MEETING

STATE OF CALIFORNIA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

BOARD OF ADMINISTRATION

PENSION & HEALTH BENEFITS COMMITTEE

OPEN SESSION

ROBERT F. CARLSON AUDITORIUM

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TUESDAY, APRIL 18, 2017

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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. Eric Lawyer

Mr. Rob Feckner

Mr. Richard Gillihan, also represented by Ms. Katie Hagen

Ms. Dana Hollinger

Mr. Henry Jones

Ms. Theresa Taylor

Ms. Betty Yee, represented by Mr. Alan Lofaso

BOARD MEMBERS:

Mr. J.J. Jelincic

Mr. Ron Lind

Mr. Bill Slaton

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

Dr. David Cowling, Chief, Center for Innovation

Dr. Kathy Donneson, Chief, Health Plan Administration Division

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

STAFF:

Ms. Victoria Eberle, Assistant Chief, Health Plan Administration Division

Ms. Karen Pales

Ms. Shari Little, Chief, Health Policy Research Division

ALSO PRESENT:

Ms. Donna Snodgrass, Retired Public Employees Association

Mr. Larry Woodson, California State Retirees

I N D E X

P R O C E E D I N G S

CHAIRPERSON MATHUR: You all quieted down in anticipation.

(Laughter.)

CHAIRPERSON MATHUR: Well, good morning, everyone. Welcome to the open session of the Pension and Health Benefits Committee.

First order of business is roll call.

COMMITTEE SECRETARY JONES: Good morning.

Priya Mathur?

CHAIRPERSON MATHUR: Morning.

COMMITTEE SECRETARY JONES: Michael Bilbrey?

VICE CHAIRPERSON BILBREY: Good morning.

COMMITTEE SECRETARY JONES: Eric Lawyer for John Chiang.

ACTING COMMITTEE MEMBER LAWYER: Good morning.

COMMITTEE SECRETARY JONES: Rob Feckner?

COMMITTEE MEMBER FECKNER: Good morning.

COMMITTEE SECRETARY JONES: Katie Hagen for Richard Gillihan?

ACTING BOARD MEMBER HAGEN: Here.

COMMITTEE SECRETARY JONES: Dana Hollinger?

COMMITTEE MEMBER HOLLINGER: Here.

COMMITTEE SECRETARY JONES: Henry Jones?

COMMITTEE MEMBER JONES: Here.

COMMITTEE SECRETARY JONES: Theresa Taylor?

COMMITTEE MEMBER TAYLOR: Here.

COMMITTEE SECRETARY JONES: Alan Lofaso for Betty Yee?

ACTING COMMITTEE MEMBER LOFASO: Here.

CHAIRPERSON MATHUR: Well, we do have a quorum.

And please note for the record that Ron Lind and J.J. Jelincic have also joined us this morning.

Next order of business is the Executive Reports.

Ms. Lum.

DEPUTY EXECUTIVE OFFICER LUM: Good morning, Madam Chair, members of the Committee. Donna Lum, CalPERS team member.

A few updates for you this morning, first starting with a brief update on our pensionable compensation regulations. I just wanted to make you aware that the package has been delivered to the Office of Administrative Law. We expect that the public comment period will be from April 21st to June 6th. And then we also anticipate that the regulations would come back to this committee in August for final approval.

The next item is related to our on-line direct deposits for retirees. This is an update that I've provided to the Committee over the past couple of months. I did want to share with you that as of yesterday we began

mailing a communication to our retirees who have direct deposit for their only pensions.

The communication piece looks like this. It provides information about the direct deposit initiative, why we're doing it, some of the benefits. It does have a postage-paid attached postcard on here that will enable them to elect to opt in to paper if that's something that they choose to do.

The communication is going out to about 470,000 retirees. And it does advise them that the due date to return the postage-paid card is July 1st. It also does provide information, again as I mentioned, should they decide that they want to opted in to paper, how that could be done separate.

We've also shared a draft of the communication with our retiree associations, and they did provide some feedback to help us to ensure that the communication is clear for the membership.

The next item is another update on our CalPERS educa -- benefits education events. We held our last event in Santa Barbara On March 17th and 18th. Santa Barbara is considered to be one of our smaller remote locations, as the members in that area are approximately one and a half hours away from our nearest regional office.

This event, as you know, provides quite a bit of information, education and access to CalPERS staff and team members to assist our members as they are nearing retirement or planning for retirement.

The total number of attendees for the Santa Barbara's event tripled from the number that we had back in 2008 when we were there last. So again, as we are continuing to see with each and every event that we have hosted this last year, the increase in attendance continues to grow.

One item worth noting is we have run into a situation at least on this last fair, and we anticipate in future fairs, where the Social Security Administration's absence due to federal budget constraints have prevented them for participating in the event. In order to ensure that our members continue to get information regarding Social Security, our CalPERS Social Security team stepped in and provided the presentations and they also staffed the exhibit booths so that they could continue to provide information to our members. And so that was a big change for us and something that again I wanted to thank the team for doing.

Our next event is going to be April 28th and 29th in Fresno.

And planning for the events for next year is well

underway. We currently have tentative dates and locations for nine events. And I anticipate having that schedule ready and available to share with the Committee and with the public in the next month or so.

And my last update is very exciting. As many of you may know, this is Financial Literacy Month. And I'm pleased to share with you that our customer support team in partnership with the Public Affairs Office has developed an excellent video series on helping members plan for their financial future. This is part of a project that we discussed with the Committee during the business planning process: Senator Rand financial literacy education for our members.

We believe it's important for our members to understand their responsibilities and benefits related to retirement planning early on, and especially the changes -- especially given the changes that have been brought about by the PEPRA, by the Public Employees Pension Reform. The videos help inform early- to mid-career employees about their options. This series of videos is entitled "Planning For Your" -- "Planning Your Retirement" -- or, excuse me -- "Planning Your Financial Future. And it covers a variety of topics such as budgeting, retirement income sources, examples of tax-deferred savings, managing debt, personal savings, and

health care costs. Each video is approximately two to three minutes long. And so let's take a look at video number 3, which is related to personal savings.

(Thereupon a video was played.)

DEPUTY EXECUTIVE OFFICER LUM: So as part of our marketing out of these videos, we will be promoting the videos through our employer bulletin asking our employers to engage in sharing the information. We also are providing the links to our stakeholder and our employer associations. We're promoting through social media. And we will also have these showing at our regional office monitors in the waiting rooms and made available at our Benefit Education Events as well as the Ed Forum.

And I also wanted to remind members of the public that you can access these 10 videos at the CalPERS home page at www.CalPERS.ca.gov.

Madam Chair, that concludes my updates.

CHAIRPERSON MATHUR: Well, thank you, Donna. I really appreciate your continuing to advance this important initiative around financial planning and financial literacy, which I think we've all identified as a major -- can have a major impact on an individual and their long-term sustainability.

So appreciate the work.

DEPUTY EXECUTIVE OFFICER LUM: Thank you.

CHAIRPERSON MATHUR: We do have a couple of questions from the Committee.

So, Mr. Jones.

COMMITTEE MEMBER JONES: Yeah, thank you, Madam Chair.

Ms. Lum, regarding the electronic warrant stub, you mentioned that a member that would like to continue to receive a paper copy they would opt in. And I just wanted to verify that once they opt in, that's it for the duration; they don't have to do anything in year 2, 3, 4, 5; they will continue to receive a paper copy?

DEPUTY EXECUTIVE OFFICER LUM: That's correct.

COMMITTEE MEMBER JONES: Okay.

And if some point in the future they wanted to go to electronic, they can make that option as well. But once they opt into paper, it's paper ongoing.

COMMITTEE MEMBER JONES: Okay. Thank you.

CHAIRPERSON MATHUR: Thank you.

Mr. Jelincic.

BOARD MEMBER JELINCIC: I enjoyed your little video --

DEPUTY EXECUTIVE OFFICER LUM: Thank you

BOARD MEMBER JELINCIC: -- on the question of whether you're going to have enough money in retirement. But unfortunately it kind of begs the question, do you

have enough money in your active employment years?

But my question really was: You've mentioned that the regs on sustainable comp have been -- made it over to the Office of Administrative Law. Do you know if the regs on the combo plan made it to the Office of Administrative Law?

INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS: (Nods head.)

BOARD MEMBER JELINCIC: That was a yes, just for the court reporter.

INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS: Yes, Mr. Jelincic.

BOARD MEMBER JELINCIC: Thank you.

CHAIRPERSON MATHUR: Thank you,

No further questions from the Committee.

So, Ms. Bailey-Crimmins.

INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS: Good morning, Madam Chair and members of the Committee. I'm Liana Bailey-Crimmins, CalPERS team member.

I have three items that I'd like to provide an update to you on. One is on the Affordable Care Act. Since it will be in law for the unforeseeable future, we'd like to remind the Committee of three taxes/fees that impact CalPERS; two, the successes that we've had in

relation to our employer outreach; and then lastly to highlight the accomplishments we've made to date with OptumRx.

So as we heard, on March 24th the ACA repeal and replace was -- basically hit a roadblock and they were unable to get the votes necessary. And so, as such, there have been reports and discussions of Congress and the Administration of trying to come up with a compromise. But, again, it looks like the ACA will be on the books for at least the unforeseeable future.

So what does this mean to CalPERS? There are three taxes/fees that currently impact us. One is the excess -- excise tax also known as the Cadillac Tax. The second is the Patient Center Outcomes Research Trust Fund, which is also known as the PCORI fee. And then the Health Insurer Tax, which is also known as HIT.

So the PCORI expires at the end of 2018. So that's good news. So unless there's an agreement at a federal level and they extend it beyond 2018, we'll no longer have to pay that fee. That fee currently accounts for about 20 cents or a little bit less per member per month.

And then for the Health Insurer Tax, in 2016 this specific tax accounted for about 3 percent of our rate increase in our plans. And then as we hit 2017, the

federal government had waived that tax and so our rates then went down.

But as we embark on 2018, it is unknown if it will continue. And so as such, some of the plans as we're going into rate negotiations are including the tax and others are not. So that's kind of where the magic lies with the negotiations team that we'll be watching.

And then when it comes to the excise tax, it was supposed to go in effect in 2018 but then was extended into 2020.

As you're aware, when we embark on the next five-year agreement, which goes from 2019 to 2023, that's smack right middle of our agreement. And so we have to be very conscious, and so the Health Policy and Research Division is currently monitoring alongside Legislative Affairs and our health care federal reps to ensure that we are completely aware of, as 2020 approaches, what that could potentially impact our agreements.

So I just wanted to let you know we are continuing to monitor the situation and the Pension and Health Benefits Committee will be the first place that we bring any of those impacts to; and we'll stay tuned, we'll keep you apprised of the progress that we make.

And then in March, the health policy and research team completed another round of employer outreach

sessions. Our focus engaged on employers on the upcoming policy changes and the potential impacts of ACA. We had 21 employers participate at the Sacramento event. And because we open it up, we created a call-in feature and an additional 19 employers were able to participate, resulting in quite a few individuals. And as they -- based on their comments we received, they want more from the team. And so what we're doing is working with the stakeholder engagement team to actually have another session at the end of June. So keep your eyes open because there will be more advertisement in relation to that employer outreach.

And last but not least, it's just -- we just hit our 100-day mark when it came to OptumRx. As we have talked about, the transition was less than stellar. The two teams, both OptumRx and CalPERS, have worked tirelessly to actually resolve the issues and implement changes necessary to meet the CalPERS expectations.

I also want to make you aware, there's been a lot of accomplishment, but what we realize is that the public and our members are not always aware of what's going on in relation to our progress. So we are working with Public Affairs on a communication plan which will be made available to our members via our website to make sure that they're completely aware of what we're doing.

Some of the most critical issues that still remain is specifically EGWP Medicare Part D. EGWP stands for the Employer Group Waiver Plan. The other is a Walgreens 90-day retail network. And then the last is customer service.

So specifically EGWP related to Medicare Part D, we are working with OptumRx. Our clinical team and their clinical team have boost up the review process when it comes to prior authorizations. So we want to increase the approval rates. We also want to decrease appeals. And we want to improve the member's experience.

So one of the things we've done is we've increased the clinical outreach. So instead of automatically if there's a medical office where potentially they've forgotten a middle initial or forgot to complete paperwork, we are actually having them reach out to that office to complete that paperwork on behalf of our member.

We're also reviewing the drug denials. If someone is 85 years old and have been on medication for the last 20 years, we are looking at reviewing all that to ensure that the tiering is in place and that they have the appropriate opportunities to remain on that medication.

And then when it comes to Walgreens, I mention this, especially in our rural areas Walgreens is not

always available. And so the teams have worked tirelessly again with OptumRx. And over the next 60 to 90 days, they're going to be opening another hundred plus pharmacy locations like Safeway and others for those specific areas. So that's good news.

And customer service. Despite the improvements that they have made in relation to the secret shopper pop quizzes and improving education, we still believe that they're contact center agents need more education. And as such, we are actually going to send our best of our best team and they're going to train the contact agents down in Southern California, specifically on our benefit designs and on our Medicare Part D EGWP questions. And we believe through this partnership, that will allow us to continue to improve customer service.

In addition to the ombudsman that I mentioned last committee meeting, we've also asked for a customer service rep manager that reports directly to our team. And that customer service rep manager will actually meet with us daily to go over any escalations. So we are really looking to continue to improve the OptumRx experience.

And in closing, I'd like to share some exciting news. I don't know if you're aware, Dr. David Cowling - he's sitting right behind me - was asked to present at the

June Academy Health Annual Research Meeting. And why this is so important is there will be about 2500 health service researchers across the nation that will be in attendance. And as many of you know, an academic conference they actually -- they choose who's going to speak through submittals. And only 10 percent of those submittals actually get accepted for an oral presentation.

So I'd like to acknowledge Mr. David Cowling for both -- he's done a poster review on our Sacramento ACO. And he's also being recognized on an oral report related to Castlight, which is our medical services compare shopper tool.

So with that I'd like to have you stand and be recognized.

(Applause.)

CHAIRPERSON MATHUR: Congratulations, David.

INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS: Great job.

And with that, that concludes my opening remarks, Madam Chair.

CHAIRPERSON MATHUR: Thank you very much.

I see no requests to speak. So we'll move on to Agenda Item 3, the action consent items. Approval of the March 14, 2017, meeting minutes

VICE CHAIRPERSON BILBREY: Move approval.

COMMITTEE MEMBER TAYLOR: Second.

CHAIRPERSON MATHUR: Moved by Bilbrey, seconded by Taylor.

Any discussion on the motion?

Seeing none.

All those in favor say aye.

(Ayes.)

CHAIRPERSON MATHUR: All those opposed?

Motion passes.

Agenda Item 4 are the consent items. I've had no requests to pull anything off consent.

So we'll move on to Agenda Item 5, Health Plan Trend Report.

(Thereupon an overhead presentation was Presented as follows.)

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: Good morning, Madam Chair and members.

CHAIRPERSON MATHUR: Good morning.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: Shari Little, CalPERS team member. Today I'm pleased to present to you the Health Plan Trend Report.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: The purpose of this report is to highlight the key membership trends and costs overall, and it helps --

by service category. Today's report will focus on 2016 fiscal year. And as you know, the costs are stating a per member per month basis.

The dollar amounts on these charts represent the actual contracted allowed amounts versus the net -- that net value -- excuse me -- net amounts paid by the health care plans. Your allowed amounts provide us an opportunity to take a look at what HMOs pay and what -- and PPOs pay versus what the member out-of-pocket costs are and give us an apples-to-apples comparison.

Our membership this year was about 1.2 million members. And the largest increase was in the UnitedHealthcare with the addition of 25,000 members. The largest decrease was of course with Blue Shield NetValue as we were unwinding the plan.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

The changes in allowed PMPM by service category. Overall PMPM -- excuse me. Overall PMPM rose by 7.7 percent across all the 13 service categories. Inpatient prescription drugs and ambulatory surgery account for about half of the total costs. The inpatient rose 2.8 percent, prescription drugs at 2.4 percent, and ambulatory surgery at 7.8 percent. Medical prescriptions while contributing only 5 percent increased by approximately 40

percent.

The overall finding is, while PMPM increased 7.7 percent, this rate is only slightly higher from last year.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

So we're going to use this information obviously as we move into our rate development process. You'll hear a little bit more about that moving forward in our closed session and of course in the May open session. With the increasing trends and overall costs of services, we anticipate that there will be slight increases in premiums and out-of-pocket costs in prem -- for the basic plans.

Inpatient make up about 29 percent of the total cost, and rose only about 2.4 percent.

Prescription drugs make up 16 percent of total cost and rose by 2.8 percent.

The large categories of costs with relatively small percentage may increase and mitigate some of the premium increases. So we're looking at favorable outcomes with rate negotiations.

CalPERS will continue to analyze on an ongoing basis, and of course we want to continue to deliver the best care at the lowest cost.

So with that, I conclude my report and welcome any questions.

CHAIRPERSON MATHUR: Thank you.

Are there any questions from the Committee?

I see none. So I'll thank you for the report.

And we'll move on to Agenda Item Number 6, Health Benefit Design Proposals for 2018.

Ms. Donneson.

(Thereupon an overhead presentation was Presented as follows.)

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Good morning, Madam Chair and members of the Pension and Health Benefits Committee. David Cowling is joining me at the table, because we're going to talk about some of the research that he did in terms of looking at the ambulatory surgery centers over the last two years.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: For today, we're going to -- I'm going to give you a little background on the benefit designs that I will be presenting for 2018.

Then I'm going to talk about the four items that we are going to propose, which is:

To expand reference pricing for ambulatory surgery centers to an additional 12 procedures.

To look at a -- a medical site of care for pharmacy in terms of moving our members to less costly

sites for drugs that are -- are administered through providers in their offices.

We're going to look at an application that we believe will help reduce emergency room use in both our basic and Medicare members.

And finally, we'll talk about the Castlight and Welvie tools that are made available to our basic members for Castlight. But we also want to talk about expanding the Welvie tool, which is a surgical -- a pre-surgical education tool to our Medicare population.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I'm going to now turn this part of the presentation over to Dr. Cowling, who will talk about our experience with reference pricing with procedures in the ambulatory surgery center.

David.

CENTER FOR INNOVATION CHIEF COWLING: Thank you, Kathy.

Good morning, Madam Chair and Committee members.

After the successful hip and knee value-based purchasing design program, CalPERS implemented value-based purchasing design for three inventory surgery center procedures in 2012 amongst our PPO population -- basic PPO population. And we implemented that with Anthem for

colonoscopy, cataract, and arthroscopic surgery. And the way it works is if a member goes to an ambulatory surgery center, they pay the standard deductible and their regular co-insurance. And if they go to a hospital outpatient facility, they would pay the deductible, their regular co-insurance, and then they would pay the amount above the reference price.

And so for these three procedures the reference prices were 1500 for colonoscopy, 2,000 for a cataract, and 6,000 for arthroscopic surgery.

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CENTER FOR INNOVATION CHIEF COWLING: And so slide 4 we see that to evaluate these programs we partnered with UC Berkeley. And there was some un -- Anthem gave Berkeley some unique data. They gave them the non-CalPERS commercial population for California as well. So we have a true comparison to be able to see what was going on in CalPERS population versus the rest of California.

And so what we see here is the percentage of patients choosing ambulatory surgery center for cataract surgery.

Important thing to note is that the price differential between going to a hospital outpatient is 7500 for the hospital outpatient versus 2,250 for the

ambulatory surgery centers.

And so the blue line here is the CalPERS population and the orange dotted line -- I hope it's orange but not pink or something. But what we see is that for the CalPERS population it increased -- use of the ambulatory surgery center increased from 76 percent to 91 percent; whereas for the rest of the California population it increased just a little bit.

And so the savings from this part is all due to the members changing from hospital outpatient to the ambulatory surgery centers.

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CENTER FOR INNOVATION CHIEF COWLING: And So if we go to the next slide, slide 5, is colonoscopy, we have a similar story to tell, which is that our members increased its use of ambulatory surgery center from 68 percent to 90 percent. And the rest of California was pretty flat across that time period.

And, again, the prices at the hospital outpatients are about 80 percent higher or about a thousand dollars per procedure.

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CENTER FOR INNOVATION CHIEF COWLING: And on slide 6 we can see the same story for the arthroscopic surgery. Our members went to the ambulatory surgery

centers 60 percent of the time, and that increased to 83 percent over the time period.

And again in California, it was fairly flat in terms of the use of the ambulatory surgery centers. And in this situation, the difference between hospital outpatient and ambulatory surgery centers is about $4,000. So every member who chooses to go to the ambulatory surgery center is a substantial amount of savings.

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CENTER FOR INNOVATION CHIEF COWLING: So slide 7 is the results from UC Berkeley. These results were published in peer-review journals like Health Affairs and JAMA Internal Medicine.

And what we see here is that the savings for these three procedures was between 17 and 28 percent in spend. And this accounts for about $5 million per year in savings.

And one really important part here is that there was no change in complication rates; and, in fact, they were slightly better. And this is maybe not surprising. We know that sending people to higher volume facilities usually increases quality, and that's what we saw here.

Kathy.

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CHAIRPERSON MATHUR: Can we interrupt for some

questions at this time? Would that be appropriate?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Absolutely.

CHAIRPERSON MATHUR: All right. Thank you.

Mr. Jelincic.

BOARD MEMBER JELINCIC: Looking at slides 4, 5, 6, where you compare us to the non-CalPERS population, you said that was the Anthem data. Do we --

CENTER FOR INNOVATION CHIEF COWLING: That's correct.

BOARD MEMBER JELINCIC: Do we know if any of the non-PERS Anthem that would have been included in that use reference pricing or some other forms of incentives to direct people the way we want them to go?

CENTER FOR INNOVATION CHIEF COWLING: So I don't know about other incentive items but other reference pricing programs, because Anthem does have other purchasers who are using reference pricing, and those were excluded from this population.

BOARD MEMBER JELINCIC: Those were excluded?

CENTER FOR INNOVATION CHIEF COWLING: Excluded from this non-CalPERS population. My understanding, it's not a huge amount of their commercial population, but it was excluded from these numbers.

BOARD MEMBER JELINCIC: Okay. So it really

reflects changes on the natural rather than through incentives.

CENTER FOR INNOVATION CHIEF COWLING: Yes.

BOARD MEMBER JELINCIC: Thank you.

CHAIRPERSON MATHUR: One of the outcomes of our hip and knee reference pricing model approach was that the marketplace as a whole changed and we saw pricing come down. Have we seen something similar for these other procedures that you've talked about today, the cataract, colonoscopy, and arthroscopy?

CENTER FOR INNOVATION CHIEF COWLING: Yes. So I usually tell that story as the hip and knees is a market story. Whereas that program changed the way the market priced hips and knee procedures. This is a consumer story. So in this case, our members changed their behavior rather than the providers changing their behavior.

CHAIRPERSON MATHUR: Okay. And you still --

CENTER FOR INNOVATION CHIEF COWLING: So those prices were fairly stable across time, and we didn't see price changes in the hospital outpatient charts.

CHAIRPERSON MATHUR: Okay. I wonder if -- over the long term is if others adopt this type of approach as well, we'd see more movement in the market.

Okay. Thank you. You can continue.

Kathy, you need to turn your mic on, I think.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Oh, thank you.

So we're here today to talk about four benefit designs that we would like you to consider for making a decision in June 2017 when you approve the rates.

As you can see from David's presentation, the use of ambulatory surgery centers has been a success story for CalPERS, and it's successful for a reason:

One, these are procedures that are elective and they can be prescheduled.

They're safe. And patient safety is one of our biggest concerns in terms of looking at any benefit design we propose, such as value-based purchasing for ambulatory surgery; or even the pharmacy medical side of care. So please keep in mind that safety is always our first consideration.

And also quality as equal to or better. And as David has explained, and what we originally thought, is that volume in surgery centers actually is a quality component; that the more that occurs by the surgeons, the safer is the environment for the patient.

So I'd like you to look at your agenda item on page 3 of 5, which has a table with 12 additional procedures we would like you to consider in terms of

reference pricing for ambulatory surgery centers. This is not the entire list that I was provided by Anthem Blue Cross. There are others. But these are the 12 that we thought we'd like you to consider, because you will note especially with the results from colonoscopy, the upper -- the gastrointestinal disorders is our fourth highest spend. When we created the hip and knee replacement reference pricing, we did so because it represented a significant portion of spend just on two procedures, hip replacement and knee replacement. But the musculoskeletal disorders overall accounted and still does account as our number one cost category for health spending. So we went to the gastrointestinal as number 4, number 2 being cancer care and number 3 being heart.

So that's why you see a number of the gastrointestinal procedures here, including laparoscopic gallbladder, which five years ago could not be safely done in an ambulatory surgery center but can be today because of advances in technology.

We've also added a few additional procedures outside of the GI tract such as hysterectomies, which falls under the GU system, which is another high cost - it's I think either number 6 or number 7. So we looked at both volume and we looked at cost and we looked at procedures that we know are high priced for us.

We've also provided in this table the difference, the high range and the low range for an ambulatory surgery center compared to an outpatient hospital center. And as we presented our earlier work, in moving to the procedures that David talked about, we knew that for the very same procedure for both safety prequalification, and quality, that they could have the same procedure in an outpatient hospital facility, but right across the street was an ambulatory surgery center that was considerably less. So we have provided both the high and low values for these for comparison, as well as the recommended reference price by the Anthem not just pricing team but the clinical team as well. We would not put these procedures on a list to have you consider if it hadn't been fully vetted by physicians at Anthem.

These reference prices represent the statewide geographic -- statewide geography and does not reflect a reference price by a specific region. So our members -- our PPO members who would be reference priced, it wouldn't matter where they -- where they lived in terms of the reference price that they would receive in their -- in their service area.

So that is our recommendation that we consider, and have you continue the consider for June expanding reference pricing for the procedures listed in this agenda

item.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I also want to talk to you about aligning our site of care for medical pharmacy. Medical pharmacy is provider-administered drugs, whether it's in an outpatient hospital facility, an infusion center, a physician's office; or the home. We have in the past presented the site of care alignment materials to you in terms of medical pharmacy which is paid not on the pharmacy benefit but on the medical benefit.

So you can have the very same drug with the very same infusion dosage administered in one of four settings. And let me give you an example. There's a very expensive drug called Remicade, and we -- CalPERS spends quite a bit of money on Remicade. It is an infused drug. It can be safely administered in the home under this -- with the supervision of a skilled nurse. It could be infused in an infusion center, it could be infused in a physician's office, it could also be infused in an outpatient hospital setting.

The same drug, same infusion depending on site of care will also -- will also be more costly if you're in an outpatient hospital than if you're in the physician's office or the infusion center or the home.

So we are going to continue to look at this. It is a program Anthem is making available to CalPERS as a purchaser and to other purchases as well. But we want to make sure that before we come back to talk to you in May and have you make a decision in June, that we fully understand how this particular program works.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: As this Committee knows, the use of the emergency room is another cost driver for CalPERS; and not only does it drive our costs, it drives the convenience for the member, the member's cost share. We would like to see any procedures that can safely be dealt with outside of the emergency room be handled in an alternate site of care.

So Anthem is making available an application that can go on to a personal device that allows a member to look up an alternate site of care to the emergency room. Now, it does not replace the medical component to any type of emergency. We still we have the nurse helpline. We have other methods that they -- we still want them to go to the emergency room if they feel they need to. But it's just a tool to help them determine if there's an alternate site of care; and it's called the Quick Care options.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: This last one, the last I wish to talk to you about in terms of benefit design, actually is a continuation of tools that we already have in place. The Castlight tool has been invaluable in terms of any type of reference pricing for our members to know where to go.

In addition to the EOC, our explanation of coverage, the Welvie on-line tool is offered as a tool for members to be educated on alternatives to surgery. And our members are using the Welvie tool. Currently it is available through the -- to the basic plan members which we wish to continue. However, under a CMMI, a Centers for Medicaid and Medicare Innovation grant, Medicare has identified that this tool is also valuable to the elderly in giving them an option in terms of their care. So we would like to recommend that this be expanded to the Medicare population as well.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: And then the last -- and to conclude, this presentation, I just want to reference the savings chart on page four of five of this agenda item. And each one of these options that I've provided does have savings. One of the things that David did not mention in his presentation is the increase in our membership using the

ambulatory surgery center option. And so while this page of the agenda item provides the savings for expansion, which is the first row of the 2018 net savings comparison, it is assumed 10 percent, but we've already seen that anywhere from 15 to 20 percent will migrate. So this is a very conservative estimate of $2 million in terms of expanding value-based purchasing design.

I did put the 5 million because those are ongoing for the current three that we have. And then 3 million would be the estimated savings in aligning the medical pharmacy to sites of administration.

And then the remainder -- the use of the emergency app would be a small savings but its intent is to at least pay for itself so that it adds another tool for our members who might want to have another option besides the emergency room.

So that concludes my portion of the presentation. I appreciate your attention, and thank you. And I'm available, as is David, for any additional questions.

CHAIRPERSON MATHUR: Thank you. We do have some questions.

Ms. Taylor.

COMMITTEE MEMBER TAYLOR: Yes, thank you, Madam Chair.

I just want to clarity - and I know this is what

I'm reading - but these tools are all for our PPO plans, correct.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Correct.

COMMITTEE MEMBER TAYLOR: Okay. And it's Anthem that is doing most of the work for us?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: It's Anthem who's our third party administrator.

COMMITTEE MEMBER TAYLOR: All right. Great. And I appreciate that. Thank you.

CHAIRPERSON MATHUR: But on that point though, is it -- would it be valuable to consider its use -- the utilization of some of these tools through the HMO as well? And are we having conversations about that?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: We certainly could go back to our HMOs and consider this as well and bring you a report in May on what that might look like.

CHAIRPERSON MATHUR: Seems like that might add additional value to our members and might have positive impact on some of the rates as well --

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yes.

CHAIRPERSON MATHUR: -- if utilization in the

highest costs centers goes down.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Correct.

CHAIRPERSON MATHUR: Okay. Mr. Lofaso.

ACTING COMMITTEE MEMBER LOFASO: Thank you, Madam Chair.

Congratulations, Mr. Cowling, again. Thank you both for your comments on quality and safety.

I had one question but I just wanted to -- the last two questions. I get -- I was under the impression that some of these tools that are Anthem proprietary are also in the Anthem HMO just because Anthem offers them. And the real point of the question is, I thought some of these tools the Chair made reference to were proprietary for certain plans. And are they expandable? Can you clarify?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I don't believe either one of these are -- well, let me start with Welvie. Welvie is not a proprietary tool just to Anthem. It is a company that makes this tool available to both the HMO plans as well as the PPO plan.

For the Castlight tool, it is -- it's a subcontractor relationship with Anthem in terms of how we obtain it, and it's used for our basic members. Because

it actually does require that we load claims data, both medical and pharmacy, in order for it to function. But Castlight itself is not proprietary.

ACTING COMMITTEE MEMBER LOFASO: Appreciate that. That's confused me a little bit.

But the real reason I punched up was the Medicaid -- the medical pharmacy side of care. The staff memo says it exempts oncology. Can you elaborate on that?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yes, thank you. The oncology program is actually administered as a program in its entirety in another program that we have through Anthem. And so this particular one would not include those oncology drugs because they're administered in another way through the Anthem PPO.

ACTING COMMITTEE MEMBER LOFASO: Thank you.

Thank you, Madam Chair.

CHAIRPERSON MATHUR: Thank you.

Mr. Jelincic.

BOARD MEMBER JELINCIC: You referenced a pricing chart or a savings chart.

Can you tell me where it is, because I can't --

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: It's Page 405 in the actual written agenda item.

CHAIRPERSON MATHUR: It's not in the presentation. It's in the agenda item.

BOARD MEMBER JELINCIC: Okay. But I'm looking at the agenda item and --

CHAIRPERSON MATHUR: Page 4?

BOARD MEMBER JELINCIC: Page 4 of 5, Item 6.

COMMITTEE MEMBER HOLLINGER: 38 of the iPad.

BOARD MEMBER JELINCIC: 38 of the iPad.

CHAIRPERSON MATHUR: In the middle, "2018 Net savings comparison."

BOARD MEMBER JELINCIC: I see the chart I just don't see where it's showing the savings. Maybe I'm just not reading it right.

CHAIRPERSON MATHUR: The savings are under "Basic." You see $2.04 million?

BOARD MEMBER JELINCIC: Oh, That's 2. -- okay.

CHAIRPERSON MATHUR: You see that?

BOARD MEMBER JELINCIC: I see it now. I just wasn't understanding what I was looking at.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: We will try to do better next time. Thank you.

BOARD MEMBER JELINCIC: If I'm the only one who didn't get it, I wouldn't worry about it.

(Laughter.)

BOARD MEMBER JELINCIC: They'll be happy to help

me find it.

Thank you.

CHAIRPERSON MATHUR: All right. Thanks, J.J.

I just had one amplifying question on page 3 of 5 with respect to the reference pricing for the additional 12 procedures. And I think you did address this. But these reference prices that are being recommended, our members will be able to find high quality providers at these prices anywhere in California, in any region of California; is that correct?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yes, we believe that to be true. But we will take another month and make sure that we vet this more thoroughly and come back with additional information for you.

CHAIRPERSON MATHUR: Okay. Thank you.

All right. I see no further requests from the Committee.

So we'll move on to Agenda Item 7. Health Care Beliefs - Planning.

INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:

Thank you, Madam Chair. Today's information item will lay out a framework and an approach to developing a set of CalPERS health care beliefs.

(Thereupon an overhead presentation was

Presented as follows.)

INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:

So over the past several years CalPERS has set national precedence when it developed both pension and investment believes, which has helped guide decision making, provided context to our actions, and improved our overall management of programs.

As an influencer in the health care space, CalPERS will act as a guide for others to follow.

So my three main takeaways for you today is:

One, the timeline of events, which will be milestones over the next seven to eight months of our journey that we'll be embarking together.

Two is our inclusive approach, which we will be reaching out to our stakeholders, which are actives, employers, and our retirees, and we'll be asking them their priorities of where we will have the strongest voice on behalf of the health care industry.

And then, last, pull back the curtain and show some of the considerations that we will be discussing as we develop health care belief statements.

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INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:

So as you can see by the graph, beliefs are built on a set of foundational building blocks; starting at the

most specific, which will be the laws and regulations. And as we move up the pyramids to the beliefs, that's where you reach the highest level, which is where the Board has decided it wants to be.

We already have established guidelines. And we have set priorities. In the February Board meeting where we set the federal rep, I think there was four or five priorities. CalPERS has a set of core values. And obviously we'll be working on our belief statements.

As a reminder, beliefs are the lens with which we see everything. So that is extremely important that we establish a timeline that we think we can be successful at.

So what you have in front of you is in -- today we are talking about our framework. May and June is where we're going to be working with public affairs and stakeholder engagement to reach out to our population of employers and retirees and actives. We're also going to be looking at internal stakeholders such as the staff and the executives.

As question hit the July off site

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INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS: As we hit the July offsite, based on those stakeholder outreach efforts, we're going to look at where

we can come up with eight to ten priorities that overlap between all of those outreach efforts. And we'll be working with coming to the July offsite with a set of actual belief statements with which the Board can react to.

And as you know, July will end and we'll only have about two weeks before we actually start the August Board session. If we need to, this schedule actually permits us to add another workshop or another session in August if we need more time.

And then in September, the goal is to present here at the Pension and Health Benefits Committee our belief statements, with then goal after the October Ed Forum to publish those beliefs and then retire the guidelines.

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INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS: So what type of milestones will we hit along our way? One is we want to build upon the successes we've already established. In our current state we currently have the guidelines and the priorities which will help guide the conversation.

And then as we progress on the milestone chart, we want to establish a desired state. Again, where can CalPERS continue to have the highest amount of -- the

largest voice in the health care industry?

And then discussing perspectives is extremely important as we look at a health care belief statement, and I'll go into more detail on a future slide. But understanding the lens and perspective by how that belief statement is actually written.

And then, last, the industry says that about 8 to 10 beliefs are really the sweet spot. You go more than 10 beliefs, a lot of times it ends up being very difficult for people to remember, because a belief is something that we all should be able to live by and be able to cite. So that's kind of the goal is to hit the 8 to 10.

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INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:

So as I was talking about our reach to the stakeholders, we want to look at where again we can provide the biggest influence. So as an example, if disease management innovation, you have a list of those that are in the center of the slide. But as you establish what those -- those focus areas are, we also have to be very conscious of the drivers. There are obviously driving forces to ensure that when we develop a belief statement, it's a good fit for CalPERS, that it reflects the members that we -- we serve, and then obviously the right -- you know, with the triple aim, and then a quality

access and affordable health care is extremely important.

But on the flip side, we also have restraining forces. So as you're aware, there's federal and state policies that we're going to need to be aware of. There is changing technology; every 18 to 24 months health care technology changes and so sometimes those costs are trying to be built into our plans, and so we have to be very cognizant of that.

And health care is a very dynamic market. So just being very aware of hospital consolidations and how that actually reduces the, you know, competition in the market, and then trade-offs. So as we decide in one area, sometimes there's a tradeoff on the other. So as we go through this, it's important that we'll be discussing that more in July.

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INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS: And then perspective. So as we look at this example, is -- this is an example specifically related to pharmacy. So as a State department, we are an employer. And so if you look at writing a belief statement related to pharmaceuticals, you will see that from an employer's belief statement we might write, "We will only pay for new drugs that are more effective than alternatives." But also, we have federal pol -- you know, we have federal

reps and we may be actually lobbying for certain federal policies from a lobbyist's viewpoint. So if you take the same belief statement, you would actually change it, which says "Faster approval of new drugs is a regulatory priority." Very different than if you write a belief statement from the employer.

And then obviously as an investor, making sure that the drugs save lives and they're priced at a price point that the market will bear.

And then a purchaser, because CalPERS is the second largest purchaser of health care services in the nation, you would write that belief statement in a very different way, which would be "New drugs must be proven effective and priced in and aligned with their impact on health."

So as we look at the focus areas, we're also going to be working with the stakeholders of saying, "Well, we like those belief statements. Where would they like to see that lens?" And again we'll be bringing that back to you.

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INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:

And the next steps. So as we saw in the timeline, May and June is a vital time for us to really do a lot of outreach. There are already sessions on the

stakeholder engagement calendar we plan to leverage. We would have loved to have waited to the October Ed Forum, because a lot more employers; but then that would have really pushed the belief statements to probably mid of next year.

And we get asked on a consistent basis to write letters of support and actually have an active voice in legislation. Recently we were asked related to Medicare-Medicaid invocation. And the beliefs would have helped to decide if we actually provide that letter of support or not. Because we don't want to water down our voice. We want to make sure we focus on the things that we believe.

And then obviously July we'll have our belief work -- I don't want to call it a workshop. It will be an opportunity for all of us to interact. And then hopefully in August we'll be presenting that back to the Pension and Health Benefits Committee.

So this is again a high level. It's just kind of a taster of the planning process we'll be undertaking. But that concludes my presentation, and I'm available for questions.

CHAIRPERSON MATHUR: Thank you.

Mr. Jones.

COMMITTEE MEMBER JONES: Yeah, thank you, Madam

Chair.

First of all, thank you for a very clear picture of where we're going with the investment beliefs. It's very well --

CHAIRPERSON MATHUR: Health beliefs.

(Laughter.)

COMMITTEE MEMBER JONES: I know why I'm saying investments.

(Laughter.)

COMMITTEE MEMBER JONES: Health beliefs.

But the question I have is that -- and I agree that it should not be more than 8 to 10. But lessons learned from our investment beliefs strategy, they bought us only 8 or 10 first and the Committee started asking questions, so they have to bring more. And from that we came up with our 10. So I just wanted to know what was your view of, you know, how many you're going to bring for us to get to the 8 or 10.

INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:

Well, I'm all about full transparency. So what I'm going to show you is what the employers come up with, the retirees, and really show you where the overlap is. And then basically we'll provide you 8 to 10, which is where all the overlap will occur, where all of us are in agreement. But I'll also provide you some areas of belief

statements in some of the others that are also maybe not as common theme but show you the full picture so that you can react to.

COMMITTEE MEMBER JONES: Okay. Great. Thank you.

CHAIRPERSON MATHUR: Thank you, Mr. Jones.

Ms. Taylor.

COMMITTEE MEMBER TAYLOR: Thank you, Madam Chair.

So -- and I as I'm looking at this specifically for the -- you're using the pharmaceuticals, I was hoping that I could encourage you to look at not just -- we're kind of in a box here with the pharmac -- what you're looking at here. So I'm hoping to encourage you folks to look at not just market-based but is there -- you know, is this belief going to translate into can we purchase across, you know, Canada and Mexico, you know, that kind of thing? Are we -- it can't just be that we're trying to contain the cost here in the United States. Are there other avenues as well as in health care itself? You know, let's not just keep ourselves in this box of it's only this market-based as we look at believes.

INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS:

So if I hear you correctly, Ms. Taylor, it's just being very open. I know I gave four examples and -- of the types of lenses and perspectives we can take on.

COMMITTEE MEMBER TAYLOR: Right.

INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS: But obviously there are more that we can be discussing as we have conversations with the stakeholders and with the Board.

COMMITTEE MEMBER TAYLOR: Right, bigger picture. Yeah, absolutely.

Thank you.

INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS: Thank you.

CHAIRPERSON MATHUR: I think one other thing that's important to note and to keep in mind is, in the Pension Beliefs, we have our 11th belief, which is, you know, that we believe that all working Americans should have access to health care or should have -- sorry -- retirement security. And I think there's probably some appetite to consider something similar on the health side.

So that exhausts the questions on this item.

So that will bring us to Agenda Item Number 8, Health Care Combination Enrollments.

(Thereupon an overhead presentation was Presented as follows.)

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: Good morning again, Madam Chair and members.

At the February Board meeting you asked -- we

asked the Board to approve the submission of a reg package to go to the Office of Administration[sic] Law clarifying that all family members in combination plans enroll in one basic and one Medicare plan from the same insurance -- health insurance carrier.

We also heard from retirees that expressed desire to kind of move forward and explore other opportunities where they had the opportunity to enroll in multiple plans. So we went back and we -- you directed us to go back and provide an analysis to you. So we started out by asking some basic questions of:

Why don't we allow members to do this already?

What would happen if we do?

And what would that entail from an operational standpoint to do so?

So this required looking at numerous processes and policies and systems. And I will thank my team and HPRD for doing a great job in a very short amount of time. I think we've done a pretty good job with a thorough analysis, but I'm sure there will be questions to follow.

So with that, I'm going to turn it over to Karen Pales, who's going to talk to you a little bit about our findings.

MS. PALES: Good morning, Madam Chair, members of the Committee. Karen Pales, CalPERS team member. This

morning I'm going to present Agenda Item Number 8, and it's an information item.

As you may recall, the proposed Medicare Combination Plan --

CHAIRPERSON MATHUR: Karen, I'm sorry to interrupt you. Could you move the mic a little bit closer to you.

MS. PALES: Sure.

CHAIRPERSON MATHUR: Thank you.

MS. PALES: As you may recall, the proposed Medicare Combination Plan regulation didn't change the way that we do business. However, we believed that the regulation clarification was necessary to dispel any confusion about CalPERS enrollment rules or our intentions. At the February Pension and Health Benefits Committee meeting and then the next day at the Board meeting, we understood there was some confusion for both the Board and our retirees. Therefore we're here today to clear up any misconceptions.

Medicare plan enrollees and their families need to know that we are their advocates when we analyze health benefit options. We want the best for our members.

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MS. PALES: Today I'm going to present our analysis of what the CalPERS health benefits landscape

would look like if we allowed members to enroll in health plans offered by multiple carriers. The multi-carrier concept would cost between 12- and $15 million for CalPERS system changes and take about four years to submit a budget change proposed and then develop and implement the system change.

I realize that in prior discussions there was a million-dollar figure that was mentioned. We did some digging on that and found that it actually wasn't related to the multi-carrier enrollment within CalPERS systems and partners. The one-million-dollar figure actually related to one of the Medicare optimization ideas that was researched back in 2012. It was specifically the Medicare exchange pilot project that we were thinking of for 2013, but we didn't move forward on that.

The multi-carrier concept would mean departing from the group health plan model of an eligible subscriber and their eligible dependents currently used to develop our rates and transmit electronic data. And instead we would have to use something similar to what's used in the individual market.

Any of CalPERS' external business partners such as our health plans or the contracting employers or the State Controller's office would need to make changes to their systems also and their health contribution and

deduction processes.

Before I share more details about what we discovered in our research, I'd like to set the groundwork for what HPRD does and what our responsibility is to our members. I'll then talk a bit about how we got to this point and maybe help us understand why we're having this discussion at this point in time. And then, lastly, I'm going to talk about our experience with implementing the single UnitedHealthcare Medicare Advantage Plan back in 2016 and how that implementation affected families enrolled in the combination health plans.

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MS. PALES: As a health benefits purchaser in the large group market, CalPERS is continually assessing innovative ways to provide high quality accessible and affordable health care to our more than 1.4 million members in both our Medicare and our basic plans.

When we evaluate Medicare and basic plan options, we do so with an eye on what types of benefit design best suit all of our enrollers. For our Medicare members we strive to provide high quality plans, plans that provide a superior level of care and offer a wide range of benefits. Our retirees worked hard for these promised benefits and they deserve them.

Our Medicare members have a choice of HMO plans

from both Kaiser and UnitedHealthcare and also our PERS-branded PPO plans. These plans are accessible throughout California and out of state.

But we always strive to do better, to respond to the needs of our Medicare members.

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MS. PALES: Let's take a look at the timeline. So in 2012, HPRD embarked on multiple strategic efforts at the direction of the Pension and Health Benefits Committee. Medicare optimization was one of the 21 health benefit purchasing initiatives that HPRD pursued.

Various Medicare plan options were emerging at that time, and they allowed Medicare eligible individuals to enroll in plans that had attractive prices. But these options didn't have the Medicare plan coupled with the basic plan for the families, which was how CalPERS had traditionally offered our plans.

So at that point we realized our regulations prevented us from considering some of these options, and we proposed a number of legal changes that were enacted in 2013. These changes were intended to allow the Board to direct the CalPERS team to rapidly implement any Medicare plan options that they saw as an opportunity and to provide Medicare-eligible retirees more diverse plan options and that might best meet their needs, while also

reducing administrative costs.

In 2014, HPRD began looking at a product called a Medicare exchange. Ultimately the Medicare exchange option didn't get pursued basically because it could have exposed the retirees to hire premiums and potentially denial of coverage issues. They would also have required some benefit design data system and administrative changes. And these types of changes were not then and kind of aren't now in line with CalPERS' stated strategic objective to provide the high quality accessible and affordable health care to its members.

But with that option appearing to be at a dead-end, we considered a new option in 2015, and that was that single non-Kaiser HMO plan offered by UnitedHealthcare.

So let's look at what made this UnitedHealthcare plan so appealing.

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MS. PALES: This plan option had a basic and a Medicare plan coupled so it would provide for the families. And it provided a more affordable and benefit-rich enrollment option, and it was going to be good for the majority of our Medicare and combination enrollment families. It also required no difficult benefit design or data system changes.

It's also really important to keep in mind that although the UHC Medicare Advantage Plan did offer premium savings to the enrollees for 2016, implementing it wasn't just a financial decision. The Board looked at all aspects of the plan.

As you can see on the slide, some of the best things about the UHC Advantage Plan that made it really a good fit for CalPERS were the extra benefits that we included. The Silver Sneakers program, for example, the House Calls program, they have a comprehensive national network of providers; and they offer vision and dental options for our retirees who don't have the vision and dental as part of their retiree benefit package. These are valuable benefits that we had heard time after time from our retirees that they wanted as part of their CalPERS Medicare options, so we were pretty excited when we found a plan that offered them.

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MS. PALES: When we implemented the united single Medicare option back in 2016, all Medicare members and combination plan families that were enrolled in our Anthem HMO, the Blue Shield, Health Net, and Sharp, they would no longer be able to remain enrolled in those HMO plans. So the combination plan members were notified by CalPERS that a plan change was going to be required for the 2015 open

enrollment period, because their Medicare basic HMO option wasn't going to be available to them.

The notification informed them that if they didn't select a health plan during open enrollment, the family would be administratively transferred either to UnitedHealthcare if there was basic available in their region or to PERS Choice PPO if the UnitedHealthcare basic plan wasn't available in their area. And these changes were effective January 1st of 2016.

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MS. PALES: When you look at the CalPERS health benefit population, there's about 270,000 Medicare plan members. And in any given year, there's right around 62,000 individuals enrolled in the combination plans. That would be the association plans, our HMOs, and our PPOs. The overall population size seems to remain fairly consistent year after year.

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MS. PALES: Prior to the plan year 2016 approximately 15,000 individuals were enrolled in the Anthem HMO, the Blue Shield, the Health Net, and the Sharp, the combination plans that were no longer available after the UHC Medicare advantage implementation.

These individuals needed to take a plan change for plan year 2016. And in 2015, this population, this

15,000 represented about 1.1 percent of CalPERS approximately 1.4 million health program members.

Of the 15,000 combination plan individuals, a little over half of those people are in basic health plans. If UnitedHealthcare was not available in their basic plan service area, many of those individuals now find themselves in the PERS Choice PPO. And they do face higher out-of-pocket costs than they experience when they enrolled in the HMO. They retain the ability to access the providers they had before, but now they have deductibles and co-insurance.

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MS. PALES: Our research on the impacts to members, business partners, and CalPERS Health Benefits program from allowing a multi-carrier enrollment for combination families, it included looking at both internal and external systems, processes, regulations, and costs. Allowing multi-carrier enrollment for combination enrollment families, it would allow each member in the combination plan enrollment the ability to select the health plan and the carrier of their choice. And it could also allow those basic plan members to remain in the HMO where they would not be subject to the deductibles and the co-insurance.

The potential impacts to systems and business

partners is more far reaching though. Each of the areas we identified in our research as being impacted is explored in detail in the agenda item so I'm not going to go into a lot of detail here. I just wanted to highlight a few potential impacts at a high level.

Allowing multi-carrier enrollments for combination enrollment families could result in increased administrative costs, potentially leading to higher health premiums. This would be from things like increased transactions which could require additional resources, and things like the IT investment of up to $15 million and four years for the CalPERS system changes. It would be a movement away from group health plan processes to something much more aligned with the individual market. As a group health plan, CalPERS has the single party of that two party in the family enrollment tiers. The structure is used for enrollment, for data exchange, and for health plan rate development.

There would also be changes to data interfaces with our external partners, including our health plans, the State Controller's office, and contracting employers who would need to implement changes to their systems and would most likely incur costs to do so.

And it would be a variance from established electronic data handling practices that help ensure

compliance with the American National Standards Institute, the ANSI standards, for large group health plans under HIPAA.

As a large group health plan, CalPERS uses electronic records. The definitions of subscriber and dependent are clearly laid out in the ANSI standards. As an example, under the large group portion of the ANSI rules the subscriber is eligible for benefits based on their association with a sponsor, which in CalPERS' case would be the employer. And then the dependents are eligible for health benefits based on their association with the subscriber.

So the idea that we could do some type of a placeholder subscriber role so that the dependents could enroll in their own right is actually not allowed under the ANSI rules for the large plans -- the group plans.

It would also make changes to many of the my|CalPERS system processes including things like our health enrollments, our health contracts, and our public agency billing. As an example, many of our employers set their health contribution rate based on the plan that the employee's enrolled in. If the family was in more than one plan, that would require a change for the employer and potentially a new health contract, a resolution with CalPERS to reflect that new cost-sharing agreement.

It's also really important to keep in mind that CalPERS adopted a new five-year strategic plan in February, which includes among its overarching goals health care affordability and reduction of complexity across the organization.

So the Board would clearly take these goals into consideration in any future changes to the CalPERS business model.

--o0o--

MS. PALES: So what does this look like moving forward? This is an information item, so we're not asking the Committee to make any -- take any action here. But we do however want to provide you with some understanding of the landscape as we see it moving forward from today.

We recognize that for some of our combination enrollment families for now, they're in a tougher spot than they were before 2016. But they still have access to quality health care, and they can currently select the Kaiser or the UnitedHealthcare Medicare Advantage plans, or any of our PERS-branded PPO plans.

As I mentioned at the beginning of my presentation, CalPERS is continually assessing innovative ways to provide high quality, accessible, and affordable health care to our 1.4 million members in both our basic and our Medicare plans.

And as you all well know, health care is a dynamic industry and ideas are being introduced and tested regularly. The landscape for health care is changing constantly at the federal, the state, and the local purchaser level. So we're going to continue working with our partners across the state and in Washington D.C. to advocate for our program and to collaborate on any emerging ideas. If and when we discover a plan option that in the balance is a good fit for both our members and our program, having the ability for the enrollings in the combination plans to choose separate carries might turn out to be beneficial for us.

We're always moving forward and we're always looking for opportunities. We never know what's going to come over the next hill or what options we might discover. So if and when opportunities present themselves, we'll do the analysis and we'll assess the options, and anything promising we'll bring forward to the Committee for consideration.

This concludes my presentation, and I would be happy to answer any questions.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

And just a point of clarification. There was an earlier question. We have not submitted the reg package to the Office of Administrative Law. We're waiting for

Board direction first.

CHAIRPERSON MATHUR: Okay. Thank you.

Well, I thank you for such a thorough and comprehensive overview and analysis. I know it took a yeoman's effort to get it done for today, and I think you did a wonderful job.

You have spurred quite a lot of questions from the Committee, so I'll move to those questions now.

Mr. Jones.

COMMITTEE MEMBER JONES: Yeah, thank you, Madam Chair.

I also want to thank you for the analysis. It's a -- it could serve as a template to be used to provide information so that informed decisions can be made when you're making major changes that affect so many members. And because I look through my lens differently now based on this information than I did when I was told $1 million and now it's $15 million and that doesn't even include the impact on the state agencies and local school districts and cities and counties. And so -- and also the impact the risks that are involved with HIPAA and some of the other memorandums of understanding, et cetera.

So I have the information now to be informed. So I just want to thank you for it.

MS. PALES: You're welcome.

CHAIRPERSON MATHUR: Thank you, Mr. Jones.

Ms. Taylor.

COMMITTEE MEMBER TAYLOR: Thank you, Madam Chair.

I also want to thank you for this. I know we asked you to come back because we had some concerns about this. Really, really thorough. I appreciate it.

I had one question on our 15,000 folks that needed to make plan changes. And then I think you said half may have to go to the PPO. Are those our rural folks basically?

MS. PALES: It depends on the coverage in their area. So it just depends on whether -- what plans we have available in their area.

And also an interesting point for consideration, is that of those 15,000, only 1500 were in a position where their only option was the PPO. In many of the areas of California we have more than one option.

COMMITTEE MEMBER TAYLOR: That's awesome?

All right. That's what I wanted to clarify.

Thank you.

CHAIRPERSON MATHUR: Thank you.

Mr. Lawyer.

ACTING COMMITTEE MEMBER LAWYER: I appreciate the report.

I was curious that since over a year has elapsed

since United has served as the sole non-Kaiser Medicare Advantage plan. What has been the member experience for those impacted combination enrollees in terms of customer service, complaints, or anything of that sort?

MS. PALES: So we reached out to our member account services area and the call center folks, and they don't actually track to that level of detail. So they didn't have numbers for us on, you know, folks that had called with concerns. Although they were able to tell us that there was only one situation that rose to the level of an appeal.

ACTING COMMITTEE MEMBER LAWYER: Appreciate it.

CHAIRPERSON MATHUR: Thank you.

Please note for the record that Mr. Slaton has also joined us this morning.

Mr. Lofaso.

ACTING COMMITTEE MEMBER LOFASO: Thank you, Madam Chair.

Again, also, thank you for the report.

Just one quick background question. There's been a lot of measurable savings throughout the system from the Medicare option, just to point that out for the record.

I wasn't around for the history in 2012, '13, '14. This item's helped me understand a lot of these small group exchange HIPAA nuances relative to the large

group plan ones. But since you mentioned that the Medicare exchange option that was being looked at in '12-'13, I think you said it put -- would have put those retirees at risk for some cost increases, and I think I heard you say some benefit limitations. So not to dwell on the past, but is there any relevance to that exchange consideration experience that has any relevance to what risks me might incur if we tried to get ourselves in an exchange mindset. Not withstanding the reasons why it's super gargantuan task, but are there other risks to enrollees based on the other experience with the other exchange analysis? That's really my question.

MS. PALES: So that exchange analysis was actually a private exchange, so the Medicare enrollees would have left CalPERS. And so they wouldn't have the guaranteed issue that we offer. So it's a -- really if we do something within the CalPERS program, CalPERS rules would apply. This was actually something separate.

ACTING COMMITTEE MEMBER LOFASO: Okay. Apples and orange. I appreciate the clarification.

CHAIRPERSON MATHUR: We would have had no control over benefit design changes or whether people would be admitted for health insurance or denied coverage.

MS. PALES: Right. So when they first start and if they never move plans, they would have been fine. But

if they made a change to plans, they could have gone through some issues in terms of like the issuance of the health plan and the costs of the health plan.

CHAIRPERSON MATHUR: Thank you.

Mr. Jelincic.

BOARD MEMBER JELINCIC: Yeah. I raise the issue on the briefing. ANSI as an excuse -- I -- I find difficult to believe. At least I looked at the website of one of the vendors, and there was no indication that a dependent couldn't be listed as a subscriber. I don't know about the particular provider we use, but I think that's solvable.

But more troubling is actually going back to February, when we said, "This regulation was just a clarification. We weren't taking anything away from anybody." And as you -- at least some of you are aware, I asked, "Pull the old agenda items," because I was told the Board made this decision, you know back in '12.

But when you look at the agenda item, which was when we adopted at that point the amended regs that we have now amended again, the agenda item and the regulatory history says that CCR thought 99.501 subdivision A currently requires employees, annuitants, or family members enrolled in part A and B of Medicare to enroll in a Medicare supplement plan provided by the same carrier as

family members enrolled in the basic plan.

Amendments to this section remove the requirement that Medicare Supplement plans be provided by the same carrier providing coverage to family members in a basic plan.

So it seems to me that we have actually made a significant change, not just a clarification.

Now, we've giv -- I thought your report was excellent in explaining why we very well probably want to do what we are doing. But it -- we did in fact take something away.

The other problem is, it's another example of changing the policy to match our procedures rather than changing our procedures to match our policy.

So I thought it was an excellent report. I understand why we do it. I think it's actually probably the right decision. But it is -- the change was much more than just a clarification.

Thank you.

MS. PALES: Mr. Jelincic, I understand what you're saying. And back -- I was not part of the actual team that worked on this back in '12 and '13. But the intent of the regulation change that happened in 2013 was to allow the Board flexibility. And what we discovered was that the actual language in the regulation - and we

didn't really notice this till later obviously - it didn't say exactly what we thought it said. So it -- it was -- the clarification from our perspective was to change the language to be what the intent was. When we went back to look at the actual regulatory package, the intent was not to allow members to choose; it was to allow the Board options to offer them better products. And I think that was lost in translation.

BOARD MEMBER JELINCIC: But that wasn't what the agenda item said. And so, I mean, that's -- you know, if that was the intent, it wasn't well done. But again I will point out, that's not what it said. And, you know, at some point regulations are rules so that people know what the rules are. As you know, I voted against the one that's currently -- had -- either is or is not currently at Office of Administrative Law. I thought earlier -- or I was told it was. I thought I heard you say it was not yet there.

MS. PALES: Just a confusion. It hasn't left the building yet.

BOARD MEMBER JELINCIC: Okay. It has not left the building yet.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: Waiting for your direction.

BOARD MEMBER JELINCIC: Okay. But one of the

issues -- you know, I voted against that because it said this is our rules unless we change our rules. And I think that a regulation ought to be, "This is the rule." And if at some point we change our mind on what the rule ought to be, then we go back and change the regs; because it defeats the purpose to say "This is the rule maybe."

But thank -- but, you know, given the complexities, I understand why we are doing it. So I'm not going to have heartburn over the decision. But the process really does in fact trouble me.

Thank you.

CHAIRPERSON MATHUR: Thank you.

INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS: Madam Chair, this --

CHAIRPERSON MATHUR: Yes.

INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS: I'd just like to comment.

I want to make sure that the Committee is aware, that the regulation, the way it stands today with the revision, it does leave it open for the Committee to make a decision at any point in time. If you decide for us to decide to move to a split care without an additional regulation change. So that did -- the intent of what your vote was to provide that flexibility did actually come to fruition, so I wanted to make sure you're aware of that.

CHAIRPERSON MATHUR: Thank you.

Mr. Slaton.

BOARD MEMBER SLATON: Thank you, Madam Chair.

When I first got on this Board I thought the investment side of this organization was the most complex. I have changed my mind.

(Laughter.)

BOARD MEMBER SLATON: So thank you for the report. That of it to me is it costs way too much money to do it, it takes four years to do it, and it has privacy issues, has all sorts of complexities that make it essentially impractical to go down that path.

So the question is, what other paths might there be? And I did receive some data from staff about the actual -- the basic members with only a PPO option when we implemented the UHC Medicare Advantage. And that the actual basic members in combination enrollment total 850 families. Is that --

MS. PALES: 850 individuals from that one snapshot. And so it's a point-in-time look.

BOARD MEMBER SLATON: Okay. So that -- 850 individuals, that includes --

MS. PALES: In basic plans. So the rest were in the Medicare.

BOARD MEMBER SLATON: Right. So that's the

universe. And it's like a large bucket with a drip coming in and a hole coming out. There's people coming in and out of that all the time. But the number I presume stays relatively consistent.

MS. PALES: The 62,000 in combination plans stays consistent. We do not know the age and regional location and availability of PPO versus HMO of who is in a combination plan at any particular time.

BOARD MEMBER SLATON: So it could grow or it could shrink --

MS. PALES: Absolutely.

BOARD MEMBER SLATON: -- we don't really know.

But statistics being what they are, it's not going to go 5 times this number or 10 times this number.

So my question is -- and I had some conversations earlier about the chance to do a reimbursement thing, because, you know, there's a maximum out of pocket in a PPO. So you can kind of forecast what the actual number is. And in dollar numbers it's a lot smaller than the $15 million to revise the system.

But then it looked like maybe there's an opportunity here to have another -- I mean, it's kind of back to the future. So we kind of consolidated and came up with one Medicare Advantage plan. That's a great plan, great services, new SilverSneakers, all the great options

that are in there. But now we have this group. So the question is, could we do a procurement to have another Medicare Advantage -- and again I'm sorry about my lack of knowledge of the terminology -- but essentially solve this problem with another carrier for people in those areas where they essentially can have a low cost plan plus Medicare Advantage.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

We thank you for the question, Mr. Slaton, and we're actually exploring that option right now. We heard your feedback and it's a great solution. We will -- we can come back to you with that. We're researching it as we speak.

BOARD MEMBER SLATON: Well, you'll come back to the Committee. I'm --

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

Yes, to the Committee.

BOARD MEMBER SLATON: Right, yeah. Because I think that, you know, sometimes there's kind of an out-of-box solution that we hadn't thought of. And although this is great for 99 percent of the universe, there's that 1 percent that, you know, it's important for the Committee to pay attention to.

So I hope that could happen, and I look forward to seeing it.

CHAIRPERSON MATHUR: Okay. Thank you. That will come back to the Committee at a future time.

Mr. Lofaso.

ACTING COMMITTEE MEMBER LOFASO: Thank you, Madam Chair.

I appreciate the thoughtfulness of Mr. Slaton. And I know of course he'll be back next month when you come -- whenever the future month.

But one key issue -- and thank you all for - as I've heard about this morning - for your tolerance of my rapid-fire questions to try to understand it. But it seems to me a key challenge is what you mentioned a moment ago, Ms. Pales, which is, as we drill down on that smaller population where there are gaps in the availability of Medicare HMO, which is to say Advantage coverage, there's some fluidity in that 850-person population. And I'm still confused that you focused on the number on the basic side of the equation in contrast to the Medicare side of the equation. But with a combination family, there's always one accompanying the other, so it is what it is.

That said, it seems to me your challenge - and it's just more a comment unless you want to respond - is zeroing in on what is available to meet the needs of that discrete population. And that sounds very challenging and I know you all are up to it.

Thank you.

MS. PALES: So just to clarity, Mr. Lofaso. The reason that I drilled down on the basic members is that the Medicare plans are available. It's the lack of the basic plan. So the Medicare enrollee in the PPO is not facing the co-insurance and the deductibles like the basic plan member. So they're experiencing something way different than what they experience in the HMO. So they really are the population that's concerned more, right?

But to your question about the regional, I guess, coverage and the way that this population, can we agree with that? And I believe they're looking for a solution that would offer the areas, you know, that are not covered currently. So wherever people would be, that would be the goal, to offer something in those areas. So there's nothing I guess ideally where there's no HMO option, or do the best that we could.

ACTING COMMITTEE MEMBER LOFASO: But not to belabor the issue, especially at this degree of research, but it seems to me the problem comes to multiple levels. The immediate problem is the -- the Medicare cost sharing is what it is. So the family's immediate challenge is the cost sharing on the basic side.

MS. PALES: Agreed.

ACTING COMMITTEE MEMBER LOFASO: That's the

initial problem. But if you want to -- but one of the reasons that problem exists is because they don't have a Medicare option that they can go into to combine with a more favorable basic HMO option. So while the immediate experience of the problem is on the basic side with the co-insurance, the avenue to the dissolution is expanding the Medicare options.

Again, I know it's very confusing to discuss because of the way the two interact.

MS. PALES: But I think you have both the symptom and the problem, yeah. Yes, I think you understand perfectly.

ACTING COMMITTEE MEMBER LOFASO: Appreciate it.

Thank you, Madam Chair.

CHAIRPERSON MATHUR: I think it's important to note that despite our best efforts and the efforts of our plan partners, we've been unable in our history to get HMO coverage throughout the entire state --

MS. PALES: Agreed.

CHAIRPERSON MATHUR: -- for basic or Medicare. And so any expansion would unlikely cover every additional county that's not included in the UnitedHealthcare coverage area. It would be -- hopefully we're able to achieve some expansion through a second solicitation, but I don't want to set expectations too high that we're

going --

MS. PALES: Thank you for the clarification.

CHAIRPERSON MATHUR: -- to be able to provide a very broad --

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: Thank you, Madam Chair. We'll certainly look into it and --

MS. PALES: There's never, you know, perfection.

CHAIRPERSON MATHUR: Mr. Bilbrey.

VICE CHAIRPERSON BILBREY: Thank you, Madam Chair.

So these possible other solutions, how soon would that come back to the Committee? And more specifically, would it be something that we could make recommendations on and maybe having time for our open enrollment this year?

MS. PALES: Ms. Donneson is going to speak to that.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Good morning, Madam Chair, members of the Committee.

As you're aware, under Government Code 22850, you do have the ability to engage in plans. We have run a number of solicitations in a very creative way. We believe that we could immediately begin work on looking at

coverage areas where we used to have the basic plan match to the Medicare under some of our larger plans such as Blue Shield or Anthem HMO. So you have my commitment that we would immediately start to look at it.

We have developed documents actually back to 2015 when we examined through the benefit design and pricing mechanism for rates, we do have those documents that we can pull off the shelf.

I agree that we can't be too optimistic, but we certainly have the capabilities and the knowledgeable staff in the procurement arena, which falls within my division, to be able to at least attempt to do so within the next couple of months. But I don't wish to make promises I can't keep.

CHAIRPERSON MATHUR: Yeah. Thank you.

So we do have two members of the public who wish to speak, and I'll ask them to come down at this time. Take these two seats to my left. Donna Snodgrass from RPEA and Larry Woodson from CSR.

And please identify yourself and your affiliation for the record. And you will have three minutes in which to speak.

MS. SNODGRASS: Before I start, I've tried to whittle this down as short as possible, but I may go 3 minutes and 30 seconds. Is that okay?

CHAIRPERSON MATHUR: I will allow both of 3 minutes 30 seconds.

MS. SNODGRASS: Thank you.

I'm Donna Snodgrass, Director of Health Benefits for the Retired Public Association -- Retired Public Employees Association.

In history, on May 15th, 2013, that's the date that Secretary of State filed the language for the California Code of Regulations Title 2. That language then was written and recommended by CalPERS to allow for combination plans families to have the same or different carriers within the same household.

Beginning in May of 2012, staff first presented recommendations for this language, quoting, "Proposed regulatory amendments will provide the Board the flexibility to offer one or more Medicare supplemental plans by the same or different carriers, even under combination family enrollments."

In August of 2012, CalPERS Board of Administration approved revised proposed language to further clarify rules regarding enrollments and to specify that Medicare supplemental plans can be offered by the same or different carriers even under combination family enrollments.

And, further, in August of 2012, amendments

actually remove the requirement that the Medicare supplemental plans be provided by the same carrier providing coverage for family members enrolled in a basic plan. This proposal was moved and carried at the Board meeting that month.

In February of 2013, the report to the Board through the Committee, Agenda Item 10, public comment had begun on November 2nd, 2012, and now the language was back to the Board to adopt.

The CalPERS Board, through this Committee and staff recommendation, wrote and approved the regulation in 2012 and '13. The language was very specific and the meeting was very clear during discussions. There were no substantial risks cited or discussed during the process, even during the public comment section or period.

Now, in September 2016, staff recommendation is to clarify the regulation. In 2012 and '13, CalPERS staff and this committee spent a year being very open and specific. Even though written and approved by CalPERS, you never implemented your own regulation.

The language that was changed in '16 and '17 did nothing to clarify existing language. The new language not only reverses the ability for the member to decide the best coverage for their family, but it appears to preemptively deny separate carriers in certain instances

so that no exception can be approved.

Now we're hearing negatives concerning HIPAA, exorbitant My|CalPERS and related costs, increased staff work, employers, et cetera.

Why are the issues arising now? Were they there four years ago? And if so, why weren't they addressed then? Were they overlooked?

If a mistake was made, can't you just admit it, say "We made a mistake" and explain that it has to be changed?

There are roughly 62,000 members in combined families today. That number will increase each year. Will there be insurance plans available to meet the needs of this aging membership? Through this process, we received the message, maybe not intentionally, that the good of the many outweigh the good of the few.

This issue is just one example of why we get so frustrated at times with the Board and the process.

And thank you for allowing me to vent.

CHAIRPERSON MATHUR: Thank you, Ms. Snodgrass. Mr. Woodson.

MR. WOODSON: Good morning. Can you hear me okay?

CHAIRPERSON MATHUR: Yes.

MR. WOODSON: All right. Larry Woodson, Chair of

the Health Benefits Committee, California State Retirees.

Madam Chair and members of the Board, thank you for the opportunity to comment. I'm commenting as well on the staff analysis regarding the obstacles and costs to implementing multiple-carrier choice for combo families. We concur with Donna Snodgrass's comments.

And why is this important to us? Just for some historical perspective, I think a little over a year ago Dr. Donneson presented to this Committee as well as stakeholders a trend analysis in which she said that in the year 2002 there were approximately a dozen carriers and health plans available to our retirees.

Today there are three. So choice is -- has become limited. We've lost a lot of choice.

I'd like to clarify something regarding the Kaiser -- the non-Kaiser HMO, specifically UnitedHealthcare. It does have some advantages. But it has a much more restrictive provider network for basic plan members. And it's -- the 1500 that was cited is -- where rural community members where UnitedHealthcare was not available, there's a much larger number, myself included, particularly in the Sacramento area that had to make a choice of whether to lose all their physicians for their family members or go to PERSCare, which is a more expensive plan to you and to us.

And to me personally it cost me $2,800 more last year. So I am sensitive to that.

Regarding the staff analysis. Just four years ago, when you adopted the regs allowing the multiple-carrier choice, the staff analysis concluded that the benefits outweighed the risks something like 4 to 1.

It was a good idea. The only potential risk was identified as, quote, impacts to my|CalPERS may include system changes required to accommodate different plan options.

Four years later, the analysis concludes many, many obstacles and a hundred thousand dollar -- hundred thousand staff hours to change my|CalPERS and related work. That's 56 staff working full time for a year to make the changes that would be necessary, at a cost of $15 million. And to me this defies reason. I think it needs more inquiry. Four years ago it was projected to be acceptable risk. And so why are these -- I mean, HIPAA hasn't changed, ANSI rules haven't changed. And so it's -- it really I think begs the question -- I would hope that the Board would perhaps ask the staff for more analysis regarding that hundred thousand hours. We intend to do the same.

Thank you.

CHAIRPERSON MATHUR: Thank you very much for your

comments.

Okay. That will bring us to Agenda Item 9, which is a Summary of Committee Direction.

Ms. Bailey-Crimmins.

INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS: Thank you, Madam Chair.

So I have two items that I had as a Committee directive. One was to bring back as a report additional information related to Castlight and the Welvie tools and the potential of using those within the HMO. So that was one item.

And then the other item was basically -- based on our discussion related to combo enrollment, the team is going to bring back in several months - we'll get you an actual date - of analysis of potentially another program or plan that would be available to individuals that were impacted that don't have coverage within either UnitedHealthcare Medicare Advantage or Kaiser.

So those are the two actions that I have listed.

CHAIRPERSON MATHUR: Thank you. I have those two. The one other one I have is additional information on the reference pricing to ensure that there is access across California at the reference pricing.

INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS: Great. Thank you.

CHAIRPERSON MATHUR: To good quality care.

Oh, Mr. Jelincic.

Excuse me. Sorry. One moment.

There you go.

BOARD MEMBER JELINCIC: One of the other things is, in lieu of a lack of direction, I assume that these will -- the proposed regs from February will be going to OAL now.

INTERIM DEPUTY EXECUTIVE OFFICER BAILEY-CRIMMINS: That is correct, Mr. Jelincic.

BOARD MEMBER JELINCIC: Okay. Thank you.

CHAIRPERSON MATHUR: Thank you.

That brings us to Agenda Item Number 10, which is Public Comment.

Is there any member of the public who wishes to speak at this time?

Seeing none.

The open session is adjourned.

And we will enter into closed session at 5 minutes before 10.

(Thereupon the California Public Employees' Retirement System, Board of Administration, Pension & Health Benefits Committee open session meeting adjourned at (9:42 p.m.)

C E R T I F I C A T E O F R E P O R T E R

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

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

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

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

IN WITNESS WHEREOF, I have hereunto set my hand this 24th day of April, 2017.

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