of denials is too

1 high, and we're not quite understanding why, and then
2 obviously customer service. We at CalPERS expect the very
3 best for our members. And in the last 90 days they have
4 improved customer service, but I still believe that there
5 is a lot more that we need to do.
6 I do want to commend Optum that they -- we are
7 having weekly calls. They are addressing -- we have had
8 250 escalated concerns specifically from CalPERS to Optum,
9 and they have been on top of those on a daily basis.
10 COMMITTEE MEMBER FECKNER: So as far as the, you
11 know, the prior authorization, I understand. I've heard a
12 lot about that, but what I seem to hear a lot more about
13 is wrong pricing, that it's not what our contracts call
14 for. They're putting in inflated pricing. Why is that --
15 how is that coming about, if it's already dictated what it
16 should be?
17 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
18 Another great questions. It was found to us that
19 the agents were not properly trained, and they are giving
20 inaccurate information to our members. There was one case
21 where a member had received a -- fairly said that they
22 were going to be charged $400 for a copay that there was
23 no charge. And we acknowledged that that is inaccurate
24 information, and so does Optum. And Optum has put the
25 enhanced education to make sure that those agents are

1 providing proper information, because the last thing we
2 want is for members to get information and then create
3 angst that they don't need when you're trying to get your
4 medication transitioned from a system that your felt like
5 was fairly stable to, you know, a new opportunity that I
6 think that will help CalPERS move forward. But this
7 transition period is a little bumpier than it should be.
8 COMMITTEE MEMBER FECKNER: Thank you.
9 CHAIRPERSON MATHUR: Thank you.
10 Mr. Lofaso.
11 ACTING COMMITTEE MEMBER LOFASO: Thank you, Madam
12 chair. I have 3 questions, but I'm going to inflate it to
13 5 to make 2 follow-ups from Mr. Feckner.
14 (Laughter.)
15 ACTING COMMITTEE MEMBER LOFASO: So seriously,
16 when Mr. Feckner -- the question about -- I forgot how we
17 phrase it, anticipating the scale of the CalPERS
18 membership. Are there any -- you described them
19 high -- hiring these extra 100 people to meet the
20 capacity. And I think the real question is why they
21 didn't anticipate that beforehand. So the question is, is
22 there anything in our contract that imposes any kind of
23 sanction on them for not having met the capacity
24 requirements?
25 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:

1 The contract is -- has fairly comprehensive
2 service level objectives. There are -- if there is a lack
3 to perform, there is those opportunities to financially
4 hold back fees. They -- at this point, when they looked
5 at what the type of call volume CVS Caremark was receiving
6 during -- they staffed for that level. And I'm probably
7 moving -- but maybe during the transition, they needed to
8 up that level a little bit, because when you're
9 transitioning from one to another, that may not be exactly
10 the amount of calls that will come in consistently
11 forever. But during a transition, they probably needed to
12 be more prepared for the number of calls that were going
13 to come in.
14 And then compounded on that is having the
15 technical difficulties. We had agents that were not able
16 to talk to our members because the technology did not
17 route the member to them correctly.
18 ACTING COMMITTEE MEMBER LOFASO: Appreciate that.
19 On the issue about the pricing, did I understand
20 that there were some specific accommodations for CalPERS
21 members? The point of the question is, if the pricing was
22 the pricing that Optum had before the contract, what was
23 it that their call center people didn't understand before
24 this all started?
25 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:

1 It was specifically agents were taking calls for
2 CalPERS members that they -- they -- the call center
3 actually answers calls for a lot of clients of OptumRx.
4 And it was apparent that the technology was routing calls
5 to people that were not educated on our specific -- our
6 copays and our specific information, so that's what first
7 created the issue.
8 And then they realized quickly, when you train --
9 when you bring on 100 new people, you need to train them
10 fairly quickly, so that's why they've put that enhanced
11 education program in place.
12 ACTING COMMITTEE MEMBER LOFASO: So not
13 withstanding the ramp-up of the new individuals to train,
14 the other issues were CalPERS specific pricing issues like
15 copays, question mark?
16 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
17 I believe that it was just because those
18 individuals were not trained on how to answer the
19 questions and look up the information correctly.
20 ACTING COMMITTEE MEMBER LOFASO: Okay.
21 Appreciate that.
22 On the prior authorization issue, I understand a
23 substantial number of matters have been elevated. And
24 have we resolved most of these or do we have a -- do we
25 have a time frame for that?

1 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
2 Of the 250 that I mentioned earlier, many of them
3 have been resolved. We have -- and actually, one of their
4 best of their best, there - it's an ombudsman - has been
5 assigned to us, and they are interacting with the CalPERS
6 team on a daily basis to look over those escalated tickets
7 to make sure that people are getting responding fairly
8 quickly.
9 ACTING COMMITTEE MEMBER LOFASO: Appreciate that.
10 When you mentioned that the secret shopper's goal
11 with the -- with the -- with the call center was to ensure
12 that the -- that once the patient got off the phone, that
13 they were ensured that the patient had the necessary
14 medications. How does that square with the prior
15 authorization system? Are you saying that the call center
16 person could short circuit that or what does that mean?
17 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
18 So several things. One, our first and foremost
19 is to ensure that our members have medication. And so as
20 you're transitioning, there is an -- if there is a prior
21 authorization issue, and that's going to create a
22 situation where a member will not have their medication.
23 There is an opportunity for Optum to work with the
24 pharmacy to do -- it's a short transition, so that they
25 can get that medication while we're working out the prior

1 authorization problem in the background.
2 So there should never be a situation where our
3 members are without the medications that they -- they --
4 they need.
5 ACTING COMMITTEE MEMBER LOFASO: Okay.
6 Appreciate that.
7 So my last question goes to the ACA issue and you
8 mentioned equilibrium, and you basically mentioned cost
9 shifting and incorporating shifted costs into the -- of
10 course, that invokes a lot of complicated -- but aren't
11 you referring to just going back to the situation we had
12 before the Affordable Care Act, where all of our providers
13 in the charges they have -- I mean, it's not -- we don't
14 have a lot of tools to -- we have a lot of tools, but we
15 can't go it alone on this equilibrium thing protecting
16 ourselves from cost shifting just with the tools we have.
17 Isn't that -- isn't that the case?
18 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
19 You are correct. So there is the equilibrium
20 that you were saying. It would -- pretty much all the
21 progress that we had made to reduce the number of
22 uninsured in California would also go to -- that if we
23 rolled it back, you'd have a lot more individuals going to
24 emergency room services, which are much more costly.
25 And at the end of the day, the commercial market

1 is what bears the brunt of those costs. And so when you
2 start to shift that, we would pretty much go back to where
3 we were potentially before ACA.
4 ACTING COMMITTEE MEMBER LOFASO: Thank you.
5 Thank you, Madam Chair.
6 CHAIRPERSON MATHUR: Thank you.
7 Ms. Taylor.
8 COMMITTEE MEMBER TAYLOR: And thank you very
9 much, Madam Chair.
10 I had a couple of questions on the ACA also. And
11 I wasn't writing fast enough. So I got the first -- you
12 had 3 things that you were concerned about, the Cadillac
13 Tax, which has been pushed back. And then I didn't get
14 the last two.
15 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
16 Oh, okay. Ms. Taylor, there's -- so obviously
17 anything to do with ACA taxes. Two is the equilibrium
18 that we were just talking with Mr. Lofaso.
19 COMMITTEE MEMBER TAYLOR: Right.
20 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
21 That's important, because as we're going into the
22 2018 rate negotiations, if there's uncertainty in the
23 market, potentially the plans could be trying to address
24 that uncertainty through rate negotiations.
25 And then 3, as we shift, you know, individuals

1 where the State is then paying, and there's not federal
2 subsidies for Medicaid, then that will directly impact our
3 employers who we are very, you know, concerned about to
4 make sure that we have affordable health care, both for
5 our members and our employers.
6 COMMITTEE MEMBER TAYLOR: Okay. So --
7 CHAIRPERSON MATHUR: I think the two things
8 though that Ms. Taylor might not have heard -- or might
9 not have caught is the tax on the employer sponsored plans
10 is not included in the new American Health Care Act, nor
11 the employer and individual mandates. Those are also
12 not -- they've been removed in the new A -- the new AHA.
13 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
14 Yes.
15 COMMITTEE MEMBER TAYLOR: So that's actually what
16 I wanted to address. The tax on the employer plans helps
17 pay for the ACA, so once they get rid of that, there's
18 more cost shifting on to the workers and the insured,
19 right? And then the individual mandate, if you don't have
20 the individual mandate, you can't keep people insured.
21 You can't keep the healthy on the plan, so that you can
22 offset the sicker folks.
23 So I just wanted to reiterate and clarify that
24 the negotiation for 2018, I had heard 2 months ago that
25 the insurance industry was already feeling the pressure of

1 uncertainty. So how do we go about determining whether or
2 not they're trying to put in rate increases to cover their
3 uncertainty as we go forward with our rates?
4 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
5 Ms. Little will be giving you an update later
6 today on where we are in our rate negotiation. But I
7 think part of it is we have actually enhanced our process.
8 We've added an additional step, so that the plans are now
9 giving us numbers a month earlier than they have before,
10 which puts them a little -- makes them a little
11 uncomfortable, but I think that allows across the next 3
12 stops to continued to refine and have those conversations
13 with them to ensure that as we see clarity related to the
14 taxes, that they aren't building that into any of their
15 rates.
16 And just again, I think part of it is
17 understanding if there is a cost increase, we need to
18 understand why the cost increase, not that it's patted or
19 buffered somewhere that we don't -- just based on their
20 uncertainty.
21 COMMITTEE MEMBER TAYLOR: So that's my concern,
22 because right now theres' -- we don't know what's going to
23 happen, but it sounds like it's not going to pass right
24 now. So if they're building in a buffer, we need to be
25 able to determine that before -- obviously, they're going

1 to pass on the rate increases to employer health plans,
2 because that's how that works. But I just want to make
3 sure they're not doing it too early before it's even been
4 determined whether or not they're going to have all this
5 fallout from the repeal of the ACA. So I'm glad you guys
6 are on your toes. I appreciate it.
7 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
8 Yeah, keeping a close eye on it. Thank you, Ms.
9 Taylor.
10 CHAIRPERSON MATHUR: Thank you.
11 I see no further requests. So we'll move on to
12 Agenda Item 3, which is the action consent item, approval
13 of the February minutes.
14 COMMITTEE MEMBER JONES: So moved.
15 COMMITTEE MEMBER TAYLOR: Second.
16 CHAIRPERSON MATHUR: Moved by Mr. Jones, seconded
17 by Ms. Taylor.
18 Any discussion on the minutes?
19 Seeing none.
20 All those in favor say aye?
21 (Ayes.)
22 CHAIRPERSON MATHUR: All opposed?
23 Motion passes.
24 There has been a request on the consent items to
25 take off 4c, so we'll do that at the end of the agenda.

1 And we'll move on to Agenda Item 5, Proposed
2 Regulation for Pensionable Comp under PEPRA.
3 DEPUTY EXECUTIVE OFFICER LUM: Good morning
4 again, Madam Chair, members of the Committee. Donna Lum,
5 CalPERS team member. Joining me this morning is Renee
6 Ostrander, CalPERS team member.
7 Agenda Item number 5 is an action item requesting
8 approval of the draft regulations defining pensionable
9 compensation. Until January 1st, 2013 employers submitted
10 reportable compensation on behalf of their employees that
11 are CalPERS members under the guidance of Government Code
12 and associated California Code of Regulations 571. AB
13 340, also known as the Public Employees Pension Reform Act
14 of 2013, also known as PEPRA, added, amended, and repealed
15 numerous sections of the Government Code related to public
16 employees retirement, including what is defined as
17 reportable compensation for new PEPRA members.
18 Since the enactment of PEPRA, the Board has
19 approved several regulations that have been adopted to
20 clarify related items to PEPRA. And this regulation is
21 one of the final remaining items.
22 In your folder, you will find a recently modified
23 version of the draft regulation package. In order to
24 provide additional clarity on the ability of future Board
25 actions, minor changes were made to the final paragraph

1 Section 571.1(d). And Renee will cover further in her
2 presentation the amendment, so that it is read into the
3 record.
4 At this time, I'll turn the presentation over to
5 Renee to discuss the draft regulation package.
6 EMPLOYER ACCOUNT MANAGEMENT DIVISION CHIEF
7 OSTRANDER: Good Morning. Renee Ostrander, CalPERS team
8 member. This action item brings forward a proposed set of
9 regulations to clarify CalPERS's interpretation of what is
10 considered pensionable compensation for PEPRA members, and
11 to help ensure uniform compliance amongst all covered
12 employers.
13 Again, these are only intended to provide
14 direction for PEPRA new members, and would be effective
15 back to the effective date of PEPRA, January 1st, 2013.
16 Classic members will continue to be governed by
17 current statutes and California Code of Regulations 571.
18 As you may recall in April of 2014, the CalPERS
19 Board approved the proposed regulation for pensionable
20 compensation to be released for public comment, and again
21 in August 2014, the CalPERS Board approved the proposed
22 regulation to move forward to the Office of Administrative
23 Law for adoption. However, that draft regulation was
24 never adopted.
25 The noticeable distinction between this package

1 and the previous package submitted in 2014 is the
2 exclusion of temporary upgrade pay. The proposed
3 regulations coming forward in this package aligns to the
4 direction provided to employers in the late 2012 circular
5 letter, which excluded the following items:
6 Bonuses, uniform allowance, management incentive
7 pay, the value of employer paid member contributions,
8 off-salary schedule pay, temporary upgrade pay. As a
9 result, no reconciliation efforts will be required by our
10 public agency and school employers. We have met with
11 stakeholders and have received feedback that they do not
12 oppose this package moving forward as developed.
13 As Donna mentioned, a minor change has been made
14 to the financial section of the draft regulation. While
15 the intend hasn't changed, the modification was made to
16 further clarify the Board's ability to make changes to the
17 regulation in the future.
18 The new language of 571.1(d) now reads as
19 follows: "The Board reserves the right to add to or to
20 delete from the list provided in subdivision (b). The
21 Board also reserves the right to add to the list of items
22 excluded from pensionable compensation provided in
23 Government Code section 7522.34(c)".
24 If the Board approves the proposed regulations
25 and the initiation of the regulatory process, we will

1 request the publication of Noticed of Proposed Regulatory
2 Action in the California Regulatory Notice Register. As
3 part of the Notice of Proposed Regulatory Action, a
4 minimum 45-day comment period is required. This draft
5 regulation package will then come back to this Committee -
6 we anticipated it in August - with all of the comments
7 received from our stakeholders and our responses to them.
8 This completes my presentation, and I'd be happy
9 to answer any questions you may have.
10 CHAIRPERSON MATHUR: Thank you. Any questions
11 from the Committee?
12 Yes, I see a couple.
13 Mr. Gillihan.
14 COMMITTEE MEMBER GILLIHAN: Thank you, Madam
15 Chair.
16 I just want to thank the staff and all the
17 stakeholders for their work on this to hopefully bring
18 this to some landing spot, so we can all move forward.
19 And that said, I'd like to move the staff recommendation
20 with the amendments as noted by staff this morning.
21 COMMITTEE MEMBER HOLLINGER: Second.
22 CHAIRPERSON MATHUR: Thank you. Motion made by
23 Gillihan, seconded by Hollinger.
24 Discussion on the motion?
25 Mr. Jelincic?

1 BOARD MEMBER JELINCIC: I would encourage the
2 Committee not to adopt this. We went through this drill
3 earlier after they passed PEPRA. One of the things that
4 we particularly looked at was the temporary upgrade. We
5 talked to the author of the bill, we talked to the
6 legislative staff, and they all agreed that it was not the
7 intent to change that provision.
8 So we adopted the regulation. The Governor's
9 office argued against it. But we said we're going to send
10 it to the Office of Administrative Law. Their job is to
11 review regulations to make sure they are compliant with
12 the law. The Governor wasn't willing to trust OAL to
13 uphold his position, so he basically took the position
14 that we have -- the Board has plenary authority, except
15 that he's got an administrative veto by directing his
16 appointees to not put the thing forward.
17 I would point out that the employer has absolute
18 control over whether they put people in positions of
19 temporary upgrade. And if they don't want to pay it, you
20 know, they shouldn't put people there.
21 I believe that if you ask people to do a job, you
22 ought to pay them. And part of their compensation is the
23 pension. And I will also point out that Luke 10 verse 7
24 says that the worker deserves his hire. And if you've
25 asked people to do the job, you ought to pay them. So I

1 would encourage you not to adopt that.
2 And in terms of the new addition to 8, quite
3 frankly to adopt a regulation that says this is the rules
4 unless we change our mind, and particularly one that says
5 we've got the right to change Government Code, is not
6 something that I think we ought to be adopting.
7 Thank you.
8 CHAIRPERSON MATHUR: Thank you.
9 Mr. Slaton.
10 BOARD MEMBER SLATON: Thank you, Madam Chair.
11 I have the opposite opinion from Mr. Jelincic. I
12 think this meets the intent of PEPRA, and I think it's
13 just consistent with what has happened since the law has
14 passed. And I think it's a reasonable interpretation
15 where we should be going, so I encourage the Committee to
16 vote for it.
17 CHAIRPERSON MATHUR: Thank you.
18 Any further discussion on the motion?
19 Seeing none.
20 All those in favor say aye?
21 (Ayes.)
22 CHAIRPERSON MATHUR: All those opposed?
23 Motion passes.
24 We will -- that will take us to agenda item --
25 thank you very much.

1 That will take us to Agenda Item number 6,
2 Federal Health Care Priorities. And we have on the phone
3 with us our health care federal representatives are -- are
4 they both on the line?
5 Chris -- thank you. Chris Jennings and Yvette
6 Fontenot.
7 MR. JENNINGS: Yes, we are.
8 MS. FONTENOT: We're here.
9 CHAIRPERSON MATHUR: Welcome to the auditorium.
10 Good morning, Ms. Ashley.
11 LEGISLATIVE AFFAIRS DIVISION CHIEF ASHLEY: Good
12 morning. Good morning, Chair Mathur, and members of the
13 Committee. Mary Anne Ashley, CalPERS team member. And
14 here also is Gretchen Zeagler. She is an Assistant
15 Division Chief in Legislative Affairs, and she oversees
16 the Federal Policy Unit. And as noted, we have Yvette and
17 Chris our federal health care representatives on the line.
18 Today, we will be presenting Agenda Item 6, which
19 is the Federal Health Care Priorities. It is an action
20 item. And we are seeking Board approval of the
21 recommended federal health care priorities for the 115th
22 Congress.
23 If you recall, in November 2016, we began the
24 process of reviewing and updating the Legislative and
25 Engagement Policy Guidelines for health care. That

1 discussion was held over until post-election, and was
2 discussed further in January. And then in February, the
3 Board ultimately decided to retain and approve the updated
4 Legislative and Engagement Policy Guidelines for health
5 care, until such time Health Care Beliefs could be
6 developed and approved.
7 And the Committee did direct staff to begin work
8 on developing Health Care Beliefs. And that work is
9 currently underway and is in the planning stages.
10 Also in January, the Board directed CalPERS team
11 members to work with our federal health care
12 representatives in developing federal health care
13 priorities for the 115th Congress. The priorities will
14 provide a framework for CalPERS to engage in legislative,
15 regulatory, and policy proposals in a manner that is
16 consistent with existing Board Beliefs, principles, and
17 policies.
18 The federal policies are mar -- are more
19 specific, and they are particular to a given congressional
20 session and the dynamics of the current administration.
21 The recommended guidelines were developed
22 collaboratively with CalPERS team members, and with our
23 federal health care representatives. And they are based
24 on CalPERS strategic plan, the Legislative and Engagement
25 Policy Guidelines for Health Care, and also taking into

1 consideration the current dynamics and the political
2 atmosphere with the new Trump administration.
3 I'd also like to note that the federal priorities
4 for health care, investments, and retirement security have
5 been shared with each of our federal representatives. And
6 we hold conference calls on a monthly basis with CalPERS
7 team members, and each of the federal representatives.
8 And those provide a forum for everyone to provide updates
9 and identify opportunities for combined efforts.
10 And with that, I will ask Gretchen to take over,
11 and she will review the recommended health care
12 priorities.
13 LEGISLATIVE AFFAIRS DIVISION ASSISTANT CHIEF
14 ZEAGLER: Thank you. Thank you, Madam Chair, members of
15 the Committee. Thank you Mary Anne for the introduction.
16 As Mary Anne said, I'm Gretchen Zeagler, Assistant
17 Division Chief of Federal Policy. And today, I'm here to
18 present the recommended action item on the federal health
19 care priorities.
20 In order for CalPERS to remain relevant in the
21 Trump era, it is essential that we are strategic about how
22 and when to engage policymakers on CalPERS's priorities.
23 Accordingly, as Mary Anne said, our teams, along with the
24 federal representatives, recommend for your approval the
25 following priorities:

1 First would be the Affordable Care Act. In here,
2 we would ask that you reduce disruption in the repeal and
3 amendment of significant parts of the ACA and other health
4 care reform changes. Specifically under this, we would
5 ask that we advocate for parts of the law that are
6 important to CalPERS, including delivery system reforms.
7 We would advocate against proposals that increase cost
8 shifting to CalPERS. We would embrace repeal of the
9 excise tax, and we would advocate against limits on the
10 federal tax incentives for health coverage that create
11 inordinate pressure on employers to excessively reduce
12 benefits and/or increase cost sharing.
13 Second, we would constrain prescription drug
14 costs. And under this, we would maintain appropriate
15 quality of and access to brand name, generic, biosimilar,
16 interchangeable drugs. We would advocate for increased
17 pharmaceutical market competition. We would advocate for
18 direct negotiation of pharmaceuticals, and we would
19 advocate against anti-competitive arrangements between
20 brand name and generic pharmaceutical companies.
21 Third, we would ensure affordable quality
22 Medicare coverage for our members.
23 Fourth, we would limit health care cost growth.
24 Under this, we would seek to test, evaluate, and expand
25 new payment structures, while maintaining quality and

1 access to care. We would promote transparency and cost
2 and quality reporting. We would strengthen the
3 Medicaid -- or, excuse me, Medicare program to constrain
4 cost growth. And we would seek to advocate for proposals
5 that establish and implement benchmarks and targets
6 intended to improve delivery of health care services.
7 Lastly, we would stabilize and enhance public
8 agency and school employer participation in the CalPERS
9 health program. We respectfully request your approval on
10 these priorities, as they are consistent, as Mary Anne
11 said, with the CalPERS strategic plan, Pension Beliefs,
12 Investment Beliefs, and in this case, the Legislative and
13 Policy Engagement Guidelines on Health Care.
14 I would like to add one note to the Board.
15 Yesterday, and action item was taken on some language
16 change in the Investment item. That same language does
17 also appear in this item, so if the Board would like to
18 consider that same change.
19 With that, I would like to open the discussion up
20 at this time to any questions that you might have. Thank
21 you.
22 CHAIRPERSON MATHUR: Thank you.
23 Ms. Taylor.
24 COMMITTEE MEMBER TAYLOR: Could you -- thank you
25 very much. Could you explain to me, "advocate against

1 limits on federal tax incentives for health coverage that
2 create inordinate pressure on employers to excessively
3 reduce benefits and/or increase cost sharing"? What does
4 that mean?
5 LEGISLATIVE AFFAIRS DIVISION ASSISTANT CHIEF
6 ZEAGLER: I think in this case just the discussion prior
7 to this about cost shifting about equilibrium. I think
8 this specifically speaks to that point.
9 COMMITTEE MEMBER TAYLOR: Okay. That's what I --
10 I just wanted to -- because it sounds very grand. It's
11 kind of aspirational, so I wanted to make sure that we --
12 we got a handle on that. That's all my questions for
13 right now.
14 Thank you.
15 CHAIRPERSON MATHUR: Thank you.
16 Mr. Jones.
17 COMMITTEE MEMBER JONES: Yeah. Thank you, Madam
18 Chair.
19 Yeah at the Investment Committee meeting
20 yesterday, we did modify the language. And I just want to
21 be sure that the piece that was referenced about the Board
22 engaging congressional staff and members is also what
23 you're referring to.
24 LEGISLATIVE AFFAIRS DIVISION ASSISTANT CHIEF
25 ZEAGLER: That is specifically. I believe it is under the

1 background section on page 2 of 4. And I think that it is
2 in the second paragraph, last sentence, and it says -- and
3 it's speaking to the priorities, but specifically the
4 sentence says, "They do not bind the Board in considering
5 or adopting a position on any specific proposal, nor do
6 they supersede or alter any existing policies, Beliefs, or
7 principles".
8 I believe in the case yesterday, the language was
9 changed from, "They do not bind the Board...", to, "They
10 do not bind CalPERS".
11 COMMITTEE MEMBER JONES: Yes. Right. But the
12 component where Board members would be engaged with
13 congressional members is what I'm referring to.
14 CHAIRPERSON MATHUR: I think that wasn't a
15 language change per se, but it was direction to the -- as
16 I recall --
17 COMMITTEE MEMBER JONES: Right, yes.
18 CHAIRPERSON MATHUR: -- it was direction to the
19 staff to -- if there opportunities in --
20 COMMITTEE MEMBER JONES: Right. And I just want
21 to be sure that the record -- maybe, Madam Chair, you can
22 give that direction.
23 CHAIRPERSON MATHUR: Yes. That is so made.
24 LEGISLATIVE AFFAIRS DIVISION ASSISTANT CHIEF
25 ZEAGLER: Taken.

1 CHAIRPERSON MATHUR: Thank you.
2 Okay. Mr. Lofaso.
3 ACTING COMMITTEE MEMBER LOFASO: Thank you, Madam
4 Chair. Also 3 questions. I'm going to switch the order.
5 So on this question of stability in the employer based
6 system, and just to amplify the question, Ms. Taylor. I
7 mean this tax stuff could mean everything from the excise
8 tax, to repealing all or part of the employer exclusion,
9 to some pretty far-reaching stuff in some of the Ryan
10 plans, and some of the Price plans, like allowing HSAs to
11 pay for alternative health coverage, or allowing the tax
12 subsidies to encroach into the employer market, all that
13 kind of stuff.
14 So with all that, my question is, I know that our
15 fundamental place in this debate is that 80 percent of the
16 market that's the traditional employer based place. And
17 there was some good discussion at the off-site, and some
18 of the language there is in the memo about our role as a
19 purchaser, but we're a purchaser in the employer context.
20 So I'm just curious if staff or the reps can
21 elaborate, how -- where are our best alliances in the
22 employer community, or do we have people in the employer
23 community who want to go places we don't want to go, and
24 that impacts how we have alliances in the employer
25 community? Just a little more strategic background on how

1 we're approaching the stability of the employer pay
2 system, which we're part of.
3 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
4 May I respond, Mr. Lofaso. I just wanted to
5 point out that CalPERS is an active participant in
6 numerous committees and boards and coalitions. And
7 listening to your -- you know, your question basically
8 stating that there are times where, as a purchaser, we
9 have to be looking out, at the end of the end day, for
10 CalPERS. And so we have a voice, not only at the federal
11 rep level, but at the coalition level, to ensure that we
12 only move and proceed as far as we believe either this
13 committee or the staff recommend, or what has been
14 delegated to the CEO.
15 So we are very careful on not pushing farther
16 than we need to when it comes to our role in the
17 purchasing market.
18 ACTING COMMITTEE MEMBER LOFASO: Appreciate that.
19 I'm just, as an ongoing basis, trying to understand how
20 that gives us opportunities and constrains us
21 strategically. Again, all this is in the context of the
22 delegation done in February. But the delegation, there's
23 a lot of -- you know, we're hoping to get -- to make this
24 communication easy for staff in the context of that
25 delegation. And I'm just trying to amplify the

1 communication.
2 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
3 And we also believe by -- because with the
4 Beliefs, which we'll be bringing back in April to this
5 Committee to bring a framework, we believe the Beliefs
6 will also help provide some guidance and framework to us,
7 as a Committee, to decide where we want to progress when
8 it comes to health care. So that's one thing.
9 Right now, we have Investment Beliefs. We have
10 Pension Beliefs. We do not have Health Care Beliefs. And
11 as we discussed at the off-site, we will be bringing that
12 back through several workshops with this Committee. And I
13 think that that will continue to drive the details that I
14 think you are looking for.
15 ACTING COMMITTEE MEMBER LOFASO: And I'm -- I'm
16 looking for some strategic stuff, but I really appreciate
17 your last comment, because what you're really saying is
18 even in this challenged environment, we're not going to
19 shirk away from our role as an innervate[sic] -- as an
20 innovator. And I think not doing that is important.
21 My second question is, and I raised this in
22 February, about removing of the language referencing
23 specifically supporting direct pharmaceutical negotiation
24 by Medicare. And there's language in here about
25 encouraging direct negotiations in general.

1 And again, the federal representatives report
2 early in our staff package talks about, of course,
3 President Trump being quite bullish on this proposal and
4 that creating opportunities. So again, not worrying about
5 the words themselves, but just understanding how they
6 practically play out, what is the thinking on this
7 Medicare opportunity, and the way it's expressed in the
8 priority -- in the priorities here?
9 LEGISLATIVE AFFAIRS DIVISION ASSISTANT CHIEF
10 ZEAGLER: I would say --
11 ACTING COMMITTEE MEMBER LOFASO: Is that a
12 priority still is really the question?
13 LEGISLATIVE AFFAIRS DIVISION ASSISTANT CHIEF
14 ZEAGLER: It's a priority. I would say, at this point,
15 it's a very important factor. It's a strategic decision
16 as you said. And so I want to back this up for a second,
17 and address your -- you comment directed toward the
18 stakeholder community.
19 As part of the initial, I would say, analysis
20 process it's going through right now with the AHCA, that
21 we're taking on, our federal representatives are prepared
22 for us, in a encompassing stakeholder comment document.
23 And what that is, is it's noting all of the
24 stakeholder communities that we interact with, and what
25 their specific comments are on the AHCA/ACA in general.

1 So that's really an active part of our strategy is to
2 really be aware of, at least right now initially, what
3 voices are out there, what they're saying, and where
4 they're going forward with this. And so we're taking that
5 into the overall analysis and consideration moving
6 forward.
7 More specifically to the point, you know, we're
8 getting through our analysis. So right now, we're looking
9 at how this plays into the strategy, and how we'll be
10 addressing that going forward. I think what we'd like to
11 really do is take a look at the legislation, and see what
12 opportunities there are for CalPERS, because we are seeing
13 some encouraging developments and some concerning
14 developments, right? And we want to be extremely
15 thoughtful in how we engage going forward, given the
16 political atmosphere that's out there right now.
17 CHAIRPERSON MATHUR: It might be worth bringing
18 in our federal reps to see --
19 LEGISLATIVE AFFAIRS DIVISION ASSISTANT CHIEF
20 ZEAGLER: Yeah, absolutely.
21 CHAIRPERSON MATHUR: -- to see if they have
22 anything they want to add on this question.
23 MR. JENNINGS: This is Chris Jennings. I'll just
24 briefly comment, and then ask Yvette if she has any
25 further words to add.

1 First, I would say that as it relates to the
2 employer dynamic, CalPERS being the largest public
3 employer non-Medicare in the nation, we value flexibility
4 to execute and implement our policies free from, or
5 liberated from, external policy intervention that would
6 constrain our ability to do so.
7 So, for example, on the Cadillac Tax or tax
8 exclusion caps anything along those lines, the benefit
9 managers within CalPERS feel that that creates a financial
10 incentive that limits our ability to design a benefit
11 package according to the needs of your members. And other
12 policies would be filtered through and evaluated in that
13 context.
14 As for pharmaceutical cost containment, and
15 direct negotiation, it is encouraging to see a Republican
16 administration very proactively engaged in the concerns
17 about pharmaceutical cost containment. And it would not
18 be just focused solely and only on direct negotiations,
19 because as our guidance has given us, we're told to
20 provide for policy avenues that would increase competition
21 in the marketplace to help constrain cost growth.
22 So those are -- those are strategic guidance
23 examples of how we filter your direction to position
24 CalPERS most effectively to be consistent with the
25 guidance you have given us on your policy priorities.

1 CHAIRPERSON MATHUR: Thank you very much for that
2 Chris.
3 Okay. Any further questions?
4 Mr. Lofaso.
5 ACTING COMMITTEE MEMBER LOFASO: Just -- just one
6 last quickly stated big one. So apropos to cost shifting
7 and equilibrium, how much in our program includes
8 addressing the 24 million to lose coverage that Mr. Jones
9 referred to earlier, which is why the cost shifting is
10 probably going to occur? Where does it -- where does that
11 just fit into our advocacy program?
12 LEGISLATIVE AFFAIRS DIVISION ASSISTANT CHIEF
13 ZEAGLER: I think it's a really good consideration, and
14 it's something again that we're analyzing right now. I
15 think we're all still trying to absorb what those numbers
16 are, what that impact really is to CalPERS, but it's a
17 definitely a top-of-mind consideration. And I think it
18 does fall right in line with that, with constrained cost
19 growth, and again to advocate on any type of limits or any
20 type of cost shifting. So broadly, it's very much there.
21 I can speak more specifically to the point.
22 ACTING COMMITTEE MEMBER LOFASO: Appreciate it.
23 And I acknowledge all this is still pretty early.
24 Thank you, Madam Chair.
25 CHAIRPERSON MATHUR: Thank you.

1 Mr. Jelincic.
2 BOARD MEMBER JELINCIC: Yeah. I have three
3 points.
4 One, I want to thank Henry for his question and
5 staff for their answer. When they -- in the presentation,
6 they made a reference to the change in the language, but
7 didn't describe that it was changing it from the Board to
8 the System, which I thought was important to get out,
9 because there are a lot of people here who weren't here
10 yesterday who wouldn't know what we were talking about.
11 The second point is on 4c, I had a question - and
12 you put it to the end - but I would like to get to it
13 before we let the reps off the phone, since it relates to
14 that, so at -- but at the end of the item.
15 CHAIRPERSON MATHUR: Sure.
16 BOARD MEMBER JELINCIC: And the other question I
17 have is actually for our federal representatives. Given
18 that things are changing rapidly, if you were writing this
19 today rather than 3 weeks ago, are there any changes you
20 would have made?
21 LEGISLATIVE AFFAIRS DIVISION ASSISTANT CHIEF
22 ZEAGLER: I think -- are you directing the first part of
23 this question to the federal representatives or...
24 BOARD MEMBER JELINCIC: Actually, yeah, I was
25 directing to the federal rep, but I also would like to

1 hear your opinion, if...
2 CHAIRPERSON MATHUR: So why don't we -- why don't
3 we let Chris And Yvette take a first crack at that. And
4 then, if there's anything you want to add, we can come
5 back to you.
6 Did you hear that question?
7 MR. JENNINGS: Yes, I'm sorry. I did. And just
8 very briefly, I'd say that both as Mary Anne and Gretchen
9 have indicated, and has the question suggests, there is so
10 much movement going on on a literally daily basis on both
11 policy and analysis of that policy. And so with a greater
12 sense of information, as we've just received just
13 yesterday with the Congressional Budget Office analysis,
14 you know, we might be able to be a little bit more clear
15 or explicit on some of our analysis of how -- you know,
16 what -- for example, how we would evaluate very large
17 Medicaid cuts and potential for both impact on the State,
18 but also the employers, with -- and public employers
19 within the State that we care a lot about, as well as the
20 size of the coverage loss to maybe get a better sense of
21 what kind of impact that could potentially have on
22 shifting premiums upward in other sectors, including, of
23 course, the sector that CalPERS purchases its health care.
24 But I think large overall, the guidance still
25 remains the guidance. I think it still fairly accurately

1 portrays what our priorities are, which are flexibility to
2 administer CalPERS benefits and protections against cost
3 shifting. And I think those are the two overall charges
4 that we are utilizing as we evaluate any policy from any
5 corridor, Republican or Democrat.
6 And so I think it gives us the flexibility we
7 need. Although, Yvette, please correct or amend, if you
8 think you would suggest anything else.
9 MS. FONTENOT: No, I agree with that. I mean
10 we're continuously incorporating new information into the
11 overall strategy and the work with the groups. But
12 generally speaking, the guidelines persist in terms of
13 what the ultimate goals are for protecting CalPERS and
14 their employers.
15 CHAIRPERSON MATHUR: Okay.
16 BOARD MEMBER JELINCIC: Thank you.
17 CHAIRPERSON MATHUR: So -- so --
18 BOARD MEMBER JELINCIC: But did staff anything
19 they wanted to add?
20 CHAIRPERSON MATHUR: Oh, yes. Please, if you
21 have anything, Ms. Zeagler or Ms. Ashley to add.
22 LEGISLATIVE AFFAIRS DIVISION CHIEF ASHLEY: Yeah,
23 I would just like to add on to what Chris and Yvette said,
24 flexibility is the key. So while these priorities were
25 developed specifically for the 115th Congressional

1 session, we did make them broad enough to allow us to be
2 nimble and flexible as things changed, and as the
3 administration took shape.
4 CHAIRPERSON MATHUR: And I think that's where the
5 language on page 2 of the agenda item in the second
6 paragraph, do not -- that they do not bind the Board, and
7 I think we're -- we're -- we also would like -- I think
8 the Committee would also like to change that to CalPERS,
9 consistent with what the Investment Committee did in
10 considering or adopting a position. I think that
11 preserves the flexibility.
12 I had one question, and then Mr. Jelincic I'll
13 come back to you to -- so you can ask your question on 4c.
14 BOARD MEMBER JELINCIC: Sure. Fair enough.
15 COMMITTEE MEMBER MATHUR: And that is with
16 respect to the final priority, "Stabilize and Enhance
17 Public Agency and School Employer Participation". That
18 one is -- has the least explanation of what that means.
19 And I would appreciate a little bit more -- more around
20 that.
21 LEGISLATIVE AFFAIRS DIVISION ASSISTANT CHIEF
22 ZEAGLER: Absolutely. And that's constructive feedback.
23 Thank you. I think that it speaks to broadly our efforts
24 to align our advocacy with our national providers who all
25 have a voice in this. There are many, many voices out

1 there in Congress right now.
2 And it also speaks to our unique identifying
3 factor within the federal space. I think that it is
4 important, as a System, that we remind policymakers why
5 we're here, what the relevance is that we have in this
6 conversation. And that grounds us and uniquely identifies
7 us as well, as we're having these conversations with
8 folks. It gives a good perspective as to what our needs
9 are and what our purpose is with them.
10 CHAIRPERSON MATHUR: So how -- maybe I need an
11 example of how this translates into legislation or
12 regulation or what does that mean?
13 LEGISLATIVE AFFAIRS DIVISION ASSISTANT CHIEF
14 ZEAGLER: You know, I think that it's meant to be very
15 flexible. So in this case, when we're speaking with the
16 many voices that are out there, you know, we're starting
17 to hear a lot, even on, say opposition -- in general, just
18 opposition, right? And speaking to this generally can
19 determine our actions going forward. But what we want to
20 do is make sure that when we have conversations, when
21 we're having really relevant conversations, and after
22 we've gained some positive traction, and we're really
23 taking perhaps some oppose positions, we want to be
24 specific in why we're here and the conversation that we're
25 having, is that in the end -- our end goal is to enhance

1 that experience for our members, for the participation on
2 this level.
3 While we are the largest provider of public
4 health benefits, while on a State level, what's that
5 relevance to the federal level, because it enhances our
6 programs here. And it's a broad and very flexible bullet
7 point.
8 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
9 And Madam Chair, can I just add something to that
10 as well?
11 CHAIRPERSON MATHUR: Okay. Yes.
12 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
13 Two points. One is as we decide where we lean
14 in, when it comes to the federal, I think it's also
15 important that's always been one of our principles is
16 to -- things that need to stay at the federal level, stay
17 at the federal level, and allow us to focus on things
18 local. And so I think that that's in relation to the
19 spirit. And also when we were talking about as things
20 shift, they will impact public agencies, especially, you
21 know, we know how that works when it comes to -- you know,
22 when Medicaid and uninsured rates, so that -- if that gets
23 dispersed to our public agencies, that could potentially
24 impact their ability to be a participant in our system.
25 And so, we just have to be cognizant of all of

1 those effects. And I think that it's not just -- these
2 priorities are not just for the federal reps, but also for
3 the staff. And so we felt -- left them broad enough, so
4 that we -- these are priorities that we are working on on
5 a day-to-day basis.
6 CHAIRPERSON MATHUR: Okay. I think maybe it's
7 the participation word that is -- because it seems to me
8 like it's really about legislation that would allow public
9 agency member and school employers to enroll in CalPERS.
10 And I think that's not what you're getting at. You're
11 really getting at what might deter them from
12 participating, or be -- you know, in terms of the cost or
13 the benefit options that are allowable. Am I capturing
14 that correctly? Is that --
15 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
16 That is correct, Madam Chair.
17 CHAIRPERSON MATHUR: Okay. So I don't -- I don't
18 have an alternative suggestion for language. Maybe we
19 just leave it as it is and just sort of try to understand
20 what it means, but it -- it doesn't exactly tell me, I
21 think, what you just said.
22 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
23 Okay.
24 CHAIRPERSON MATHUR: All right. Any further
25 questions on this?

1 So this is an action item to approve the
2 priorities.
3 COMMITTEE MEMBER TAYLOR: So moved.
4 COMMITTEE MEMBER JONES: Second.
5 CHAIRPERSON MATHUR: Motion made by Taylor,
6 seconded by Jones.
7 Any discussion on the motion?
8 Seeing none.
9 All those in favor say aye?
10 (Ayes.)
11 CHAIRPERSON MATHUR: All opposed?
12 Motion passes.
13 Before we leave this item, I just want to come
14 back to Mr. Jelincic, since the -- so that we can let the
15 health federal representatives off the phone to come back
16 to 4c. So lets -- let's do that now. Oh, I'm sorry.
17 Yes, of course.
18 Go ahead, Mr. Jelincic.
19 BOARD MEMBER JELINCIC: In your monthly report on
20 page 3 of the report, 15 of the iPad -- although -- you
21 talk about CMS delaying Medicare bundled payment
22 regulations. Can you expand a little bit on that, and is
23 that a -- looking at your crystal ball, is that really an
24 intent to ultimately kill bundled payments?
25 MS. FONTENOT: Sure. I can take a shot at that

1 and then Chris you can add or correct.
2 The -- our understandings of the delay of the
3 regulation was initially prompted to come into compliance
4 with the Executive Order that the President had issued
5 that all regulations issued by the previous administration
6 that had not yet taken effect should be delayed for
7 further review.
8 It's -- over the past few weeks, it's become a
9 little clearer what the Secretary and UCMS Administrator's
10 view is of the kind of programs that were coming out of
11 the Center for Medicare and Medicaid Innovation, which I
12 would say is that they've -- given CMMI, and those
13 demonstrations, a -- sort of a lukewarm review, in the
14 sense that they've said they've been innovative in terms
15 of measuring quality, but that the role of the federal
16 government is not totally clear.
17 But Secretary Price has been very clear that he
18 is not going to be supportive of any nationwide and/or
19 mandatory quote unquote demonstrations that were coming
20 out of CMMI. So to the extent, for example, that the
21 joint and hip bundled payments was actually a nationwide
22 mandatory program, it's likely that we'll see a repeal of
23 that proposal.
24 However, the demonstrations that did not fall
25 under that bucket were more limited -- time limited and

1 geographically limited. We'll -- you know, it's not
2 totally clear yet, but we anticipate that they will move
3 forward and continue to sort of pursue delivery system
4 reforms. But we think there may be changes around the
5 margins in terms of how they pursue them versus how the
6 Obama Administration has pursued them.
7 BOARD MEMBER JELINCIC: Thank you.
8 MR. JENNINGS: And the only thing I would say to
9 supplement is -- and by the way, the CMS administrator
10 Seema Verma was confirmed just yesterday, and so we will
11 also be looking to see how her leadership impacts
12 day-to-day oversight and management of the delivery
13 reforms within the Department as well.
14 But as -- there's two sort of moving parts. One
15 is the Secretary's desire not -- and discomfort with
16 having a regulatory agency shift to a -- even a success on
17 a demonstration to a national level without additional
18 legislative authority, and there is some interest in the
19 Congress, as well as reasserting its authority on
20 authorizing national applications of demonstrative --
21 demonstration authority.
22 In terms of CalPERS, CalPERS is usually ahead of
23 the game in most of these activities. There continues to
24 be a great interest on Republican and Democratic
25 administrations in working collaboratively in developing

1 bundling or any other type of policy.
2 But I think the reason why we raised this is,
3 number 1 in that area, is that we feel it's important to
4 note that this is a point of transition, and we will need
5 to make certain that the CalPERS interests are well
6 served, whether it's a demo-type of approach, or an impact
7 on how national policy is done, whether that be
8 administrative or legislative.
9 BOARD MEMBER JELINCIC: Thank you.
10 CHAIRPERSON MATHUR: Okay. Thank you very much.
11 I see no further requests on this item.
12 So we're going to move on to Agenda Item number
13 7, the Federal Retirement Security Priorities.
14 LEGISLATIVE AFFAIRS DIVISION CHIEF ASHLEY: Hello
15 again. Mary Anne Ashley, CalPERS team member. We have
16 our federal retirement security representatives on the
17 line, Tom Lussier and Tony Roda. Tom and Tony, are you
18 there?
19 MR. RODA: Yes, here. Good morning.
20 MR. LUSSIER: Yes, we are.
21 CHAIRPERSON MATHUR: Good morning.
22 LEGISLATIVE AFFAIRS DIVISION CHIEF ASHLEY: Good
23 morning.
24 We are presenting Agenda Item 7, which is the
25 Federal Retirement Security Federal Priorities. It is an

1 action item and we are seeking approval of the recommended
2 Federal Retirement Security Priorities for the 115th
3 Congress.
4 I won't repeat the background that led up to this
5 agenda item, as it's the same background as that for
6 establishing the Federal Health Care Priorities.
7 Although, there is one difference that I'd like to note.
8 In February, the Board decided to dispense with the use of
9 the Legislative and Policy Engagement Guidelines for
10 Retirement Security in favor of relying on other
11 Board-approved documents, for example the CalPERS Pension
12 Beliefs.
13 And as noted previously in January, the Board
14 directed CalPERS team members to work with our federal
15 prior -- or excuse me, our federal representatives in
16 developing priorities for the 115th Congress.
17 And so we did work collaboratively with our
18 federal representatives and CalPERS team members. And the
19 recommended priorities are meant to be specific to this
20 given congressional session, the 115th Congress. And they
21 also are taking into consideration the new dynamics given
22 the new Trump administration.
23 And with that, Gretchen will review the
24 recommended priorities with you.
25 LEGISLATIVE AFFAIRS DIVISION ASSISTANT CHIEF

1 ZEAGLER: Thank you. And thank you again. I won't repeat
2 all of the introduction that led up to these particular
3 priorities. I would like to say that these priorities do
4 reflect the reality that it will be necessary for CalPERS
5 to select its policy targets very carefully and identify
6 areas where there might be opportunities to forge
7 bipartisan coalitions.
8 With that, our teams present for your approval --
9 or recommend for your approval the following priorities:
10 First is to advance retirement savings and
11 security for all employees. And under this, we would
12 evaluate the Windfall Elimination Provision, and
13 Government Pension Offset Reform Proposals, and, where
14 appropriate, develop strategies to actively engage in
15 efforts that alleviate any negative penalty implications
16 for CalPERS members. We would also advocate for proposals
17 and policies that would extend the Social Security
18 System's long-term solvency without reducing retirement
19 security for CalPERS members.
20 Second, we would ensure appropriate plan,
21 funding, and accountability. And under this, we would
22 advocate for transparent financial reporting using
23 industry-recognized accounting and actuarial standards.
24 We would also advocate against retirement benefit plan
25 changes that would result in an unfunded liability without

1 proper actuarial funding to address the liability.
2 Third, we would evaluate federal tax reform
3 proposals, and where appropriate, develop strategies to
4 engage with the administration and Congress.
5 Fourth, we would reasonably protect defined
6 benefit plans. Under this, we would advocate against
7 federal incentives or options to replace defined benefit
8 pension plans, and we would also advocate against federal
9 intervention and State and local pension plans.
10 Now, with that, we respectfully request your
11 approval of these priorities, as they are consistent with
12 all of our existing policies and priorities, the strategic
13 plan, Pension Beliefs, Investment Beliefs. And one last
14 note, that the same language appears again in this item
15 too.
16 CHAIRPERSON MATHUR: Well, I think, let's just
17 assume that it's direction of the Committee that we change
18 "Board" to "CalPERS" in all 3 sets of priorities.
19 Are -- is there any discussion by the Committee?
20 Any comments, any questions for our federal
21 representative or for our staff?
22 VICE CHAIRPERSON BILBREY: Move approval.
23 CHAIRPERSON MATHUR: Motion was made Mr. Bilbrey.
24 Is there a second?
25 ACTING COMMITTEE MEMBER JUAREZ: Second.

1 CHAIRPERSON MATHUR: Seconded by Mr. Juarez.
2 Any discussion on the motion?
3 Seeing none.
4 All those in favor say aye?
5 (Ayes.)
6 CHAIRPERSON MATHUR: All opposed?
7 Motion passes.
8 Well, I think that was a simple one. Thank you
9 very much, everyone, for your work on all of these
10 priorities.
11 Okay. We will now move on to Agenda Item -- to
12 the information agenda items, Agenda Item 8, 2017 to '22
13 Health Initiatives.
14 (Thereupon an overhead presentation was
15 presented as follows.)
16 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
17 Thank you, Madam Chair.
18 Presenting with me is Kathy Donneson, Chief of
19 the Health Plan Administration Division. And today's
20 information item is a look ahead strategically for the
21 next 5 years at the CalPERS Health Program. It will focus
22 on setting a new set of health care initiatives that we
23 believe will positively impact quality, access, and
24 affordable health care for our employees, members, and the
25 communities they live in.

1 As we move towards our future, it's important to
2 recognize all the success that CalPERS and the Pension and
3 Health Benefits Committee has already had to date.
4 --o0o--
5 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
6 And so today's agenda will highlight 3 things:
7 One, the CalPERS 2012-2017 21 health care
8 initiatives; two, it will provide insight on the team's
9 journey in evaluating on how CalPERS can influence and
10 also where we can drive positive outcomes in the health
11 marketplace; and then lastly, we want to unveil the 9 new
12 health care initiatives for 2017-22.
13 And so now, I'm going to turn the presentation
14 over to Kathy who's going to highlight all the successes
15 that we've seen over the past 5 years.
16 Kathy.
17 --o0o--
18 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
19 DONNESON: Thank you. Madam Chair, members of the
20 Committee, back in 2012, we set a very ambitious strategic
21 planning agenda, in which we designed and delivered upon
22 21 initiatives.
23 As I come to you today, I want to tell you the
24 status of each of those initiatives. By December 2015, we
25 had met and delivered on 18 of those initiatives. We had

1 three initiatives that we set aside for now that I'd like
2 to just -- to remind you of what we did.
3 For the spousal surcharge, that was an initiative
4 that we did not pursue in terms of this strategic plan,
5 because of the complexity at the employer level, both the
6 1,500 contracting agencies as well as CalPERS.
7 For the additional family tiers that we
8 considered, we did not continue to pursue that one due to
9 some system constraints related to enrollment and
10 eligibility systems.
11 And finally, for the expansion of the public
12 agency marketing, we wound down the 21 initiatives, not
13 necessarily abandoning this, but putting it on hold
14 pending identification of future resources outside of the
15 BP3 Branch.
16 Between 2012 and 2016, we brought you updates on
17 our progress, our successes, and our closure of each
18 initiative. And we believe that as a result of these 21
19 initiatives over the last 5 years, we have improved member
20 health, we have maintained and sustained affordability,
21 and we have decreased our costs.
22 We are strategically positioned now to move
23 forward to the next 5 years.
24 --o0o--
25 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:

1 Thank you, Kathy.
2 So over the past several months, the team has
3 developed a framework. And that framework included
4 evaluating the initiatives that we've already successfully
5 completed and operationalized, we confirmed that there
6 were still ongoing items that we could improve upon, and
7 we aligned those ideas with the CalPERS strategic plan.
8 And then obviously last, we established the 9 new
9 initiatives that we believe will provide the highest value
10 to CalPERS.
11 So let's take a quick look on what that journey
12 entailed.
13 --o0o--
14 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
15 So there is an info graphic that is in your
16 folders and also available on your iPad. And it's a
17 fairly comprehensive list of what the 5 years looked like.
18 But in respect of time, I'm going to just cover 3 of them.
19 So dependent eligibility and verification. We
20 removed 18,000 ineligible dependents, and provided savings
21 and cost claim avoidance of $122 million.
22 Value-based purchasing, which is the second
23 accomplishment, established a reference pricing model for
24 hip and knee replacement that generated a cost savings of
25 $5.5 million in a little over a year.

1 And then three, the Medicare Employer Group
2 Waiver resulted in better managed care. And that reduced
3 costs by $60 million by -- through subsidies.
4 So having health care affordability is one of our
5 6 goals for CalPERS.
6 --o0o--
7 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
8 So having health care affordability is one of our
9 6 goals for CalPERS. It signifies our continual
10 commitment to transform health care purchasing -- sorry, 5
11 goals, purchasing and delivery.
12 Of the -- under health care affordability, there
13 are 3 objectives. The first objective is to restructure
14 the benefit design; two is to improve the health status of
15 our members and the communities they live; and then three
16 is to reduce the overuse of ineffective or unnecessary
17 medical care.
18 --o0o--
19 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
20 The health care strategic members -- measures
21 listed in the CalPERS plan uses standardized State and
22 national benchmarks. We didn't want to reinvent the
23 wheel. We believe, such as reducing C-sections rates, and
24 reducing opioid use, is important across the country.
25 It's important to us. And while CalPERS does not directly

1 affect those numbers, the influence we have as the second
2 largest purchaser of health care services in the nation
3 allows us to move the dial on many of these medical
4 outcomes.
5 So how can we do that?
6 We can do that through legislation, contract
7 negotiations such as the 2018 rate negotiations are under
8 way right now, also the active participations in the
9 coalitions and the organizations that we discussed
10 earlier, such as the Integrated Health Association, and
11 the National Coalition of Healthcare Services.
12 --o0o--
13 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
14 So the 9 new initiatives are as follows:
15 We have 4 under restructuring benefit design, we
16 have 2 under improving health status, and we have 3 when
17 it comes to reduce overuse.
18 And I'm going to go have Kathy provide you a
19 little bit more detail on that. But before we do that, I
20 want to point out that this is a first step of a
21 multi-step process. So we wanted to share the goals and
22 initiatives with you today.
23 But between now and June, we will be working with
24 the Enterprise Strategic Planning Division to develop
25 action plans, which include success metrics and

1 measurements. And we will be bringing that back to this
2 Committee at a later date.
3 So, Kathy.
4 --o0o--
5 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
6 DONNESON: So we have 3 objectives and 9 initiatives. The
7 first one is to restructure benefit design. And under
8 that one we have 4 initiatives.
9 --o0o--
10 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
11 DONNESON: Value-based insurance design. We gave you a
12 very detailed presentation back in January at the
13 off-site. And as we went through looking at alternative
14 benefit designs in terms of structuring a VBID approach to
15 benefits, we looked at the timeline and found that maybe
16 we need to step back and look at feasibility first, and
17 make sure that we understand what it is that we want to
18 thoroughly vet and bring forward to you.
19 And so value-based insurance design, we will
20 spend the next year looking at the different approaches to
21 high-value, low-value care, and how to structure benefit
22 designs that allow us to get there.
23 Site of Care Management. This is something that
24 we did back in 2012 when we looked at the high cost of
25 outpatient hospital surgeries versus ambulatory surgery

1 centers. So we moved, under a reference pricing approach,
2 the arthroscopies, the retinal surgeon -- surgeries, and
3 the colonoscopies to the ambulatory surgery centers. And
4 our members responded by using those centers, which had
5 equal or better quality and patient safety.
6 We would like to continue looking at those
7 opportunities in other areas. And so this is our second
8 initiative.
9 For our third initiative, our PBM, our pharmacy
10 benefit management company, has proposed some pilots that
11 we may wish to explore. We do have to look at the
12 inflation that's happening in the generic market. And we
13 will come back as part of a broader strategy on dealing
14 with all of our pharmaceutical programs. We'll
15 beginning -- we'll begin reporting on our strategies in
16 April.
17 So I will come back and ask you to consider that
18 we have to worry about generic inflation. But we also
19 have a value-based contracting pilot that Optum brought
20 forward as part of the contract that we wish to explore.
21 And we'll bring back a little more information next month.
22 For reference pricing expansion, it was very
23 successful with hip and knee replacement surgeries. Later
24 on in the presentation, you're going to hear from Dr. Toby
25 where he talks about low back pain. Some of the things I

1 want you to think about as he goes through that
2 presentation is what is high value care for low back pain.
3 We spend a lot of money on musculoskeletal
4 disorders, and so we need to really look at what is high
5 value, what is low value. And that's a bit of a longer
6 term approach. So in the mean time, we also need to look
7 at the high cost of spines and spine pain, and think about
8 how we may approach a benefit design around a center of
9 excellence.
10 Those are the 4 initiatives. Lets move on.
11 --o0o--
12 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
13 DONNESON: On this one, we are looking at improving the
14 health status of our employees, our members, the families
15 and communities where they live. And there are 2
16 initiatives.
17 The first I'd like to discuss with you is
18 population health alignment, and the Let's Go Healthy
19 California Taskforce. In our last 5-year plan, we
20 developed a population health model. We spent the first
21 year developing the model within an integrated health care
22 management structure. The second year we reported in
23 December that we had developed a dashboard for how we look
24 at population health for the CalPERS members.
25 For this initiative, we would look at moving that

1 needle forward to look at the -- how we align to statewide
2 efforts, such as the Let's Go Healthy California
3 Taskforce.
4 I would like to say for this one we are going to
5 need data analytics. And we believe that we have the
6 capability through our current decision support systems to
7 support this approach.
8 --o0o--
9 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
10 DONNESON: The second one is a little more ambitious, I
11 think, because we're partnering with our health plans to
12 engage in community activities. And in population health,
13 there are social determinants of health that we may or may
14 not be able to directly manage. But indirectly perhaps
15 through our health plans, we can influence the broader
16 narrative around promoting and engaging health within our
17 communities.
18 --o0o--
19 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
20 DONNESON: The last objective is to reduce the overuse of
21 ineffective or unnecessary medical care. And under this
22 one, there are 3 initiatives. We're -- I'm particularly
23 pleased to talk about the SmartCare collaboration,
24 SmartCare California.
25 It started out as the Work Group on Reducing

1 Overuse in Health Care. It is a coalition between Covered
2 California, between the Department of Health Care
3 Services, and CalPERS. And for over 2 years we've been
4 working in collaboration to look at broader level policy
5 issues around C-sections, opiate use, and for CalPERS now
6 low back pain. Combined, our 3 organizations reach over
7 15 million lives in California.
8 The second of the 3 initiatives is to review and
9 update the shared savings account -- Accountable Care
10 Organizations. This is what we call our integrated health
11 care models. We wish to continue to look -- continue to
12 look at how we incent our providers to direct our members
13 to high value care, and to eschew low value care. We also
14 want to look at how we incent our members to have that
15 same objective.
16 And finally, none of this is going to be possible
17 without expanding and exploring evidence-based medicine.
18 Evidence-based medicine has to be the foundation upon
19 which we decide the benefit designs that we're going to
20 move forward to, as well as the other aspects of all 9
21 initiatives.
22 That concludes my part. Thank you.
23 --o0o--
24 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
25 So in closing, we believe that these 9 new

1 initiatives that Kathy just detailed will move the dial
2 when it comes to health care here at CalPERS. And we
3 believe it will enable us to provide affordable quality
4 health care to our members.
5 So this concludes our presentation, and we are
6 welcome to take any questions that you may have.
7 Thank you, Madam Chair.
8 CHAIRPERSON MATHUR: Thank you.
9 Any questions. I see Mr. Jones.
10 COMMITTEE MEMBER JONES: Yeah. Thank you, Madam
11 Chair.
12 Yeah, I would just like to know how you will
13 include the outreach to our stakeholders as you go through
14 these changes moving forward?
15 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
16 Excellent question, Mr. Jones. So one of the
17 things that we will be doing is we -- through our
18 stakeholder groups, we have monthly meetings with them.
19 We will be making sure that we provide information to
20 them, which would allow them to provide input. And we
21 have, up to this time, to establish health care
22 affordability and the objectives we have, the stakeholders
23 have been involved. So it's a journey.
24 It's just as we go between now and June, there
25 will be plenty of opportunities to interact with the

1 stakeholders, and make sure that they feel like they're a
2 part of the process, which this is all for them. So
3 that's one of the things we want to make sure that they
4 feel it's inclusive.
5 COMMITTEE MEMBER JONES: Okay. Thank you.
6 CHAIRPERSON MATHUR: Thank you.
7 Mr. Gillihan.
8 COMMITTEE MEMBER GILLIHAN: Thank you, Madam
9 Chair.
10 So I just had a few questions. Missing, I think,
11 in our path forward, at one point we were at least
12 discussing the possibility of providing members with
13 choice. And choice can include things low cost, high
14 deductible plans. And I didn't see anything in this
15 presentation, so I'm wondering, as a policy, has staff
16 moved away from that, because at one point we were talking
17 about that as an option? And I've got a couple more
18 points I want to make, and then I'll let -- turn it over
19 to you to respond.
20 I heard that tiering. We -- it was in the 21
21 objectives, but we stopped pursuing it because of system
22 limitations, but we think there's value in looking at
23 tiering structures. Our model today is fairly simplistic.
24 And is our system limitation still in effect or is that
25 something that we can now revisit, because technology has

1 advance, especially given our investment in our technology
2 systems?
3 And then things like spousal surcharges and
4 tobacco penalties for people that use tobacco. Again,
5 we're -- I think things on our list at one point, for one
6 reason or another, we moved away from. And so I don't
7 know if, in the case of spousal surcharges, if technology
8 has advanced to the point where it's something that should
9 be put back on the table for consideration.
10 But we think all options to reduce the escalating
11 costs of health care should be before us. And in our last
12 item, we talked about opposing, you know, the Cadillac Tax
13 as a policy initiative. Yet, that's a -- that was one of
14 the vehicles to pay for the Affordable Care Act.
15 And so we're talking about on one side -- on one
16 hand, we're talking about, you know, opposing a funding
17 mechanism, and on the other hand, I don't know that we're
18 being aggressive enough at looking at ways to bring costs
19 down for us, that, in some ways, would have otherwise been
20 funded by that tax.
21 Thank you.
22 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
23 DONNESON: Thank you, Mr. Gillihan.
24 The high deductible plan, or just deductibles in
25 general, will continue to be part of the VBID feasibility

1 study, because that will be benefit design and cost share,
2 not just benefit design.
3 So as we move forward looking at value based
4 insurance design, and what is feasible or not feasible, we
5 will also be looking at cost share, and how cost share can
6 be used as an incentive to move our members to value based
7 providers. We did propose that it be through our PPO,
8 where there is not the managed care arrangements that
9 exist in the same way as they do in the HMO.
10 So we talked about how if we had a member who
11 attributed to a primary care physician and was directed by
12 that physician to the higher value care, there would be an
13 incentive in terms of cost share. If they did not, there
14 would be an alternative incentive in terms of cost share.
15 In terms of the other 3 that we -- or at least
16 the 2 of the 3 that we just could not pursue at the time,
17 the tiered families, we certainly could look at that
18 again. The eligibility enrollment system is just not a
19 my|CalPERS system, it also extends to the employer's
20 system design, and the employers, including our own
21 payroll office. So again, we can revisit where we are
22 today technologically versus where we were back in 2012.
23 Your point is well taken on the spousal
24 surcharges. One of the constraints to spousal surcharges
25 related to the individual employers having to manage their

1 benefit office -- offices, in terms of knowing who had
2 overlapping coverage. So that was the reason really for
3 the spousal surcharge. It doesn't mean it's not important
4 or it can't be revisited. But in the context of the
5 number of initiatives that we wish to accomplish,
6 including bringing our premiums down to a low single
7 digit, that's kind of where we were and where we are
8 today.
9 COMMITTEE MEMBER GILLIHAN: So Madam Chair, I
10 would just ask that we keep these options on the table as
11 we move forward, and that we don't sort of dismiss things
12 prematurely, as we all work together to try and rein these
13 escalating costs in.
14 CHAIRPERSON MATHUR: Thank you. So perhaps we
15 ought to -- well, I think perhaps we ought to bring back
16 an assessment on the tiering, on sort of what are the
17 barriers, and what might be a cost estimate for overcoming
18 them, or maybe not just cost, but also what would -- what
19 would it take to overcome those barriers and so -- and
20 what is the cost-benefit analysis? Because it might -- it
21 potentially could be more costly than the benefit that
22 would accrue.
23 On the spousal surcharge, is that something that
24 employers can implement on their own? Do they really even
25 need CalPERS to be involved?

1 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
2 DONNESON: I think that's a good question that I would
3 like the opportunity to take away and explore with our
4 Legal Office.
5 CHAIRPERSON MATHUR: Okay. I think that might
6 be -- that might be a simpler way of achieving it, is not
7 having it be administered by CalPERS necessarily, but, you
8 know, perhaps sharing information with employers that that
9 is something they could pursue.
10 I had one comment and that is that there seems to
11 be some -- a little bit of overlap between some of these
12 initiatives, which perhaps is by design sort of all
13 converging around value, and reference pricing, and
14 evidence, and incorporating that into better -- to achieve
15 better care and better outcomes for our members. So it
16 seems to be sort of thematic throughout the different
17 initiatives, but I think that's appropriate.
18 So thank you.
19 And -- oh, Mr. Jelincic. Sorry.
20 BOARD MEMBER JELINCIC: Thank you. If we're
21 going to do systems work to do some of those things, I
22 would actually encourage us to do the systems work to
23 create combo plans as an option before we do systems work
24 to charge members more.
25 But my question goes back to slide 3, the

1 expansion of the public agency marketing. The slide says
2 that we're not pursuing it. What I heard you say was,
3 well, we're looking for the resources elsewhere, but I've
4 also been told that it is actually going on in Donna Lum's
5 area. And those three may not be contradictory, but they
6 don't seem terribly consistent. So I was wondering if you
7 could expand?
8 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
9 DONNESON: We went back and did a little more research on
10 what happened to expanding marketing to contracting
11 agencies. And it was an initiative that was a
12 collaborative between what, at the time, was the Health
13 Branch and the Customer Support Service area in the
14 organizational state it was in at the time.
15 So it was a collaborative between health and
16 public agency health marketing that -- on the public
17 agency health marketing, again, there -- it's not that the
18 work stopped, it's that there was some activity going on
19 over there in which they -- they picked it up more than
20 health, because that's where it resides. So while we have
21 supported always public health marketing, we did not in
22 health lead this initiative.
23 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
24 And, Mr. Jelincic, if I could just add on to
25 that. So the -- Donna Lum's area has done a lot in this

1 marketing related -- in operations, her and her team has
2 done quite a bit. They just haven't made it a strategic
3 initiative. So I want to at least commend them for the
4 work that they have done. They are doing a lot from a
5 day-to-day perspective, but it hasn't been raised to the
6 strategic level as of yet.
7 BOARD MEMBER JELINCIC: Okay. So we're not
8 pursuing it in health, but we are pursuing, expanding the
9 public agency participation.
10 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
11 That is correct.
12 BOARD MEMBER JELINCIC: Okay. Thank you.
13 CHAIRPERSON MATHUR: I think, at some point, it
14 might be worth having an agenda item on marketing and sort
15 of what is -- you know, we do it, and it's something we
16 have done for ever since I've been here for quite a long
17 time. But what is the value of getting new employers in?
18 Are all new employers of equal -- do they all contribute
19 equally to the pool that we have created at CalPERS?
20 What -- how -- how do we target our marketing?
21 So it might be worth sort of reviewing for the
22 Committee sort of how we think about marketing and the
23 value it adds to CalPERS and to our existing pool of
24 members. I don't think it's an urgent item, but maybe we
25 can talk about when would be appropriate to do that, and

1 then the strategies also that we employ, of course.
2 Okay. I see no further requests on this item.
3 Thank you very much for the overview.
4 Let's move on to Agenda Item number 9, the
5 Statewide Collaboration Through SmartCare California.
6 So we did start at 9:00 o'clock. I think
7 that's -- we still have enough time to go through this
8 item, don't you think, before taking a break?
9 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
10 Yes.
11 CHAIRPERSON MATHUR: Okay. Great.
12 (Thereupon an overhead presentation was
13 presented as follows.)
14 CHAIRPERSON MATHUR: Good morning. Welcome.
15 Can we turn --
16 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
17 DONNESON: While we try to deal with our technical
18 difficulties here, which means I probably wasn't pointing
19 at the screen properly, we're here to talk about the
20 statewide collaboration that we have through SmartCare
21 California, a coalition with Covered California, and with
22 Department of Health Care Services.
23 And we've asked Dr. Tobias Moeller-Bertram --
24 DR. MOELLER-BERTRAM: Toby is fine.
25 HEALTH PLAN ADMINISTRATION DIVISION CHIEF

1 DONNESON: -- which he calls himself Dr. Toby, to come in
2 and talk to you about low back pain. But before I
3 introduce formally Dr. Toby, I would like to tell you a
4 little bit about what our history is with -- financially
5 with back pain, in general, and medical diagnoses coding
6 for muscle, bones, and joints, which is our -- what is our
7 leading cost driver for what we pay for health care
8 through our premiums.
9 --o0o--
10 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
11 DONNESON: So it's our musculoskeletal disorders, as we
12 have talked about all the way back to 2009. It's what we
13 spend the most -- the bulk of our money on in terms of
14 care.
15 And so if you look at the -- so today, we're
16 going to talk about -- a little bit about the background.
17 Dr. Toby is going to give you the presentation, and then
18 we'll talk about some next steps.
19 --o0o--
20 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
21 DONNESON: So it's the leading cause of disability
22 worldwide, and it accounts worldwide -- or in the U.S. for
23 $90 billion, but most importantly what it accounts for at
24 CalPERS -- this is low back pain only. Now, it includes
25 surgeries. It includes non-invasive procedures. It

1 includes pharmaceuticals, but still $106 million just for
2 low back pain.
3 And through SmartCare California, we, CalPERS, is
4 engaged as a leader in looking at how we approach as a
5 State the costs associated with low back pain. We can --
6 we will collectively look at our own costs, but also more
7 Bradley look at how do we measure low back pain, how do we
8 set a benchmark, and how do we know if the effort, such as
9 Dr. Toby is going to talk to you about, are actually
10 improving our position.
11 So I would like to now introduce Dr. Toby, who's
12 to my left, and Dr. Rich Sun, our CalPERS physician. And
13 before I ask Dr. Toby to proceed with his presentation, I
14 want to give you a little bit of background on him.
15 He was educated in Hamburg, Germany, where he got
16 his physician's degree. And then he went to San Diego to
17 do his clinical training, and had an Assistant
18 Professorship appointee.
19 He's in private practice, but he's also double
20 board certified in anesthesiology and pain management.
21 Particularly, dear to my heart, is Dr. Toby supports the
22 Veterans Administration through the University of
23 California at San Diego, and he also has worked with the
24 University of California at San Francisco which ranks
25 among the best in pain departments.

1 He joined the VA San Diego Health Care System and
2 established pain clinic. And there he served the veterans
3 population, especially for those members suffering with
4 post traumatic stress disorder and fibromyalgia.
5 He now brings all of his experience to the Desert
6 Clinic Pain and Wellness Group. And we're very pleased to
7 have him here. He is excited to serve his patients in the
8 Coachella Valley. And I'd like to now turn it over to Dr.
9 Toby.
10 CHAIRPERSON MATHUR: Well, welcome Dr. Toby.
11 DR. MOELLER-BERTRAM: Thank you so much.
12 Thank you, Madam Chair, and thank you, members,
13 for the opportunity to present on center of excellence
14 model.
15 --o0o--
16 DR. MOELLER-BERTRAM: What I'm going to go over
17 in the next 20 minutes or so with you is going to be 3
18 main topics. The first one, I want to go over why we
19 choose to treat the patients with chronic low back pain
20 the way that we do it. The second part is going to be how
21 did we take the theoretical background and implemented
22 that into a system that we can deliver care through. And
23 the last part is going to be looking at some outcome data,
24 both clinical outcomes as well as cost savings.
25 The whole concept of our treatment model in the

1 center of excellence is based around the understanding
2 that chronic low back pain is really a whole patient
3 problem. And when one aims to achieve meaningful and
4 sustainable improvements, the treatment requires a whole
5 patient solution.
6 It is intuitive and also fairly simple to
7 understand if one realizes that the human being is a very
8 complex system, and that all sensory information is not
9 processed in isolation, but always processed in relation
10 to the environment and the overall State of the being.
11 --o0o--
12 DR. MOELLER-BERTRAM: And I want to explain that
13 concept a little further when you look at these squares.
14 Let's focus on the square on the left. What you see there
15 is a gray rectangle. And if I were to ask you to give me
16 a grayness rating of this sensory information that you're
17 getting right now on a scale of from 0 to 10, most of you
18 probably would struggle to give me a number, because
19 humans are bad in giving absolute value to a sensory
20 information looked at in isolation.
21 But if you look at the upper right corner, for
22 example, and you look at the grayness of this rectangle in
23 relationship to the surroundings, one could say, well, in
24 relation to this dark environment, the gray looks pretty
25 bright, and you may give me like a low intensity rating of

1 or a 2.

And if you look at the lower one, you may say in relationship to the brighter background, the gray looks fairly dark, and you may give me a higher intensity rating.

Now, obviously, all 3 of these rectangles that we are looking at have the same shade of gray. But the same shade of gray is perceived as different intensities based on the background. And the same is true when we look at the chronic low back pain patients when they rate the intensity of their pain experience to us. It is the result of the integration of the sensory information and the patient's overall circumstances in life.

So if I, as a practitioner, only focus on the pain sensation and I'm trying to treat patients with low back pain focusing on the pain generator in their back, I'm only treating one part of the patient's pain experience.

In order for me to achieve a appropriate results, I have to look at the patient as a whole, and also look at the circumstances in which the patient is integrating this sensory information

--o0o--

DR. MOELLER-BERTRAM: So it's not a surprise that if you look at the International Association for the Study

1 of Pain's definition of pain, that the whole concept is
2 reflected here too. Pain is defined as an unpleasant
3 sensory and emotional experience which is associated with
4 actual or potential tissue damage or described in terms of
5 such damage.
6 And the last part I want to focus on right know,
7 so you will have a subset of chronic low back pain
8 patients that are describing their pain experience in
9 terms of the damage of their low back, but the pain
10 generator is not even in their low back to be found.
11 --o0o--
12 DR. MOELLER-BERTRAM: And there is good evidence
13 in the research behind that now. And don't worry, I'm
14 going to walk you through this -- this slide here real
15 quick. The concept is fairly easy.
16 This group of researchers took a cohort of
17 patients with acute back pain and just followed them over
18 the course of one year, and then separated them into the
19 patients that recovered, did not go into developing
20 chronic pain, which is shown in the lower end, and the
21 second group, which went ahead and developed chronic pain.
22 And at each visit - they had them come in 4 times
23 over the course of the year - they not only rated their
24 pain, they also did a functional MRI scan to look what's
25 going on in their brain. And starting with the recovered

1 area, you can see there that on the initial picture you
2 see a lot of activity in the areas that represent the
3 activity of acute back pain.
4 So this is the acute pain center so to speak.
5 And then over the course of the time, the activity goes
6 down and completely disappears totally, reflected recovery
7 from pain and the patient's pain ratings went down too.
8 Now, the interesting part is the group in the --
9 reflected on the upper panel. These are the patients that
10 went on and developed chronic low back pain. And here,
11 you also see that in the initial picture it looks pretty
12 much the same on visit one. You also have a lot of
13 activity in the centers that process the acute pain.
14 And now the interest part is if you look at those
15 2 areas, they also reduce over time. By visit 4, there's
16 no activity in the areas that process the pain information
17 coming from the low back. But what you realize there is
18 that you have a lot of activity in areas that you don't
19 see in the recovered group. And these areas represent
20 areas of memory information.
21 So it's a very good piece of evidence that shows
22 that for a subgroup of our low back pain patients, their
23 pain is maintained, not from acute input from their back
24 anymore, but from a pain memory that was formed.
25 But if you were to ask these patients to describe

1 their pain, they will use the same descriptors and values
2 then on the first visit. So for us as practitioners, it's
3 very difficult to make this distinction
4 --o0o--
5 DR. MOELLER-BERTRAM: So based on all of these
6 reviews, the idea is we have to treat the whole patient,
7 but what's the best way of doing that.
8 And posing a question like that is like posing
9 the question what is the best recipe to prepare a turkey
10 dinner. There's many, many different ways of doing that.
11 And if you look at the literature, there's some treatment
12 models that are very short, and use only very inexpensive
13 ingredients. And there's other models that are very long,
14 and they use a little more expensive ingredients.
15 So when we put the plan together with IEHP,
16 particularly for the Medicaid population, we first looked
17 at our population and then we looked at the literature.
18 And over the next few slides, I just want to highlight a
19 key concept that we based our treatment model on.
20 --o0o--
21 DR. MOELLER-BERTRAM: This is a very good review
22 article published on interdisciplinary pain management.
23 And I'm just going to quote from this article.
24 "Historically, management of patient's pain was addressed
25 by individual health scare providers, usually a physician.

1 However, the presence of pain affects all aspects of an
2 individual's functioning. As a consequence, an
3 interdisciplinary approach that incorporates the knowledge
4 and skills of a number of health care providers is
5 essential for successful treatment and patient
6 management".
7 --o0o--
8 DR. MOELLER-BERTRAM: Further from this article,
9 "Interdisciplinary care involves the execution of the
10 treatment planned concurrently. That is, disciplines
11 involved in care will be engaged in parallel and in
12 collaboration and not sequentially whenever possible".
13 This is in sharp contrast to how health care is
14 delivered right now where the patient has to go to the
15 different compartmentalized treatment opportunities.
16 Moving on, "The availability of interdisciplinary
17 care is not solely the responsibility of team members or
18 all stakeholders (institutions, people with pain,
19 referring clinicians and payers) need to support,
20 encourage, and demand a comprehensive approach to pain
21 management, as it is in all of their best interests".
22 --o0o--
23 DR. MOELLER-BERTRAM: These interests are also
24 reflected by the next quote. This is from the Center of
25 Disease Control recent guidelines on the opioid use

1 disorder. And I'm quoting again. "Although, there's
2 perceptions that opioid therapy for chronic pain is less
3 expensive than more time-intensive non-pharmacological
4 management approaches, many pain treatments are associated
5 with lower mean and median annual costs compared with
6 opioid therapy".
7 Further on, "Multi-modal therapies and
8 multi-disciplinary bio-psycho-social rehabilitation
9 combining approaches, like psychological therapies and
10 exercise, can reduce long-term pain and disability
11 compared with usual care, and compared with physical
12 treatments like exercize alone".
13 --o0o--
14 DR. MOELLER-BERTRAM: So based on that, we put a
15 treatment team together where we combined all modalities
16 that are beneficial for patients with chronic low back
17 pain. And although the team treats the patients together,
18 for logistic reasons we divide it into 4 different
19 departments. You can see it in blue, we have a medical
20 department where we have the doctors, physicians
21 assistants, nurse practitioners, and interventional pain
22 specialists.
23 And they work closely with the behavior
24 department where we have psychiatrists, psychologists,
25 cognitive behavior specialists, and we also added social

1 workers, and family and marriage counselors. The physical
2 reconditioning department we have chiropractors, physical
3 therapists, fitness instructors, yoga, and tai chi. The
4 idea here was that most of the patient population that we
5 are serving is so deconditioned, that regular physical
6 therapy using the exercise machines is simply not doable
7 for them. So we have to take a more passive approach.
8 And sometimes we -- even if we start only with energy
9 work, like Reiki, to get more engaged into the bodies
10 again, and then slowly build them up to the point where
11 they can engage more.
12 And then we obviously also have the alternative
13 care, which plays a major role in our program. We have
14 naturopathic doctors, acupuncturists, Chinese medicine
15 that use, and dietitians.
16 --o0o--
17 DR. MOELLER-BERTRAM: So this is the service that
18 we offer. How do we offer that? The whole program is a
19 1-year program. And although it's a 1-year program, we
20 have subdivided it in 3 different phases, because the
21 emphasis on what we want to achieve with the patient is
22 different in all 3 of those phases.
23 The first one we call the rescue phase. That's
24 the first month of the program, where we basically meet
25 the patients where they are. The main goal in the first

1 month is to engage the patients. These are Medicaid
2 populations that usually don't have a lot of own reasons
3 or motivations to participate in a 1-year long treatment
4 plan. So we've really got to engage the patients. We've
5 got to meet them where they are, but we also have to
6 stabilize them. This is where we say it's our time to put
7 out the fires and really get the patients in a position
8 that they're stable enough to maintain the program.
9 We then move into the -- what we call the
10 restoration phase. That's month 2 to month 6. During
11 that time, based on the patient's individual needs that we
12 found in the first phase, we have a treatment algorithm
13 were we combined the different modalities that I just
14 outlined in the most meaningful way for the patients.
15 They get reassessed on a regular basis, and the treatment
16 plan is then adjusted based on their progress throughout
17 the program.
18 And then the last phase, which is the last 6
19 months of their treatment, it's the reentry phase. This
20 is where we, literally speaking, take the trainings wheel
21 -- training wheels off and let the patients take over more
22 responsibility of their care.
23 Still, obviously, help them out as much as we
24 can, but also try to reintegrate them into their
25 communities, and make community resources available for

1 them to help them, landing pat, so to speak, when they
2 graduate from the program.
3 --o0o--
4 DR. MOELLER-BERTRAM: This slide I wanted to
5 present because the treatment philosophy that we use in
6 our Center of Excellence is fairly different to what is
7 typically used. In the upper-left corner, if you look
8 there, typically treatment were chosen based on the
9 diagnosis. If you come and see me as a pain doctor and
10 you have low back pain, my book would tell me which kinds
11 of treatment to give for low back pain patients. If you
12 came with headaches or arthritis, the treatment would be
13 based on the diagnosis that you come with.
14 Now, the medical community moved away from that
15 approach over the last couple of decades and looked more
16 at their mechanistic-based approach, where, for example,
17 if you have neuropathic pain, which is pain in the nerves,
18 it doesn't really matter if the nerve is damaged from
19 diabetes and high blood sugar, or if the nerve is damaged
20 from a virus, like and HIV virus. The mechanism is nerve
21 damage, so let's treat the mechanism.
22 Now that we -- what we are trying to do is we
23 don't focus on the patient's diagnosis, and we don't focus
24 on the mechanism. We focus on the patient. We really ask
25 what is the suffering -- the primary suffering for the

1 patient?

2 Is it more the emotional problems, is it more the

3 physical one, or is it really a mixed picture? And based

4 on this rating system that we developed, we then -- our

5 algorithm then predict the best combination of the

6 treatments to get the patients better.

7 --o0o--

8 DR. MOELLER-BERTRAM: This is just a snapshot.

9 You can imagine at this point we're talking about several

10 hundreds of patients having a lot of different modalities

11 to them, so we have thousands of patient contacts in a

12 week. And organizing all of those, documenting all of

13 that, and billing for all of that poses a challenge.

14 So one solution that we developed for that, which

15 is in beta testing right now, is that we developed an app

16 that every patient can download on the smartphones. And

17 this app provides them with their treatment schedule.

18 They can also look at past treatments done. They can look

19 at opening in schedule, so if a patient particularly

20 benefits from a certain treatment, has a crisis, he or she

21 can look up on our app if there is an opening for that

22 service that they are requiring in a clinic close to them,

23 and they can put themselves on the schedule.

24 And lastly, we're starting to implement using an

25 electronic ID card with a unique bar code, so it's very

1 easy. The patients can scan themselves in and out. It's
2 easy to document their walk through the program.
3 --o0o--
4 DR. MOELLER-BERTRAM: Now, moving to the last
5 part to the outcome measures. We looked at our cohort,
6 and although we are a Center of Excellence for complex
7 patients with pain in general, not surprisingly, close to
8 90 percent of the patients that we've cared for so much
9 have either low back pain as their primary or one of their
10 diagnoses.
11 We also serve a fairly complex patient population
12 reflected in the fact that about 60 percent of our low
13 back pain patients have at least 5 different pain
14 diagnoses. And you can also see that reflected in the
15 fact that more than half of them have actually a comorbid
16 behavior diagnosis, which is typically depression, anxiety
17 disorder, or stress disorder.
18 --o0o--
19 DR. MOELLER-BERTRAM: Now, I've very proud to
20 show some of the clinical outcomes that we have.
21 Although, we have hundreds of patients that we have in the
22 system where we collect data on, we only have a subset of
23 them already at the 6-month mark. So this is the
24 representation that you should look at the slide right
25 now.

1 And we've separated physical and emotional
2 outcomes. What you're looking at here are physical
3 outcomes. We have chosen the outcome measurement to it in
4 collaboration with IEHP, which basically reflect the gold
5 standard right now, because we wanted to have our program
6 be comparable to other treatments in the medical
7 literature using the same outcome measures.
8 And you can see that for the physical outcomes,
9 across the board the patients improve. For the numeric
10 pain rating scale, and the pain intensity interference
11 scale, we see a nice reduction in the numbers, some of
12 them even significant. And also with the disability of
13 the patients, we're using the Oswestry Low Back Pain
14 Disability Questionnaire, as well as the Pain Disability
15 Index, both of them significant improvements after 6
16 months in the program.
17 Looking at the emotional outcomes, here we're
18 looking at pain catastrophizing, the PHQ-9 is the measure
19 for depression. We have a general anxiety measure, and
20 patient global impression of change.
21 Again, to summarize these, nice, mostly
22 significant, improvements of the patient's emotional
23 well-being and the patient global impression of change in
24 the lower right corner, reflects the patient's really
25 actively engaged in the program and like the program.

1 High impression of change ratings.
2 --o0o--
3 DR. MOELLER-BERTRAM: We also looked at clinical
4 outcomes for substance use. And here again, the same
5 trend, nice reduction in problems through the program at
6 6-month mark.
7 --o0o--
8 DR. MOELLER-BERTRAM: Now the next and final set
9 of data was made available to us by the Inland Empire. So
10 we collected the clinical part of the outcomes. The
11 Inland Empire was looking at the cost and health care
12 utilization and cost analysis.
13 The first slide here shows you that over the
14 course of the treatment, we had more in our cohort
15 decreased the likelihood of going into high-cost patient
16 category, than not.
17 --o0o--
18 DR. MOELLER-BERTRAM: The next slide is -- well,
19 I was very pleased with the finding. The health plan
20 looked at their average cost for the patient members
21 before our treatment and after our treatment. And you can
22 see that the intervention reflected a nice reduction in
23 overall costs for the patients -- for the patient and the
24 members.
25 --o0o--

1 DR. MOELLER-BERTRAM: Now, I want to end with the
2 eye to the future, so to speak. The Inland Empire's
3 approach to scaling the program now is their vision is,
4 and, you know, lining up with our vision that all members
5 should have -- that are utilizing high levels of opioids
6 suffering from severe pain refractory to other
7 interventions should have access to this integrative and
8 wholistic treatment program. And the way that we want to
9 do that is to develop a network of Center of Excellences
10 in the IEHP network based on our model.
11 --o0o--
12 DR. MOELLER-BERTRAM: So we sat down with IEHP
13 leadership. And you can see in the right lower corner,
14 that's the Coachella Valley. And we have locations there.
15 The rest is the Inland Empire, and they provide us with
16 data on their need. The darker the area, the higher the
17 need for pain care. And we then together pick areas where
18 we want to put the next Center of Excellence. And just
19 from the time I submitted these slides to today, we
20 already have opened another one in the lower Hemet,
21 Temecula area. And we have 2 more that we hope to open in
22 the next 90 days.
23 So this is -- the expansion and the scaling is
24 something that we basically do in collaboration with IEHP
25 just going where the need is.

1 --o0o--
2 DR. MOELLER-BERTRAM: Obviously, we want to
3 continue to look at what we are doing. It makes sense not
4 only for the patients, but also for the health plan. So
5 we have an ongoing program where we look at return on
6 investment. They look at total medical costs, pharmacy,
7 facility, and professional costs. They do utilization
8 analysis. They look at the emergency room and
9 hospitalization data of the patient population. And we
10 continued to look at the patients' outcomes, pain levels,
11 disability, and then the emotional measures. And
12 obviously, we also track how often the patients show up
13 and active they're actually participating in the program.
14 So the member engagement and number of encounters that we
15 have with them is something we look for, too.
16 --o0o--
17 DR. MOELLER-BERTRAM: And I'm going to finish
18 with the lesson learned slide. This is -- you know, we
19 started the program about 2 and a half years ago. Really
20 had everything hammered out over the last year, I would
21 say. And the engagement of the patient is very, very
22 important. Most of the multi-disciplinary programs that
23 you read about, they exist in environment like Mayo Clinic
24 or Harvard. And you have highly motivated patients that
25 pay a lot of money to participate in that. So it's a

1 completely different level going into this,
2 engagement-wise, than having a Medi-Cal population and
3 trying to commit -- you know, have them to commit to a
4 1-year program, where actually somebody is looking at what
5 they're eating, and make sure that they actually exercise.
6 So the engagement is very, very important.
7 And the implementation of transitional support is
8 important, because once you're done with the program, you
9 can't just drop the patients.
10 Third point, coordination of care between all
11 treating providers is essential. Our solution to that was
12 is I have everything in-house. I have one program, which
13 is shown to be the most beneficial way of doing that.
14 Trying to set something up with remote clinics is close to
15 impossible.
16 And the staff obviously, both clinical and
17 non-clinical, have to treated -- sorry have to be trained.
18 So what we developed just to be able to scale, we have our
19 own training program. We have our own training website,
20 so everyone that is working in our clinics undergoes the
21 special training, because this concept that we developed
22 is fairly unique compared to currently -- the current
23 standard.
24 And the last thing, the linkage and coordination
25 with carve out services and the community services is

1 essential for the Inland Empire.
2 --o0o--
3 DR. MOELLER-BERTRAM: So with that, I'm going to
4 conclude. Thank you for your attention. And I think the
5 take-home message here might be that it's really important
6 for us to refocus the patients on the basics. And the way
7 that I like to state it to my patients, and I'm going to
8 finish with this, it is very hard, if not impossible, for
9 me as a physician to out-treat their life choices.
10 So this is something that I can't do for them,
11 only with them.
12 Thanks a lot.
13 CHAIRPERSON MATHUR: Well, thank you so much for
14 that very interesting overview of how you approach back
15 pain care.
16 Did you want to say anything before I turn it
17 over to questions?
18 --o0o--
19 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
20 DONNESON: So the question is what are our next steps?
21 As we move forward through the 5-year strategic
22 plan, we need to really work at what is high value, low
23 value care. I told you that $106 million were spent on
24 low back pain alone in 2015. The evidence shows that
25 invasive surgery may not be the best approach to managing

1 back pain.
2 There are several reasons for back pain, and Dr.
3 Toby knows much more than I do. But in an acute back
4 pain, that is the point at which an injury may have
5 occurred that doesn't necessarily mean that they need to
6 either go straight to surgery, straight to an orthopedist.
7 Actually, what the evidence shows is exercise, some pain
8 management through non-steroidal antiinflammatories, like
9 ibuprofen, are effective. Perhaps a visit to the physical
10 therapist is more in line than even to primary care.
11 So the reason that we have brought this
12 presentation to you today is because as we go through
13 looking at high value, low value care, we also look at
14 what we're spending our money on. And maybe, as part of
15 the benefit design, how do we direct our members to higher
16 value lower cost care?
17 So the other point I wish to make before turning
18 it over to questions is that periodically we will come
19 back to you to look at some of our high cost conditions,
20 and what the evidence shows in terms of what is high value
21 care versus low value care. So that's why we're here
22 today, not just to speak to our participation in
23 SmartCare, but the broader issues.
24 Thank you.
25 CHAIRPERSON MATHUR: Thank you very much.

1 I just want to ask the court reporter, it's --
2 we're at 2 hours. Can we go a little bit.
3 THE COURT REPORTER: (Nods head.)
4 CHAIRPERSON MATHUR: Okay. Thank you.
5 Mr. Jelincic.
6 BOARD MEMBER JELINCIC: Yeah. If I can go back
7 to slide 20, it seems to me that you make a lot of
8 progress in one, and then it pops up in 3. And if I'm
9 reading it right, it looks like it's statistically
10 significant. What is it about the third month that is
11 leading to the regression in emotional outcomes?
12 DR. MOELLER-BERTRAM: It's a very good question.
13 It is one that we actually -- actively looking into too.
14 We have different theories. My main interpretation
15 currently is that this is about the time frame where the
16 patients start to engage and get active again. So in the
17 first month, as I laid out, we take them by the hand.
18 It's really -- they lay down nice music, chiropractic
19 adjustment. It's really a lot of what we do to them.
20 And then they start to realize I want to change.
21 They kind of get hope again, and they start to actively
22 engage. And then by months 2 or 3, they may have picked
23 up the phone and called -- you know, reached out to family
24 again. They may have started to interact with the
25 neighbors that they didn't really like, and they might --

1 may have started to go for walks again.
2 So although you can see that the patient global
3 impression of change track continues to go up, so the
4 patient feel like their life is getting better. On the
5 specific measures of their maybe depression, or their
6 anxiety, or their pain ratings, we actually see this
7 little dip, which I believe is a reflection of the
8 patient's engagement.
9 BOARD MEMBER JELINCIC: So you really think it's
10 about that point where they realize this is work?
11 DR. MOELLER-BERTRAM: Yeah.
12 BOARD MEMBER JELINCIC: Okay. Thank you.
13 CHAIRPERSON MATHUR: Thank you.
14 Mr. Lind.
15 BOARD MEMBER LIND: Thank you. A question for
16 Dr. Toby. Very comprehensive presentation. And you
17 talked about some of the alternative medicines, Reiki and
18 Chinese medicines, and so on. You didn't mention
19 medicinal cannabis. And I was wondering about your
20 thoughts on that, and particularly as a sort of a
21 transition treatment to help get people off of the
22 opioids?
23 DR. MOELLER-BERTRAM: Yeah. I'm happy to comment
24 on that. A lot of the research that support the medical
25 use of medicinal marijuana came actually out of UCSD and

1 Dr. Wallace, the Chair of the Pain Department, who was my
2 boss at that time, did a lot of that research. So I've
3 experienced, you know, the progression of the data, and
4 how it evolved.
5 And there is clear evidence that the right
6 amount, not too much, not too little has a positive effect
7 of -- on pain perception. And I am in support of my
8 patients using medical marijuana as part of the treatment
9 modality. The one thing that I point out, obviously, is
10 it's just not going to be another addition to their Soma,
11 Xanax, and Norco kind of cocktail as a chaser kind of
12 thing. So they really -- it's a medication.
13 And the other realization is that I often give
14 them -- give them a choice. So they can either continue
15 to use opioids, which I highly discourage, or they
16 transition to that. Fortunately, a lot of the benefits
17 that we can see in medical marijuana does not necessarily
18 require ingestion and systemic approach. There's a lot of
19 topical ointments and creams that we can use for patients
20 that have a lot of benefits.
21 And also, with a lot more of the sides going into
22 that, most of the compounds that the patients can utilize
23 for pain treatments now are fairly specific for the 2
24 different cannabinoid receptors. So it's not -- they
25 don't have to ingest the marijuana leaf with, you know, I

1 don't know, several hundred of difficult active
2 ingredients and compounds. They can be very specific for
3 the CB-1 or 2 receptors, which reflect more relevance for
4 pain kill.
5 CHAIRPERSON MATHUR: Thank you.
6 Mr. Lofaso.
7 ACTING COMMITTEE MEMBER LOFASO: Thank you, Madam
8 Chair. A very interesting presentation, both clinically
9 and system -- systemically. My question is, and I think
10 you may have quickly answered it, Dr. Moeller-Bertram, but
11 the -- your clinical cohorts in the six and seven hundred
12 range, and your cost trend cohorts in the 79 patient
13 range. What caused that difference?
14 DR. MOELLER-BERTRAM: The difference is the
15 timing. This is the first we got the date from IEHP about
16 several weeks ago. And the only reason why we're only
17 looking at a shorter cohort -- or a smaller cohort, I
18 should say, is that this was the data that IEHP could make
19 available for the SmartCare California presentation and
20 also this one.
21 Currently, as we speak, all the data sets from
22 IEHP for the cost utilization as well as our clinical data
23 set was submitted to an evolution committee at UCSD, which
24 is an independent third party. And they're doing a more
25 comprehensive review of all of that.

1 So it was simply the timing. We have data on all
2 of the patients. They could -- simply couldn't pull it.
3 It's a large institution with a slow system.
4 ACTING COMMITTEE MEMBER LOFASO: So you might
5 have an opportunity for the cost data to be more robust in
6 the future?
7 DR. MOELLER-BERTRAM: Absolutely. And we
8 already -- I mean, our treatment -- we have 500 patients
9 that entered the next evaluation stage. So the numbers go
10 up as we speak.
11 ACTING COMMITTEE MEMBER LOFASO: Appreciate that.
12 Thank you.
13 CHAIRPERSON MATHUR: Thank you.
14 Mr. Jones.
15 COMMITTEE MEMBER JONES: Yeah. Thank you, Madam
16 Chair. Thank you for a very comprehensive report also.
17 This particular chart that's on here, the man and woman,
18 what were the numbers in terms of men versus women, and
19 what were the differences in the rate of improvement or
20 outcomes?
21 DR. MOELLER-BERTRAM: I can only answer the first
22 part of the question. Thank you. It's about the same.
23 It was either 48/52 -- so basically around about 50/50. I
24 don't recall if it was more male or female, but we have a
25 very balanced patient population. We have not done any

1 sub-analysis on the -- on the groups yet.
2 There is a -- I have about a million questions
3 that I want to have answered with this data set that we
4 have available. I wait for the numbers to go a little
5 higher. I project to have about 1,000 real life patients
6 in my data set by the end of the year, which is a very,
7 very robust number if you look at medical literature.
8 And we have 10 different standardized
9 questionnaires. We have all the clinical data. Plus, we
10 get all the unbiased utilization data from IEHP. So it's
11 going to be a very, very rich data set, where we can
12 answer all kinds of questions, including the one you just
13 asked.
14 CHAIRPERSON MATHUR: So thinking about this from
15 a payer perspective, it's wonderful that there are
16 providers like yourself and your clinic that are offering
17 the kind of coordinated care, which seems to be key, and
18 focusing on the 4 different areas, the medical, the
19 psychological, et cetera, so -- but as a payer, we have
20 members all over the State in very remote rural areas,
21 where there's not a dense population, and not a dense
22 provider population, and not all specialties are available
23 to the -- you know, to the urban centers where, of course,
24 we do have access to much more -- we have a, well,
25 certainly denser population, and also access to much more

1 medical services.
2 How can we as a payer encourage this kind of
3 coordinated approach to pain management, particularly
4 around lower back, given sort of the dynamics of our
5 population, and the fact that we work through health
6 insurance, you know, plans -- through the providers to the
7 patients?
8 DR. MOELLER-BERTRAM: Thank you. That's a very
9 good and very complex question. And I'm going to attempt
10 to answer that by first reconfirming your initial
11 statement, to have these services available together in
12 one whole treatment program is the most important part of
13 this treatment.
14 And I'd like to explain that by giving the
15 analogy of if you were to go to a bakery and you want --
16 you want to buy a piece of apple pie, it's going to be a
17 completely different experience, if somebody gives you a
18 nicely baked piece of apple pie, or they give you a cup of
19 water, and a cup of flower, then a little bit of salt,
20 then a raw egg, and then an apple.
21 It's the same ingredients completely different
22 experience, one very good, the other one may even be a bad
23 one. So it's important to make this available together.
24 We are having a similar situation in the Inland
25 Empire, where we have some patient population in remote

1 areas. The one thing that we're trying to do right now is
2 that we have a transportation service that IEHP is
3 sponsoring, where we offer that to the patients.
4 We have a case and care manager that actively
5 reach out to those patients. But you're absolutely right,
6 this is one of the main problems that we have to deal
7 with. There's no substitution for the patient coming and
8 getting the whole experience.
9 So I think to answer the second part of the
10 question, identifying areas where Center of Excellence
11 would be of highest value to the most amount of providers
12 is probably going to be the first step. Certain areas of
13 our treatment could potentially be serviced through tailor
14 medicine, or things like that, but the -- one of the key
15 ingredients is this community bidding, patient engagement,
16 the physical touch which unfortunately is so rare in
17 modern medicine.
18 CHAIRPERSON MATHUR: So just a follow-up
19 question. How far do you think patients with back pain
20 can or will travel to reach a center such as yours?
21 DR. MOELLER-BERTRAM: We currently have about an
22 hour and a half that the furthest patients that travel.
23 CHAIRPERSON MATHUR: Okay. Thank you. That's
24 helpful.
25 Well, I think we've really enjoyed your

1 presentation. Thanks so much for sharing your time with
2 us today. This item is adjourned and we -- is over.
3 We're going to take a break now for 15 minutes. We'll
4 come back at 11:30.
5 Thanks, everyone.
6 (Off record: 11:14 a.m.)
7 (Thereupon a recess was taken.)
8 (On record: 11:32 a.m.)
9 CHAIRPERSON MATHUR: I'm going to ask the members
10 of the Pension and Health Benefits Committee to please
11 come forward and take your seats. We're going to get
12 started.
13 Okay. We're going to get started again with
14 Agenda Item 10, Long-Term Care Program Semiannual Report.
15 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
16 DONNESON: Thank you, Madam Chair and members of the
17 Committee.
18 I'm going to be rather brief in my remarks. This
19 is a standard report we have provided to you for at least
20 the last 5 years. So there's going to be only specific
21 slides that I want to address in the presentation.
22 And I've also asked Flora Hu from the Actuarial
23 Office to sit with me, in case there are questions of an
24 actuarial nature. Flora is the CalPERS long-term care
25 actuary, and responsible for reviewing and ensuring the

1 stability of the fund.
2 So as I begin, I want to thank you and the
3 stakeholders behind me, because 2016 came and went, which
4 meant that was the last of the rate increases. So after 7
5 years of a very long journey for us, for you, and for us,
6 and for those stakeholders who sit behind us who supported
7 us, it's nice to come to a point where we can take a pause
8 and review what it is we accomplished.
9 As I said, I'm not going to hit every page, just
10 a couple of new things that then brings us to the
11 conclusion of the SOAPP project, which was our
12 Stabilization and Open Application Project.
13 Starting with the key statistics on page 3, I
14 simply want to point out that over the past few years, we
15 have greatly stabilized the program through the necessary
16 rate increases to existing plans, which those rate
17 increases just ended. We reopened the program with the
18 introduction of LTC4. And here on page 3 are the
19 statistics.
20 You can see that primarily the reduction in our
21 participants is due to death. Later on in the -- there
22 are statistics later on in this deck, this presentation,
23 and we are growing. So we are growing slowly in our sales
24 of the new LTC4. But as we -- over time, we are going to
25 continue to lose participants terminating primarily due to

1 death.
2 You can also see that the investment -- the
3 invested assets dropped by 200 million, but have
4 increased, again. So back to the 4.2 billion.
5 And then you can see at the bottom of this page,
6 the benefits that we've paid annually and since inception.
7 And I did want to add one statistic that you, Madam Chair,
8 asked me. You wanted to know the percent of the
9 population that are in claim. And so in 2016, 5.5 percent
10 of the population is in claim status, which is an increase
11 from 5.2 in 2015 and 4.7 in 2014. So it's a little bit
12 over 5 percent that are in claim.
13 Moving on to -- I'd like to move to page 5. This
14 is the last initiative that we implemented as part of the
15 stabilization effort. It was at your request back in 2002
16 we gave an opportunity to those members who dropped their
17 daily benefit allowance to avoid rate increases. After --
18 beginning in 2010 and going forward to 2014, we have given
19 them the opportunity to buy that dba back.
20 Education went out -- education letters were
21 mailed in February, and the offer will be available
22 starting in May. So this is the very last piece from the
23 stabilization that we have now put into place.
24 Moving. The pages 6 and 7 simply provide where
25 we are with our network. Our preferred provider network

1 continues to grow. And this provides discounts to our
2 members as they enter care, and it also saves CalPERS
3 money.
4 So slides 7 and 8 show you literally by quarter
5 the growth in premiums and the growth in benefits paid --
6 or the growth in -- the growth in active claims and the
7 premiums paid.
8 Slides 9 and 10 refer to where we spend the most
9 of our money, which is in assisted living versus skilled
10 nursing or home care. That amount of money is primarily
11 driven by claimants who have pure dementia, which you can
12 see on -- which you can see on page 10. So dementia
13 continues to drive the ALF, assisted living facility,
14 prices and costs.
15 For open application activity, we continue to
16 grow with the new efforts, and we continue -- later on.
17 I'm not going to go over the marketing, but I want to
18 thank may staff. They attend all the CBEEs. You would
19 not believe the amount of materials that are provided to
20 our interested participants, whether they work in a
21 CalPERS agency or not. So the staff are actively out and
22 providing information.
23 And again, from this page 11, you can see that
24 on-line use continues to grow, which is important, not
25 just for the green reasons, but for the fact that they

1 can't file it unless it's complete. And that's really
2 important.
3 I want to talk just a little bit, and then I'm
4 going to close, about the website functionality. We
5 expanded our eligibility to meet all classification of
6 employees qual -- of employees or retirees, both current
7 and former, eligible to apply for our program under
8 Internal Revenue Code 267702(b), which the extent of which
9 those relationships are broad, sisters in-laws, brothers
10 in-laws, nieces, nephews. It's broad, and we have -- they
11 have the opportunity to apply and be considered for our
12 program.
13 Another website functionality that is really
14 important to our participants, because there are 31
15 different explanation of coverage booklets. And so what
16 we did is we make it possible for each participant to go
17 in and look at their own explanation of coverage booklet.
18 So those are the highlights of the program.
19 Again, thank you for your support over the many years that
20 we have been turning this program around and stabilizing
21 it. And that concludes my presentation.
22 CHAIRPERSON MATHUR: Thank you. Are there any
23 questions from the Committee?
24 I actually had a couple questions. I appreciate
25 your sharing with us the percentage of members in claim,

1 and how that has changed over time. It seems like it's
2 trending up, which I don't think is a surprise, but
3 certainly it gives me a little cause for concern. What do
4 we see as sort of the best -- the standards in the
5 industry, what do you expect to see as sort of your
6 percentage of members in claim versus the total
7 population? At what point do we become really concerned
8 about the relative ratio between members in claim and
9 members not in claim?
10 SENIOR LIFE ACTUARY HU: So as end of last year,
11 the average of the total population for the LTC program is
12 72 years old. So that's the most claim starts. In the
13 industry, the claims are most from around age 70. So in
14 the next 10 years, you'll see the claims going up, because
15 the most claims happens between after age 70 and between
16 age 70 and age 85.
17 So we do not have a specific number for what's
18 the percentage of the total population. But as time goes
19 on, especially when members turn age 70, so we see
20 probably an increase in percentage in the coming years --
21 in the coming 10 or 20 years.
22 CHAIRPERSON MATHUR: So but how do we factor this
23 information into our assessment of the stability and
24 sustainability of the Long-Term Care Fund?
25 SENIOR LIFE ACTUARY HU: All those -- all those

1 on claim percentages are projected in our evaluation
2 projection. So the sustainability of the program
3 incorporates all the infusion coming premiums, and also
4 the incoming future benefit payments, along with our
5 investment return. That's all combined in our projection.
6 CHAIRPERSON MATHUR: Okay. Thank you.
7 Mr. Jelincic.
8 BOARD MEMBER JELINCIC: Yeah. The next time you
9 do this, the percentage of people in claim, having it by
10 plan would probably be helpful, because obviously, you
11 know, Long-Term Care 1 is going to have a higher
12 percentage, and actually has some higher risks.
13 SENIOR LIFE ACTUARY HU: Yes. This year, we're
14 going to switch from our current claim cost based model to
15 first principal based model. In our new model, future on
16 claimed participant members will be projected. So in the
17 2017 evaluation report, we're going -- we are able to
18 provide the future on claim percentage.
19 CHAIRPERSON MATHUR: Okay.
20 BOARD MEMBER JELINCIC: Thank you.
21 CHAIRPERSON MATHUR: Terrific. Thank you.
22 Ms. Hollinger.
23 COMMITTEE MEMBER HOLLINGER: Yeah. Just a quick
24 question. Like I noticed the increase in assisted living
25 and predominantly dementia, but did we break this down

1 into the average someone goes on claim for? Like, just
2 if -- going forward and estimating our future costs? Do
3 we have that?
4 SENIOR LIFE ACTUARY HU: Currently, we do not.
5 We are going --
6 COMMITTEE MEMBER HOLLINGER: Because I think that
7 would be an important thing. For example, if somebody is
8 let's, just say by way of example - I'm not familiar with
9 all the different level of years that our programs
10 provide, but if the average someone is on claim for 5
11 years, or something like that, I think we need to see that
12 to be able to estimate our future costs, you know, how
13 long someone stays in claim.
14 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
15 DONNESON: Let me expand on that a little bit. We have
16 looked. The average -- as we looked at the design of our
17 program, especially with fixed term policies, the average
18 is about 3 and a half years that they're in claim. Is
19 there something more that we should be looking at to bring
20 back?
21 COMMITTEE MEMBER HOLLINGER: No, I -- well, if
22 that's been the average, then it gives us an idea of our
23 future liabilities. But I think it's something also we
24 need to track, because people are living longer. And
25 being in some of these assisted living facilities, you

1 know, you could be there 5 year -- you don't die from
2 dementia.
3 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
4 DONNESON: That is true. And if I could elaborate just a
5 little bit. We look very closely at the assisted living
6 care component.
7 COMMITTEE MEMBER HOLLINGER: Right.
8 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
9 DONNESON: And we do have -- in California, there's
10 difference licensing that goes on with assisted living.
11 So we try with LTCG, which is our third-party
12 administrator, to look at -- we want the care that we're
13 paying for -- we're paying for care, we're not paying room
14 and board, we're not paying hair-dressing fees. So we do
15 try to make every effort to look very closely at what is
16 being paid for in assisted living facilities.
17 COMMITTEE MEMBER HOLLINGER: Correct, but people
18 who take better care of themselves live longer. And so I
19 just think we just need to be tracking, you know, how long
20 people are on claims. Thank you.
21 SENIOR LIFE ACTUARY HU: Sure, we will.
22 CHAIRPERSON MATHUR: It's very encouraging to see
23 that we've doubled the number of preferred providers over
24 the past 4 years. That's -- I think that's really
25 substantial progress. My question for you is do we have a

1 sense of how many or what percentage of our members
2 actually use the preferred provider network?
3 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
4 DONNESON: We actually have reported that in the past, and
5 it doesn't just -- the average I think discount is around
6 10 percent that they save. And then there's another
7 portion that we save as well. I would need to go back and
8 look. But we have reported it in the past, and we can
9 certainly provide that information at a future date.
10 It was new in the industry. I don't know that
11 other -- I don't know that other programs actually
12 developed preferred provider networks, but it was an
13 innovation we introduced with the 2011 contract, and it's
14 grown and developed. And we're very pleased that it is
15 actually being used. The discounts are real for both the
16 member and CalPERS itself.
17 CHAIRPERSON MATHUR: Terrific. Okay. Thank you.
18 We do have one member of the public who wishes to
19 speak on this item James Prigoff. If you could come --
20 please come up and sit right here all the way to my left.
21 The microphone -- I'll wait till he gets up here.
22 So the microphone is already turned on for you.
23 And as you requested, I will allow you 4 minutes to speak.
24 MR. PRIGOFF: Thank you. I have 2 issues.
25 CHAIRPERSON MATHUR: And if you could just

1 identify yourself for the record and your affiliation.
2 Yes, proceed.
3 MR. PRIGOFF: Thank you, Madam Chair and the
4 Board, my wife Dr. Arlene Prigoff, Professor Emeritus, has
5 taught at CSUS. At Age 58 to 78 she developed dementia
6 shortly after retirement. She spent 5 years with home
7 care, and the last 3 years in a memory care unit.
8 I spent my life in the corporate world, retiring
9 at age 57. I had been recruited to be the senior vice
10 president of the Sara Lee Corporation to assist in major
11 restructuring. That's my credentials for these
12 observations.
13 We were advised as of January 1st that OptumRx
14 was replacing CVS. I went to Google and I found there
15 were 1,102 negative responses, 680 verified, 280 posted
16 dealing with mail order. The company was rated 1 out of 5
17 and one person complained there was no place to rate them
18 minus 5.
19 The words used were "horrible", "terrible",
20 "company reprehensible", "never use", "outrageous",
21 "blatantly lied", "they're ruining my life", "by far the
22 worst", "20 phone calls", "on the phone forever",
23 "rudest", "unethical" just for starters.
24 This is pre-OptumRx changeover. These are people
25 in the past. It's not just tweaking what's going on the

1 changeover, and that's the problem.
2 No way I was going to contact them. I went to
3 their preferred provider. They only have one, Walgreens.
4 I asked what the co-pay would be on 2 small prescriptions.
5 The pharmacist could not locate the information, called
6 another person. It took about 12 minutes, and then I was
7 told on 3/3 one prescription would be filled on 3/7, the
8 other on 3/12, but they couldn't give me the co-pay. And
9 I left and went back to CVS. They filled the 2
10 prescriptions in 10 minutes, and the co-pay was 5 bucks
11 each.
12 Previously, I paid CVS $40 for a three-month
13 supply of Pradaxa. Since they are not a preferred
14 provider, it now cost me $50 a month for one month's
15 supply, just under 300 percent increase. Over when they
16 were a provider, I called OptumRx and they found out that
17 3 months supply from them would be $100, 150 percent
18 increase.
19 My suggestion. If PERS doesn't want to drop
20 OptumRx, then at least insist that they add CVS and
21 others, so they can get a 90-day supply at a more
22 reasonable price. I recognize there are also hundreds of
23 complaints about CVS. But if you look at them, they are
24 mostly to do with the individual stores, not the 90-day
25 supply mail order.

1 Second issue, I purchased PERS LTC in 1995. When
2 I went to activate Arlene's policy, I had no idea that the
3 management of that was farmed out to a company in
4 Minneapolis named Univita Health. They are a very poorly
5 run company. My email, phone calls, and letters over
6 years have been voluminous. I wrote the letter to two
7 senior executives a few years ago, never received a reply.
8 I submit it to the Board.
9 And turn over is high. Employees agree they are
10 understaffed. Reaching care managers is extremely
11 difficult. People leave the company without any
12 notification. And errors are endless.
13 After 7 months, recently having moved from
14 Oakmont Memory Care to Aegis, and our last reimbursement,
15 of course, was sent back to Oakmont, not directly
16 deposited to our account, as had been established for the
17 past many months. Those funds were needed to pay the
18 March 1st bill, but I was told it would take 30 days to
19 reroute the funds to my account.
20 This company would benefit greatly by hiring a
21 management consultant, and PERS would be saved, that's the
22 insured, endless wasted hours. I do thank Doug Van Well,
23 who finally got into the act and got me the check. But
24 down below, there's no way to do it, and reaching upper
25 management is difficult.

1 CHAIRPERSON MATHUR: Thank you.
2 MR. PRIGOFF: I thank you very much for allowing
3 me to share my experience.
4 CHAIRPERSON MATHUR: Thank you for your comments.
5 MR. PRIGOFF: And I will provide you with copies
6 of other letters and my report.
7 Thank you.
8 CHAIRPERSON MATHUR: You can give it to Liana
9 Bailey-Crimmins, who's right next to you.
10 Thank you very much.
11 Okay. We will -- that is all the public comment
12 on this item.
13 Mr. Juarez.
14 ACTING COMMITTEE MEMBER JUAREZ: Yeah, just to
15 the last speaker, I would hope maybe a year from now, to
16 give it due time --
17 MR. PRIGOFF: I'm sorry. I have to put on my
18 hearing.
19 ACTING COMMITTEE MEMBER JUAREZ: Yeah, just to
20 the last speaker and his -- the stories that he shared
21 with us. I would hope that maybe a year from now to see
22 if we can get improvement on some of the things that he
23 cited, and get a report, if not from him, at least from
24 the staff to assure the public that, in fact, we're paying
25 attention to these types of things, and that we hopefully

1 will do better, so -- or that -- at least to the people
2 that we contract with will do better.
3 So with that, I would hope that's the case in a
4 year from now.
5 CHAIRPERSON MATHUR: Thank you.
6 Well, we are -- as was noted in the DEO report
7 earlier, we are very intensively engaging with OptumRx
8 particularly around the customer service issues that our
9 members have experienced. And so hopefully, that will
10 address Mr. Prigoff's concerns in that arena, but that we
11 will also follow up with Univita and the Long Term Care
12 Program.
13 MR. PRIGOFF: Thank you.
14 CHAIRPERSON MATHUR: Thank you.
15 That brings us to 11, Summary of Committee
16 Direction.
17 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
18 All right. Madam Chair, I have taken 2
19 directions. One is for Agenda Item 6 and Agenda Item 7
20 was to have the staff change the necessary language to be
21 consistent with the Investment Committee, specifically to
22 change the word "Board" to "CalPERS". And then the second
23 item was to bring back a cost-benefit analysis assessment
24 regarding tiering. Those are the 2 directions that I have
25 taken, Madam Chair.

1 CHAIRPERSON MATHUR: Yes. I think that is -- the
2 other thing was to explore whether the spousal surcharge
3 is something that could be administered at the -- at the
4 employer level, whether we even need to be involved with
5 that.
6 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
7 Okay. Thank you. I'll add that as a third item.
8 CHAIRPERSON MATHUR: Thank you.
9 Okay. Mr. Jones.
10 COMMITTEE MEMBER JONES: Yes. Thank you, Madam
11 Chair.
12 The language change that you made reference to,
13 which was noted in the Investment Committee, but it wasn't
14 a language change in the document about the Congressional
15 Engagement. It was a direction.
16 CHAIRPERSON MATHUR: Thank you for reminding me.
17 The other piece of the direction under the federal
18 priorities, both at the health care and the retirement
19 level, was to engage the Board as appropriate and
20 beneficial in congressional -- in meeting with Congress
21 people around items of interest and relevance to CalPERS.
22 Does that capture it?
23 COMMITTEE MEMBER JONES: Yes.
24 CHAIRPERSON MATHUR: Yes. Thank you.
25 Thank you for the reminder.

1 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
2 Thank you.
3 CHAIRPERSON MATHUR: Excuse me.
4 Okay. So that brings us to Agenda Item 12, which
5 is public comment. We have several members of the public
6 who wish to speak today, so I will call you up. We
7 have -- we will have the mics on at these 2 seats. And if
8 you could identify yourself and your affiliation for the
9 record, and each individual will have 3 minutes in which
10 to speak.
11 So Tim Behrens in Jim Anderson you're first up.
12 And then following you will be Larry Woodson and James
13 Prigoff, but I think he just -- I think he shared all of
14 his public comment in the last item, so Al Darby -- Larry
15 Woodson and Al Darby will follow Jim Anderson and Tim
16 Behrens.
17 MR. BEHRENS: Thank you, Madam Chair. Tim
18 Behrens, President of the California State Retirees. And
19 I'd like an extra 30 seconds to address Ms. Hollinger.
20 People do die from dementia. My wife is an institution.
21 She has Alzheimer's/dementia. The fifth stage of that
22 disease, the whole body shuts down, because the brain stem
23 is affected. So people do die from that disease. I just
24 wanted to let you know that.
25 So I'm here today to speak against the staff

1 recommendation that we do away with the paper, what I
2 call --
3 CHAIRPERSON MATHUR: Your warrants.
4 MR. BEHRENS: -- checks that we receive in the
5 mail. They call advices.
6 Many of our members are not computer literate.
7 They don't know how to get on a computer. They didn't
8 have a computer what they worked for the State of
9 California, and they've never had a desire to start using
10 it.
11 So if we send out this form, again like we did
12 last year for the open enrollment, and if you don't
13 respond, which means you're opting out of receiving that
14 warrant, then you're actually opting in to that plan.
15 That's also confusing to our members. They don't know
16 that if they didn't send back this form, that means
17 they're not going to get a paper warrant any more. So
18 that's confusing.
19 Finally, we think -- we agree with the $1 million
20 savings being a very important factor. I, myself, will
21 probably opt out and not receive a direct deposit, because
22 I am a little computer literate. And I would throw out a
23 request again for the consideration of CalPERS to develop
24 an app for phones, where people can go easily to CalPERS
25 site, which would be another alternative they might think

1 of in the future.
2 Lastly, I want to switch gears and talk about a
3 Senate Bill that's coming out tomorrow, Senate Bill 17 by
4 Ed Hernandez. It's a transparency law that will require
5 the drug companies to explain the exorbitant fees that
6 they charge for medication, and they keep on raising them.
7 This is an attempt again by Senator Hernandez to
8 have California become the first State where such a law
9 exists, where we can hold the drug companies accountable
10 for the overpricing we believe that they have.
11 A quick example. There is a type of muscular
12 dystrophy that affects 12,000 young boys every year. The
13 medication for that person is $89,000 a year. That's a
14 little bit exorbitant. So I'm hoping that I spoke with
15 your legislative staff. She tells me that you supported
16 1010 last year, and she sees -- they haven't seen it yet,
17 but she believes that you all will be supporting it again,
18 and I'm asking you to do the same.
19 Thank you for letting me speak.
20 CHAIRPERSON MATHUR: Thank you very much for
21 your -- for sharing your thoughts.
22 Mr. Anderson.
23 MR. ANDERSON: I'm James Anderson. I'm the
24 legislative director for RPEA. And I was noticing that
25 your last board meeting you had a split vote on the

1 regulations on co-insurance plans for the families. It
2 indicated to me that there was some interest in fixing the
3 problem, rather than just saying -- making it easier to
4 say no when somebody applies for an appeal.
5 So I was wondering if the staff, since it wasn't
6 on the agenda, that that had been referred to staff, is
7 there a reference to staff now to look at a way to solve
8 the problem? I noticed today that one of the slides says
9 you're interested in having members and their families in
10 the communities where they live be served.
11 Well, this co-insurance or co-plans do that.
12 They keep people from having to travel long distances to
13 find doctors that serve them in the area. So I would
14 appreciate that if some point you do refer that to staff,
15 or at least inform us on which staff we could work with,
16 to come up with a plan that says yes instead of no.
17 Thank you very much.
18 CHAIRPERSON MATHUR: Thank you very much.
19 Do you want to address that?
20 INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:
21 Madam Chair, based on the last comment, I did
22 want to let you know that in April we will be bringing
23 back a fairly comprehensive assessment of the combo
24 enrollment. So I just want to make sure it was a
25 direction of the Board -- or the Committee last month.

1 And so we will be bringing that back as an agenda item.
2 MR. ANDERSON: Thank you.
3 CHAIRPERSON MATHUR: Thank you.
4 Mr. Woodson.
5 MR. WOODSON: Good morning -- Good noon.
6 (Laughter.)
7 MR. WOODSON: Larry Woodson, California State
8 Retirees. Madam Chair, members of the Board, thank you
9 for the opportunity to comment.
10 I would like to add to Mr. Behrens comments on
11 CalPERS plans to cease mailing of monthly direct deposit
12 notices. We do support electronic notification where
13 appropriate, and the savings that may result.
14 CalPERS staff says that in the first year, or the
15 short-term, beginning July 1, while monthly direct deposit
16 mailings will continue for those that read the letter and
17 make the request to continue receiving monthly mailings,
18 that it will save -- CalPERS will save approximately a
19 million dollars, even with the continued mailings for
20 monthly -- people requesting monthly mailings, which they
21 estimate to be about 20 percent of all covered people.
22 And we -- frankly, we think that is a high
23 figure. We don't believe that 20 percent need the
24 mailings, but we can discuss that down the road.
25 By stopping all mailings in 2018-19, which is the

1 CalPERS staff plan now, except where there's a COLA or a
2 deduction change, then they say that it will save an
3 additional $600,000, in addition to the million already
4 saved. We don't believe it will be that high, more like
5 400,000 or less, because we didn't agree with the 20
6 percent figure.
7 The plan was presented to us as a way to help
8 offset CalPERS unfunded obligations. And we know that the
9 new figure is somewhere around 64 percent, which is a big
10 concern to all of us. But it stretches credibility to
11 think that cutting off elderly folks with no computers
12 from receiving monthly direct deposit notices, and saving
13 $600,000, or less, in addition to the 1 million is going
14 to put a dent in a billion -- you know, a multi-billion
15 dollar shortfall.
16 Why are monthly direct deposit advices important?
17 Older retirees gain a significant level of
18 assurance knowing that their pensions have been deposited.
19 And unlike Social Security, which does not have multiple
20 deductions, our notices have maybe 6 to 10 deductions in
21 every notice.
22 The importance of viewing deductions monthly was
23 demonstrated recently when 40 retirees had their long-term
24 care insurance deduction disappear from notice due to
25 human error. And had a member not seen this omission on

1 her direct deposit notice and reported it, the problem
2 would have been -- would have grown much larger.
3 So we hope that the Board will agree with our
4 concerns and direct staff not to pursue change to
5 authorizing -- to the authorizing statute, which is
6 Government Code section 21269, which clearly requires
7 monthly mailings to those who require it -- request it.
8 And we don't think that CalPERS can completely
9 change the intent and language of a statute by passing a
10 regulation, which is what the staff is planning on.
11 So thank you for your attention and
12 consideration.
13 CHAIRPERSON MATHUR: Thank you, Mr. Woodson.
14 Thank you.
15 Mr. Darby.
16 MR. DARBY: Good afternoon. Al Darby, Vice
17 President, Retired Public Employees Association. We
18 represent 23,000 members from all different employers.
19 We, too, oppose the remittance advice withdrawal.
20 It serves -- the remittance advice serves as a creature
21 comfort to seniors who -- this is their only connection to
22 CalPERS, and their livelihood. If they don't have
23 computers, and many of them don't, or don't know how to
24 use them properly, and don't know how to navigate the
25 CalPERS my|CalPERS system, this is a way for them to stay

1 connected to their source of livelihood.
2 Many of these people, as you know, do not receive
3 Social Security, so this is their only source of income.
4 An opt-in system disadvantages these seniors, because they
5 may not understand that a paper advice will not keep
6 coming, unless they actually do something themselves.
7 They have to opt-in to the program. These advices for
8 them will discontinue after 12 months, after the system
9 goes into effect.
10 Also, as Larry mentioned, it is potentially a
11 problem for organizations like our own that offer member
12 benefits. If deductions change, there can be errors. And
13 from that, there may be refunds, or overpayments, or
14 underpayments that are made, and not detected right away
15 because these folks haven't received or don't -- will not
16 be receiving the paper advice.
17 A possible solution is to retain the paper
18 advices for at least those who have retired several years
19 back, perhaps before 2010 or earlier. The people who are
20 more likely to not be computer literate.
21 It's also important to note that the savings are
22 small here. It's only a million dollars. Somebody said
23 it's like 0.001 of your total budget.
24 So to withdraw these advice notices may not be
25 saving that much money, and may be causing more grief than

1 the costs that you save.

2 Thank you.

3 CHAIRPERSON MATHUR: Thank you.

4 Mr. Fountain. Jerry Fountain.

5 MR. FOUNTAIN: Thank you Madam Chair, Board. I'm
6 Jerry Fountain, Chief Financial Officer for the California
7 State Retirees.

8 I won't belabor the points that have already been
9 addressed to you by the previous speaker, but I'd like to
10 go over the items that you cite for going paperless, the
11 amount of money that should be saved, as Mr. Darby pointed
12 out. And may be that's significant, but the printing
13 you're passing on to the retirees. If they want a hard
14 copy, they're going to have to print it themselves.

15 Your concern about the environmental impact is
16 good. But your printing facilities have to abide by
17 regional air quality management districts for the release
18 of volatile organic compounds, or VOCs. Private residents
19 aren't controlled by that. So having the retiree print
20 their own statements might be increasing what you could
21 have put out, or going beyond that level, and you could be
22 actually adding to the carbon footprint.

23 Increased security. That is great. But some of
24 the major corporations, and the even government in this
25 country, have been hacked. So you're not immune to that.

1 And I personally believe my delivered mail hasn't been
2 hacked. And if it was, they would get information on one
3 individual, not tens of thousands. So I feel more secure
4 with getting my mail.
5 And what bothers me a little bit is the last
6 statement, "Bringing our practices in line with other
7 systems that already require opting in to mailing, or that
8 do not allow mail options at all".
9 This leads me to believe that your next step may
10 be to show the large percentage of people that get their
11 electronic mail, which is mandated, and how they enjoy it,
12 which is an enjoyment they receive based on your
13 standards. They may not like it all. And the next step
14 would be no mail at all.
15 In the financial institutions I deal with, banks,
16 credit unions, mortgage companies, utility companies, life
17 insurance, car insurance, house insurance, they all give
18 me an option also to opt-in, but it's the opt-in to go
19 electronic, not opt-in to go paperless.
20 Thank you for your time.
21 CHAIRPERSON MATHUR: Thank you very much. Thanks
22 to everyone for your thoughtful comments.
23 I have no other requests to speak. Is there
24 anyone else from the public who wishes to speak at this
25 time?

1 Seeing none. This adjourns the open session.
2 Oh, I'm sorry, Mr. Jones. I missed you. Do you wish to
3 speak at this time?
4 COMMITTEE MEMBER JONES: Yes, I do.
5 CHAIRPERSON MATHUR: Please.
6 COMMITTEE MEMBER JONES: Thank you.
7 Yeah. In relation to Mr. Behrens comment about
8 the ability for people to continue to receive a mailed
9 check, if they so desire, and that is built into the
10 system, but part of the problem may be how do we
11 communicate with those people, if they don't respond by
12 missing the mailer.
13 So I would ask that you direct staff to explore
14 further how -- make sure we reach those people who may not
15 respond, so that if they do want to continue to receive a
16 hard mail copy, that they can do so. But I don't know
17 what the solution is, but I think it's worthy of exploring
18 to see if there's some additional steps that can be taken
19 to address that concern.
20 CHAIRPERSON MATHUR: Ms. Lum.
21 DEPUTY EXECUTIVE OFFICER LUM: Donna Lum, CalPERS
22 team member. Thank you, Mr. Jones, for bringing that to
23 our attention and requesting some additional information.
24 I think there's a couple of things that we have
25 already outlined, and we have discussed with the

1 stakeholders that gives a really, what we would call, a
2 comprehensive outreach to try to ensure that all of the
3 retirees that would be -- that would be impacted by this
4 are given consideration, and that we're able to reach
5 them.
6 On the document that I shared, the fact sheet, it
7 does show the various attempts that we're going to be
8 using. So we started this month with on the bottom of the
9 retiree advice, we had a statement there indicating that
10 we're going to be going paperless to start to share the
11 information. In April and in May, through PERSpectives,
12 which reaches all the homes of all the retirees, there
13 will be information about the going paperless with the
14 direct advices there.
15 And then during April and May is when we will be
16 sending out the actual document, the card, that will
17 enable them to make an election, or determination, if they
18 actually want to receive the hard copy. This is something
19 that we did very similar with the health statements we
20 that it worked.
21 But what we're also doing is that we got a lot of
22 valuable feedback from the retiree associations in regards
23 to how to make that document identifiable, so that it's
24 not something that will be received at home and tossed.
25 And so as we go through the design elements of what the

1 document is going to look like, we have committed to
2 the -- our stakeholders to be able to get input from them,
3 so that they can help us to determine that it is a clear
4 communication with clear direction.
5 Then in June, in the bottom of the warrant, it
6 will say again that if you haven't made your election,
7 recognize that July 1st you will no longer receive your
8 direct device via mail. And it will give information on
9 how to do it. And that would be by contacting our call
10 center at that point. The call center agents have all
11 been briefed on this. And will be prepared to help the
12 members, if they get a call to continue with the paper
13 warrant.
14 And then in August, we will continue to follow up
15 with messaging, either through social media, and other
16 messaging mechanisms. And then in September, again in the
17 PERSpectives, we will be reiterating the options of how to
18 get the mailing, if so desired.
19 So I think there's a number of different things
20 that we're doing. In addition to that, we're hoping, once
21 again, to leverage assistance from our retiree
22 associations to use their vehicles, their methods, either
23 through their news letters, their email blasts, or any
24 other options that they have that they feel would be
25 helpful in this transition in helping to make it

1 successful. But certainly we will continue to explore all
2 other venues that we haven't considered to see if there
3 are other options to be able to do the outreach.
4 COMMITTEE MEMBER JONES: Okay. And thank you for
5 that summary. So I would urge our retiree organizations
6 to, if you have any other thoughts or ideas, we're try to
7 address those that may not respond. Because if someone
8 elects to go electronic, that's fine, but we're trying to
9 deal with those that don't.
10 However, on the notification on the warrant stub,
11 is it possible to have an insert in the -- in the check
12 envelope, as opposed to just a statement on the warrant?
13 DEPUTY EXECUTIVE OFFICER LUM: Unfortunately,
14 we're not able to add inserts into the remittance advices.
15 I don't know if the Committee recalls sometime ago there
16 was a resolution requiring Board approval to be able to
17 add an insert. Action was taken several months ago, which
18 I believe indicated that we no longer could do inserts
19 into warrants, unless they met certain criteria, and they
20 were very specific. So, you know, acts of nature that we
21 needed to reach out and let all of our members know, but
22 there was very specific criteria. And I believe that this
23 would not fit within that criteria.
24 COMMITTEE MEMBER JONES: So you --
25 DEPUTY EXECUTIVE OFFICER LUM: I apologize. I

1 don't have it with me.
2 COMMITTEE MEMBER JONES: So you said that unless
3 approved by the Board, so this Board could make that
4 determination?
5 DEPUTY EXECUTIVE OFFICER LUM: If it were within
6 the 3 criteria that were identified in the resolution that
7 we had in place. I'd have to go back and look at that
8 again Mr. Jones. I can explore that and bring it back to
9 Ms. Priya -- Ms. Mathur and see if that's an option.
10 COMMITTEE MEMBER JONES: Yeah. And I would like
11 to see that too, if you could provide that.
12 CHAIRPERSON MATHUR: And just to note, I think
13 it's important to note that at any time if a member has
14 realized -- has not read any of the materials and realizes
15 they're not receiving their paper advices, they can always
16 call the CalPERS hotline and -- you know, customer contact
17 center and request at that time paper copies.
18 DEPUTY EXECUTIVE OFFICER LUM: That is correct.
19 COMMITTEE MEMBER JONES: Yeah. No, and I
20 recognize that, but I'm just still trying to -- what can
21 we do to address those that don't respond? That don't
22 want to have it electronic, that's what I'm trying to
23 address.
24 CHAIRPERSON MATHUR: Yes. It's not like the open
25 enrollment, where there was a cut-off by when they had to

1 request paper copies. At any time, they can request paper
2 copies be resumed.
3 DEPUTY EXECUTIVE OFFICER LUM: That is correct.
4 And similarly during -- for the open enrollment or the
5 health statements, we did the same thing. We had an
6 identified deadline to be able to meet the cutoff for that
7 period of time. But allowing members after that fact to
8 be able to opt in to the next round if they so chose to.
9 So I think the important message is it -- I mean,
10 we recognize that it is change, and that the population of
11 the change is our retirees. Certainly, having -- you
12 know, having had some experience in this area, we are
13 looking at a lot of different options, lessons learned
14 from our last time, and really doing, you know, our due
15 diligence to reach out as broadly as we can through as
16 many contacts as we can to be able to make this happen.
17 But certainly, I think the message is is no one
18 gets left behind, if, at any given point, a retiree
19 identifies or recognizes that they haven't been getting a
20 paper warrant for whatever period of time that takes for
21 them to recognize that, they can still make contact with
22 us and get the paper warrant.
23 CHAIRPERSON MATHUR: Yeah. I see you, Mr.
24 Behrens. I'm afraid I cannot allow you to have more time,
25 at this time, but maybe we can have -- take --

1 MR. BEHRENS: If you send Mr. Jones down here for
2 5 seconds, I'll have him ask the question.
3 CHAIRPERSON MATHUR: We'll take this off-line.
4 We can continue our conversation.
5 Thank you.
6 At this time, is there anyone else from the
7 public who wishes to speak?
8 Seeing none.
9 The open session is adjourned.
10 (Thereupon the California Public Employees'
11 Retirement System, Board of Administration,
12 Pension & Health Benefits Committee open
13 session meeting adjourned at 12:17 p.m.)
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1 C E R T I F I C A T E O F R E P O R T E R

2 I, JAMES F. PETERS, a Certified Shorthand
3 Reporter of the State of California, do hereby certify:
4 That I am a disinterested person herein; that the
5 foregoing California Public Employees' Retirement System,
6 Board of Administration, Pension & Health Benefits
7 Committee open session meeting was reported in shorthand
8 by me, James F. Peters, a Certified Shorthand Reporter of
9 the State of California;
10 That the said proceedings was taken before me, in
11 shorthand writing, and was thereafter transcribed, under
12 my direction, by computer-assisted transcription.
13 I further certify that I am not of counsel or
14 attorney for any of the parties to said meeting nor in any
15 way interested in the outcome of said meeting.
16 IN WITNESS WHEREOF, I have hereunto set my hand
17 this 20th day of March, 2017.
18
19
20
21
22
23 JAMES F. PETERS, CSR
24 Certified Shorthand Reporter
25 License No. 10063