MEETING

STATE OF CALIFORNIA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

BOARD OF ADMINISTRATION

PENSION & HEALTH BENEFITS COMMITTEE

OPEN SESSION

ROBERT F. CARLSON AUDITORIUM

LINCOLN PLAZA NORTH

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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 Ms. Jeree Glasser-Hedrick

Mr. Rob Feckner

Mr. Richard Gillihan

Ms. Dana Hollinger

Mr. Henry Jones

Ms. Theresa Taylor

Ms. Betty Yee, represented by Mr. Alan Lofaso

BOARD MEMBERS:

Mr. J.J. Jelincic

Mr. Ron Lind

Mr. Bill Slaton

STAFF:

Ms. Marcie Frost, Chief Executive Officer

Ms Liana Bailey-Crimmins, Chief Health Director

Mr. Matt Jacobs, General Counsel

Ms. Donna Lum, Deputy Executive Officer

Mr. Brad Pacheco, Deputy Executive Officer

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. Jennifer Jimenez, Committee Secretary

Ms. Shari Little, Chief, Health Policy Research Division

Mr. David Van der Griff, Senior Staff Attorney

ALSO PRESENT:

Dr. Richard Sun, Medical Consultant

I N D E X

I N D E X C O N T I N U E D

P R O C E E D I N G S

CHAIRPERSON MATHUR: Okay. I am going to call the open session of the Pension and Health Benefits Committee to order.

First order of business is roll call.

COMMITTEE SECRETARY JIMENEZ: Priya Mathur?

CHAIRPERSON MATHUR: Good afternoon.

COMMITTEE SECRETARY JIMENEZ: Michael Bilbrey?

VICE CHAIRPERSON BILBREY: Good afternoon.

COMMITTEE SECRETARY JIMENEZ: Jeree Glasser-Hedrick for John Chiang?

ACTING BOARD MEMBER GLASSER-HEDRICK: Here.

COMMITTEE SECRETARY JIMENEZ: Rob Feckner?

COMMITTEE MEMBER FECKNER: Here.

COMMITTEE SECRETARY JIMENEZ: Richard Gillihan?

COMMITTEE MEMBER GILLIHAN: Here.

COMMITTEE SECRETARY JIMENEZ: Dana Hollinger?

COMMITTEE MEMBER HOLLINGER: Here.

COMMITTEE SECRETARY JIMENEZ: Henry Jones?

CHAIRPERSON MATHUR: He's here.

COMMITTEE SECRETARY JIMENEZ: Theresa Taylor?

COMMITTEE MEMBER TAYLOR: Here.

COMMITTEE SECRETARY JIMENEZ: Alan Lofaso for Betty Yee.

ACTING COMMITTEE MEMBER LOFASO: Here.

CHAIRPERSON MATHUR: And please also note for the record that Mr. Lind is in attendance and also Mr. Jelincic.

Okay. Second order of business is the DEO report.

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

I have two brief updates to share with you this afternoon. The first is related to some enhancements that we've recently made to the my|CalPERS. As you know, we are continuously looking for ways to enhance our customer experience with the services that we provide. And yesterday, we debuted a new look and feel on the my|CalPERS website for our members.

Basically, what we've done is we've enhanced the account summary, so now that is at the top of the homepage. And what that does is it gives our members easy access to their most requested information. We've also added pathways to retirement contribution and service credit information, as well as the retirement estimate calculator.

And in addition to that, we've added quick links to areas such as beneficiary information, contact information, where members can find their CalPERS ID, as

well as scheduling an appointment. And so what we've done is we have solicited input from our members with regards to the things that they are most interested in seeing when the interact with us through this -- this service vehicle. And we've done that through a couple of different measures.

One, we've done quite a bit of user testing of a prototype that was done in the 2016 Ed Forum. And so we got a lot of feedback there. In addition to that, we do collect indirect member feedback from our customer service team members, as they interface with our members quite a bit, and they often have great ideas of how to enhance the service.

And also with that, we do get inquiries that come in through our secure messaging, or directly into from our members. And so we've taken some of that information and used it to enhance my|CalPERS.

With the changes that have been made also, the new homepage showcases key information and allows members to more easily complete the tasks that they are accessing on the system. In addition to that, it does improve the user experience and increases functionality and empowers our members to get to the places quickly, in which they want to achieve services.

And also, it does provide an ongoing commitment

to our commitment to our membership, and that is to continue to provide the highest level of customer service that we can achieve. So I am very pleased to share with you that again this new homepage did debut yesterday, and we will continue to monitor and solicit feedback from the membership to determine if the changes we made have been of a benefit, as well as any additional changes that they'd like to see in the future.

The second item that I'd like to update you on is our CalPERS Benefit Education Events. Since we last met in May, we hosted another event, and that was held in Eureka on May 19th and May 20th. And once again, it was another very successful CBEE. The last time that we were in Eureka, it was in 2014, and we had nearly 300 members attend that event. This year we saw more than 430 attendees at the two-day event.

Eureka is our most northern event, and it provides vital services to our members who are approximately five and five and a half hours away from either the Walnut Creek Regional Office or the Sacramento Regional Office. And so again, it's not surprising that this event was well attended.

Our next event will be on July 21st and 22nd. And it will be held in Santa Clara California. In your folders I do believe that you should have a flier that

lists the new dates for the remainder of 2017 and the rest of the CBEEs that we have planned for 2018.

Again, we continue to use the education events as a great way to connect with our members and to inform them about their Pension and Health Benefits. The events this year are nine, like we did last year. And again, it is an important measure, important way for us to interact with our membership in a face-to-face venue.

We will continue to provide updates to the Committee, and to remind you as the dates are nearing. As you can see from the list of events, we do have five that are scheduled in what we consider to be our more larger metropolitan areas, which reach a large number of our members. And likewise, we have four smaller events in some of our more remote areas.

Again, this was part of our -- you know, what we do is we look at where we've hosted events in previous years, and we look at the attendance, and we look at the population. And that helps us to drive where we're going to have our events each year.

So once again, we're looking forward to another very successful year of education events. Certainly, I know the team is always very happy to see many of our Board members and our exec staff in attendance, and we that you'll be able to join us in the 2000 -- the

remainder of the 2017 and 218 -- 2018 events.

That completes my report, and I'm happy to answer any questions you may have.

CHAIRPERSON MATHUR: Thank you very much, Ms. Lum. I don't see any requests to speak at this time, so thanks again.

Ms. Bailey-Crimmins.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Good morning, Madam Chair and members of the Committee. For my opening remarks, I want to highlight significant accomplishments that the health program has made that positively impacted the 2018 rates that we plan to publish here today.

These accomplishments fall into four categories. The first is strong rate negotiations; two is innovative benefit design; three is responsible contract management; and four, is collaborative partnerships, both internally and externally.

Today, CalPERS achieves a significant milestone. Based on the four categories that I just mentioned, today marks the lowest total weighted increase in 20 years, 2.33 percent. Individual plan rates may vary by -- so looking at specifically which plan you subscribe to. But overall, we take all those plans and weight them across each other, it is a 2.33. So on behalf of our members and employers,

we strive to make each year affordable, while delivering quality care.

This year the health program successfully negotiated a new pharmacy benefit manager contract, which has a projected savings in 2017 of 60 million -- $63 million. And it also reduced pharmacy trends, which has positively impacted the 2018 premiums.

The health benefit designs that we are proposing to the Committee today provides quality and aligns with the triple aim goals of better health, better care, and lower cost. If approved, these benefits are expected to save $6 million in the first year, and the expectation is to gain greater savings in the second year and beyond.

I would like to take a moment of privilege. And I want to thank the CalPERS rate development team, which includes the Health Program, the Actuarial Office, and Legal Office for their commitment and dedication of working long hours between January and June. And so if they would please stand and be recognized by myself and the Committee.

(Applause.)

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: It takes a small village.

(Laughter.)

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: I would

also like to let you know, Ms. Mathur, that we -- the combo enrollment, the Medicare expansion, was not in the back of the room, but we will have that on the website immediately following this meeting.

So Madam Chair, that concludes my remarks, and I'm available for any questions.

CHAIRPERSON MATHUR: All right. Thank you very much, Ms. Bailey-Crimmins.

I want to add my congratulations and appreciation to your -- to the team that worked on these rates. And has been managing this increasingly complex set of relationships and contracts with our health plans. And I think -- you know, I just want to say last evening, we had a very long day of Committee meetings yesterday that went until 6:00 o'clock. But very cheerfully, a whole number of the team stayed behind, so that they could talk to me and the Vice Chair for, you know, another half an hour. So we were -- we were still -- we were still talking at 6:45 last night, and they had already been there all weekends, and many weekends prior.

So I think they really do a yeoman's effort on behalf of our members, and I'm just so proud of the commitment, dedication, and effectiveness of this team. So thank you all.

Okay. We have a number of things on our agenda.

We are going to -- I'm just going to share that we're going to take a few things out of order. We are still going to do Agenda Item 3 and 4 next, but then we're going to do a couple of the information items. We're going to take up Agenda Items 8 and 9. Then we're going to move from there to Agenda Item 6, then back to 5, and then to 7. I'll make sure to keep you all apprised as we go along.

(Laughter.)

CHAIRPERSON MATHUR: But I just wanted to give everyone a heads up, that we're not going to take all of the items in exactly the order that are on the official agenda.

Okay. So Agenda Item number 3 is the approval of the meeting minutes from the last Committee meeting. I know there have been a couple of changes. Would you like to highlight those?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Yes. Thanks, Madam Chair. Two changes. One is we corrected that we did not meet at 11:00 p.m. We actually met at 11:00 a.m. I know you guys are dedicated. We just mentioned that. Also, there was misstatement for AHCA it's not Affordable Health Care Act. That means it's the American Health Care Act. So that's been reflected in the final minutes in front of you. So I just wanted note that

before you voted

CHAIRPERSON MATHUR: Thank you. So is there a motion for approval as amended.

VICE CHAIRPERSON BILBREY: Move approval

CHAIRPERSON MATHUR: Motion made by Mr. Bilbrey.

COMMITTEE MEMBER HOLLINGER: Second.

CHAIRPERSON MATHUR: Seconded by Hollinger.

Any discussion on the motion?

Seeing none.

All those in favor say aye?

(Ayes.)

CHAIRPERSON MATHUR: All opposed?

Motion passes.

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

I've had no requests to pull anything off of Agenda Item number 4, so we'll move right on to agenda Item number 8, which is our Federal health care policy representative update. And on the phone we have Yvette Fontenot and Chris Jennings.

And, Mr. Pacheco, you want to kick us off?

DEPUTY EXECUTIVE OFFICER PACHECO: Yes. Thank you, Madam Chair. Brad Pacheco, CalPERS staff. I'm joined by Mary Anne Ashley and Gretchen Zeagler with our Legislative Affairs team.

Thank you for your flexibility for our colleagues on the east coast. The first report we have today is our federal health care policy report to discuss our work around the AHCA. And I believe that the Committee and the Board members received a letter that we sent at the end of May expressing some concerns around this area. And, Ms. Zeagler also attended some visits with the Yvette Fontenot. So I'll turn it over to Yvette and Chris to give an update.

CHAIRPERSON MATHUR: Ms. Fontenot, Mr. Jennings, go ahead.

MR. JENNINGS: Yeah. This is Chris Jennings. And I will start off, and then Yvette will supplement with other non-AHCA - we're call calling it the American Health Care Act - information that is of importance to CalPERS.

Obviously, if you are watching the news, you know that this is a very amazing immediate time where the leadership of the Senate Republicans are trying to finalize their bill and bring it up to a final vote as early as next week.

That, according to Republican Senator Corker has said and indeed the intention that the bill be brought up for a vote next week on Thursday. It will be passed by the Republicans as better than the quite unpopular outpast version of the American Health Care Act. Democrats will

dispute that.

There will be an all-Republican members meeting tomorrow to discuss broad strokes about what's in this legislation. Much of the bill is already with the Congressional Budget Office, but no one publicly has seen it, and very few Republicans, let alone Democrats.

This is -- they're likely, by the way, even when there is an understanding of what's in this bill, after the Congressional Budget Office scores it, and the likely reaction to it, there is expected to be an amendment to it on the Senate floor on Thursday of next week.

Democrats have attempted to slow Senate business through a series of parliamentary maneuvers to protect the Republican process, but this probably will not succeed. Before going on to the rumored bill and what's in it, at least as much as we know as the best intelligence as of this hour.

I thought I would quickly remind the Board of what CalPERS had said about the House bill just recently that Chairman -- the Finance Committee, Senator Hatch, Republican from Utah, requested our comments as well as the comments of many other people.

It helped set the stage for a quick description of what we know to be the modifications on the underlying legislation. On May 23rd, it was indicated, CalPERS CEO

Marcie Frost did forward a letter that is consistent with CalPERS past positioning on ACA and reforms to the law about concerns and priorities relative to the health bill.

While this was included in your monthly Board record, as a reminder, Cadillac -- here are the four primary issues that were raised by CalPERS in their letter. First, it was a recognition that the Cadillac Tax had been delayed, and that we welcomed that from '20 to '26 -- 2020 to 2026, but we also duly indicated disappointment that it did not include any reforms to the flawed legislation as it related to the Cadillac Tax or alternatively its repeal.

Secondly, the letter goes on to talk about coverage loss, and its implications related to cost shifting back to insured populations. It pointed to a Congressional Budget Office projection of nearly 23 million newly uninsured Americans that would result from the AHCA, is what we call it for short, that could ultimately shift costs back to CalPERS and other such plans, as providers in our network seek to get higher reimbursement for uncompensated care.

Thirdly, we raised the issue of prescription drug costs. We raised concern that there was no explicit movement to address rising prescription drug costs in this underlying policy.

And fourth, we underscored a desire for, and a need for, bipartisan ship. We indicated that all sustainable policies in health care start and end with bipartisanship. And indeed, we cited Chairman Hatch's ongoing work with Ranking Member Wyden on this legislation on chronic care reform, improving the type of coordinated care we provide. And as we did that, we indicated our support for that type of approach to be made to overall health reform.

Now, let me quickly shift to what is rumored to be in the bill. Again, as I mentioned, no one really knows, but what has been rumored and seems to be true is policy related to Medicaid. The Medicaid expansion, which is an important part of the overall expansion, in addition to the exchange policy, phases-out beginning from -- over three years from 2020, to '23. In other words, beginning in 2020, that expansion that has made up probably for over half of the newly insured population, would be phased out completely, and it would be done relatively aggressively.

This is quicker than many Republicans in Medicaid expansion states have requested. For example, Senator Portman from Ohio and Senator Capito from West Virginia have asked for a seven year phase-out, but that is the compromise amongst the cause.

The House-passed bill would fully end the extra

funding for Medicaid in 2020. So some Republicans will say this is better in this -- than the House-passed bill. And, of course, Democrats will dispute largely related to the formulas, and how the overall policy affects the rest of the Medicaid program through much tighter caps on program growth.

And I won't go into all that detail, but it focuses on indexing future costs through the Consumer Price Index, rather than the Consumer Price Index of the medical cost, and as a consequence most experts believe that will be wholly inadequate. Again, that will be a debate on the Senate floor.

Now, the other issues you've heard about publicly is this whole issue and controversy about the House-backed bill as it related to preexisting condition protections. They were waivers to waive those protections altogether. The Senate is expected to keep the waivers and allow States to change health benefits, but they will not allow medical underwriting.

So Senate Republicans will claim that the fix -- that their policy actually addresses the House bill's shortcomings, while Democrats will say that the fact that you can modify the benefits to exclude services that people who have preexisting conditions require will no longer have them, undermines that argument.

Thirdly, the issue that's gotten quite a bit of attention is this so-called age tax, where older Americans will pay a lot more money, both through higher ratings, as well as less subsidies.

It appears that the Senate may continue to allow the higher ratings, but will increase the subsidies to help reduce those costs. Nonetheless, I think you can expect AARP to continue to oppose this legislation, because they'll stay it's a higher cost for the elderly, between 50 and 64.

As to prescription drugs, which was another issue, of course, that we raised, there are no additional prescription drug cost provisions in the House or in the Senate, as I mentioned, from what we've heard.

So again, these are all rumors, but it gives you an up-to-the-moment as-of-this-hour update as to where we are.

Now, the last part I'm going to convey to you is -- before I turn it over to Yvette is sort of an up-to-the-moment process update on the timing of all this, and how they're going to go about doing this.

In a way, this is the moment where this legislation will either succeed or fail in passing. Senator McConnell is not interested extending this debate, because it's deferring a lot of other policies he cares

about. So there is overwhelming pressure from himself to his members to pass this before the end of next week.

Whether he has the votes is very unclear, which I'm going to talk to you in a moment. Republicans can lose two votes, because they have 52. And there appear to be -- and while there appear to be many Republican Senators upset with the process and the rumored substance, there is sort of an ongoing respect of the Majority Leader McConnell's ability to bring members to his side, even on such a difficult vote.

In any case, this is obviously expected to be a very close vote. If it wins, it will likely be on a 50/50 vote, with the Vice President breaking the tie.

All experienced Senate watchers are projected -- are currently projecting that this vote could go in any direction, but they're projecting about a 50/50 likelihood that it will be passing. So it's not -- even the experienced ones of us have no idea.

On both sides of the aisle, on both sides of the stakeholder community, there is tremendously strong engagement, certainly in the last week or two, and up through next week, you will see much of that in the media as the debate process goes forth.

And finally, as I turn it over to Yvette, I should tell you that regardless of whether this

legislation passes or failure -- or fails, there is an ongoing issue about how the current law would be maintained, primarily because there is a monthly update as to whether the administration will provide cost-sharing subsidies that reduce premium costs. And in so doing, they're feeding a lot of uncertainty, which is contributing to -- you'll see this in California and elsewhere -- projections of higher premiums, and indeed plan pull-outs.

So in many ways, this is a very both fluid, but also -- and dynamic, but also unstable world. And it's unfortunate and, you know, I can only report on the dynamic. So please don't shoot the messenger.

(Laughter.)

MR. JENNINGS: With that, I'm going to turn it over to Yvette.

MS. FONTENOT: Great. Thanks, Chris.

The one thing I want to just add on the ACA repeal and replace front, Chris did a great overview of the legislative process. On the administrative side, tomorrow is also a very big day, in the sense that it is the deadline for plans to file premium and benefit designs to participate in the 2018 new -- open enrollment cycle.

So one of the big concerns has been whether there will be zero plan counties across the country in any

particular States. And tomorrow, we will have a much better picture of whether that may actually occur in States or not.

On -- I wanted to just touch on two of the other important issues that we track for CalPERS, one being drug pricing, and the second being delivery system reform very quickly. On the drug pricing front, there has been actually a good bit of action in all three branches of government over the past couple of weeks.

In the Congressional Branch, both of the relevant committees in the House and Senate have passed the legislation that's necessary to continue funding the Food and Drug Administration's work, both to approve novel drugs as well as generic drugs.

As those -- that piece of legislation moves through the committees, drug pricing was a part of that debate in both committees, but there was agreement to move forward, given the importance of the funding to the FDA, and to not delay the movement of that bill, in order to debate drug pricing at that moment in time.

The administration's budget that the President released includes a much higher level of user-fees than was either in the House or the Senate bill for funding FDA. And there is some expectation that the President will demand those higher levels from the industry, and

will not consider the congressional product. There is also some resistance among Senate Democratic leadership to allow this, or really any health care legislation, to be considered on the Senate floor, while the repeal and replace effort is ongoing.

So the House may move forward, but at the moment it's not clear whether that legislation will be reauthorized prior to the September 30th deadline for refunding the Food and Drug Administration.

In the Executive Brach, there is an expectation that the President will soon release an executive order that directs the various agencies to develop recommendations to lower drug prices. It's not totally clear what the content will be, but, for example, the President could use this order to direct CMS to make it easier for drug companies and insurance companies to use value-based contracts in the drug space, which was a concept that's been supported both by drug makers and plans.

But there some federal regulations that get in the way of widespread enactment. So we expect that executive order any time in the next couple of weeks. And then finally, in the Judicial Branch, about two weeks ago the Supreme Court released a heavily anticipated decision related to patent disputes between the developers of new

biological medicines, and the manufacturers of biosimilar copies.

It was -- this was the first -- the Court's first ruling on the patent provisions of the biosimilar pathways that was enacted as part of the Affordable Care Act, and is deemed by many as a pathway for more biosimilar products -- cost saving more affordable biosimilar products to come to market.

On the delivery system reform side, as was mentioned, when Gretchen Zeagler was in Washington, we did meet with the Senate Finance Committee that had unanimously passed that legislation to advance care for those with chronic illnesses. It was a bipartisan unanimously-supported effort. And it was a piece of legislation which we referenced in the CalPERS letter on the repeal of the Affordable Care Act as being an example of how health care legislation should be moved through Congress.

We did meet with the Committee and offer any technical assistance or data that might be helpful. It's not clear whether the House will consider that legislation. Although, there's companion bills in the House for most of the pieces of that legislation. But it is an effort that is widely supported and would advance chronic care management, both in the Medicare and Medicaid

programs.

The administration still seems to be contemplating how to advance delivery system reform. There's been limited administrative action in this space as the Secretary and Administrator have gotten their teams into place. And we understand that they are looking for ways to use the Centers for Medicare and Medicaid innovation, which was the vehicle for the majority of changes that were made by the Obama administration in this place -- in this space more creatively, for more sort of market-oriented demonstrations and involving greater consumer engagement.

And then finally, just about five minutes before we got on the phone, the administration did release regulations on MACRA, which is the new physician payment system under Medicare that was put into place by the last Congress, and which will be the primary mechanism for transforming care delivery from volume to value based.

Those regs -- that propose reg just came out, as I said, about five minutes ago. And this really will be our first insight into the direction of this effort under the new administration.

So with that, I will wrap-up and we're happy to answer your questions.

CHAIRPERSON MATHUR: Well, thank you both very

much for your substantive overviews and reports. We do have a few questions from the committee.

Ms. Taylor.

COMMITTEE MEMBER TAYLOR: Yes. Thank you. I totally missed your final thing on what you said the Supreme Court decided. I didn't even catch it.

MS. FONTENOT: The Supreme Court Was debating a court case about patents --

COMMITTEE MEMBER TAYLOR: Right.

MS. FONTENOT: -- under the biosimilars pathway. That was enacted as part of the Affordable Care Act.

COMMITTEE MEMBER TAYLOR: Right.

MS. FONTENOT: And as a result of the ruling, the biosimilar company will generally be able to launch their products as soon as the data exclusivity on the innovative product expires. The innovators were arguing that they -- the biosimilar companies should have to wait a prolonged period after the date of exclusivity expired, but the court ruling determines that they can actually go to market as soon as that exclusivity expires.

So it's generally seen as win for the biosimilars company, and for more production of those products.

COMMITTEE MEMBER TAYLOR: Thank you.

CHAIRPERSON MATHUR: Great. Thank you.

MS. FONTENOT: Sure.

CHAIRPERSON MATHUR: Mr. Jelincic.

BOARD MEMBER JELINCIC: Yeah. In your report, you had talked about the movement to the merit-based incentive payment system, and how less people or less physicians were being covered by it. I recognize new regs just came out, and so you may not have an answer, but why -- why did the movement to restrict and reduce the number of people moving to value based?

MS. FONTENOT: Mr. Jelincic, this was actually begun by the Obama administration. They had put out some proposed regs that had a fairly aggressive time frame for moving physicians towards more value based. And they got a fair amount of pushback that there weren't enough value-based designs yet for physicians to really be able to engage, and that they needed sort of slower pathway to transition into these new systems.

And so the Obama administration finalized regs that created more of a glide path that allows physicians to report less frequently over the first year of implementation, and then kind of move slowly and upward in their progress in the second and third year.

I'm assuming that the regs that were just released continues that glide path and probably creates even more flexibility for physicians, particularly small rural and independent practices to try and give them a

little more time to move into a real value-based system.

And I think this, you know, really has to do with the amount of practice transformation and investment that's required to move into these really data intensive value-based systems.

BOARD MEMBER JELINCIC: And on the -- you referenced Trump's budget cuts, do you think they're happening or are people going to push back on it --

MS. FONTENOT: Yeah, I think --

BOARD MEMBER JELINCIC: -- successfully push back?

MS. FONTENOT: Yeah, I think generally speaking the budget was not widely accepted in Congress. There were certain provisions that I think were probably more popular than others. But, for example, his proposal on funding the FDA by increasing the amount of industry user fees, the chairman of the relevant committee in the Senate wrote back a letter to that request saying that that was not the path they were going to be following.

And some of his additional cuts to Medicaid and his cuts to the National Institutes of Health and other, you know, popular political items, if not policy items, have sort of been roundly rejected by the relevant Chairmen in Congress.

So that process -- the 2018 budget process is

still playing out, but I don't see it being, you know, widely accepted as they move through their deliberations.

BOARD MEMBER JELINCIC: Thank you.

CHAIRPERSON MATHUR: Thank you.

Mr. Lofaso

ACTING COMMITTEE MEMBER LOFASO: Thank you, Madam Chair. Chris, if you're out there --

MR. JENNINGS: Yes

ACTING COMMITTEE MEMBER LOFASO: -- Alan Lofaso from the State Controller's office. You said two things that I wanted to understand a little bit more. So you mentioned broad outline of the Medicaid changes, and I appreciate you didn't try to go too in the weeds, but you also indicated the stakeholders were very active. And I can imagine if I was a stakeholder, I'd be just trying to figure out what's going on. But my question is are you able to appoint -- are you able to point to any incremental impacts that stakeholders are being able to get some success on, on these Medicaid and other issues that speak to the cost-shifting issue, or are we just trying to figure out what's going?

MR. JENNINGS: Yeah, that's a great question. You know, in the end of the day, the ultimate test will be the vote next week as to whether it happens or if it's pulled. If that's the case, then the stakeholder

community will have had an impact. But in the general rule, I would say that the hospitals in particular and the physician community, the Cancer Society, and AARP of -- you know, in Washington we've -- we call special interest stakeholders that we like.

So in a way, the stakeholder dynamic are the most active and probably impactful have been met -- goes through period of -- and probably labor as well, but primarily through resources that have been dedicated to advertise against this legislation.

As I mentioned, the impact will be judged by the vote. I do think that some of the reaction by Republican Senators in Medicaid expansion States suggest that it has had an impact, that they hope to at least try to ameliorate some of the policies. But in terms of what we're hearing today, I think most of those stakeholders I mentioned will conclude that it was an inadequate attempt.

And then the question will be whether their continued opposition to the legislation has an impact on the final vote? But, I mean, I think right now most people think that there are between 43 and 45 pretty certain votes in the Senate in support of this legislation. The other five to seven are very difficult to get, and that they generally come from Medicaid expansion states.

ACTING COMMITTEE MEMBER LOFASO: Appreciate.

CHAIRPERSON MATHUR: Okay. Thank you very much. Well, thank you both for being with us this afternoon. And we can release you now.

We're going to move on to Agenda Item number 9. And we'll bring in Tom Lussier and Tony Roda. Do you want to -- do you have opening comments, Mr. Pacheco?

DEPUTY EXECUTIVE OFFICER PACHECO: No, I don't, Madam Chair. I believe that Tom and Tony are on the phone, and available to make their report.

CHAIRPERSON MATHUR: Terrific. Whichever of you wishes to go first?

Hello.

MR. RODA: Thank you, Madam Chair and members of the Board, staff. This is Tony Roda with Williams and Jensen. And I'm going to talk about tax reform and then I'm going to turn it over to Tom to talk about the items related to Social Security and Department of Labor rules.

But as a State and local plan generally, and qualified members of federal tax, we are not in the position of asking for very much on the legislative front. Sometimes that is the case.

Right now, we're playing more defense. So if things don't happen, that's a positive. And tax reform, you know, you're going to hear a lot about the depth of

tax reform, the fact that it's suddenly gotten a boost. You're going to hear the back -- back and forth wildly for months.

All I can say is having been a staffer during the last tax reform debate, that was exactly the case, and it was -- it was finally something that Congress was able to grind out. So right now, tax reform has been in the position of waiting for health care, and that is because the Ways and Means Committee Chairman said he would like to see the Cadillac tax and some of the other taxes, the medical device tax dealt with in that legislation where they can be offset where they can reduce Medicare spending, as opposed to bringing those tax cuts into tax reform, which it just makes the baseline much higher and easier to deal with, if health care can go first.

The other procedural item is that, you know, they want to take the same path the Republicans that they are with health care, namely that they want to use the special budget rule called reconciliation, which essentially for the important purposes is the Senate can pass it by a majority vote, and does not need to have a 60-vote margin. So it's very powerful. And in order to do that, they're going to need an FY '18 budget resolution, and they're far from that.

So Speaker Ryan spoke today at the National

Association of Manufacturers, a big highly touted speech on tax reform. And he said they're still on track, but we're going to do in 2017. So think about that in the context of tax reform, it's a year-long process, if it can be done.

We do anticipate something more detailed from the Trump administration in September. And we expect that the House Ways and Means and the Senate Finance Committee will also be continuing to hold hearings.

The goal here, unlike what they did with health care, is at the outset to try to get the House Republicans, Senate Republicans, and the White House on the same page.

Now, the new development late last week was the Senate Finance Committee sent out an email to the public asking for input on tax reform. And Tom Lussier, Gretchen, and I had a talk about this, whether it makes sense for CalPERS to provide comments.

For the following reasons we do not, at this point, think it does make sense and would have much of an upside.

First is that Hatch in his stakeholder letter specified very specific categories, tax relief to the middle class, updating our international tax system, strengthening businesses. And probably a catch-all, which

is removing impediments and disincentives for savings and investments that exists in the current tax system.

So even that doesn't really apply to the kinds of things that we're looking at, which again is defense. The second point is that some of the items that we would certainly mention in the letter from CalPERS more than probably any other public sector pension fund, are negative to what Senator Hatch's legislative initiatives, PEPTA, the Public Employee Transparency Act and his annuity accumulation plan.

That kind of dovetails with number 3, which is with these items we're going to play defense, and we're going to play defense hard. But if these items are not really front and center in Hatch's thinking, in the context of tax reform, then why do we want to highlight it for him and for his staff. We don't want to instigate something that may not occur.

So for those reasons, we are thinking, at this point, that CalPERS comment would not be helpful and I would suspect that some of the national groups will comment. There's a meeting on Thursday this week with the Public Pension Network, which includes NCPERS and NASRA and NCTR, which I will be attending. And we're going to discuss that item at that meeting. So that's the latest in the big picture.

The substance that we're going to work against and continue to work against are the items that I -- two items I mentioned, PEPTA. If enacted, PEPTA would require would require CalPERS and every other State and local governmental plan to report annually to the federal Treasury Department on their funded status two different ways, two different methods. One, using your assumed rate of return, and second, using a different calculation using the Treasury Obligation Yield Curve, which is somewhere around three percent, I believe, at the moment.

This legislation is designed to stir headlines and create a further backlash against public plans. We've opposed this from day one with some of my other public pension plans, but certainly CalPERS has not been supportive of this legislation.

The second item in the substantive category in Senator Hatch's Annuity Accumulation Plan, which would be a new qualified plan under the federal tax code and an optional plan. But we do think, given Senator Hatch's rhetoric, that he would want to enact this and place it into the law as a clear alternative to defined benefit plans.

And what it would do is it would allow a plan sponsor to purchase single fixed-year annuities for their employees, and essentially that would be the retirement

plan.

There are lots of bells and whistles around that. One of the most negative things is that the plan sponsor could, in any year, change the salary rate at which their funding it, contribution rate. And only employer dollars can go into purchasing the annuity, not employee dollars. So we view this as extremely negative.

The newest issue, and this came out in a couple of our meetings that we did in Washington, Tom and I with Gretchen Zeagler. And this is a notion to require every new dollar in the defined contribution world so 401(k)s, 457(b)'s, 403(b)'s should be under the Roth Rule, meaning that it has to be an after-tax contribution, and at distribution it would be tax-free.

So this is being done as a money grab. There is no real policy to doing this. This is essentially to push money or pull money into the 10-year budget window. So instead of the tax-deferred contributions, you have the tax -- after-tax contribution in the budget window.

There is opposition. There is the financial services community. However, I will say while they are -- I've seen them in the action opposing it at various events with members of Congress, they're also big corporate entities that are worried about other issues than tax form, like what the corporate rate is going to be, and

what is the tax treatment of the life insurance industry, or the financial services sector in general.

So I think their opposition maybe -- if certain items fall away, or their big ticket revenue raisers -- you've probably read about Speaker Ryan's proposed border adjustment tax - I really see that this Roth proposal as having a lot of traction. And that's unfortunate.

We don't really have good numbers on what it would mean. We can't -- we've never seen numbers that would predict what a person would do faced with this new choice, 'cause it is a new choice. So we are keeping our eyes on Roth issue very closely.

And with Speaker Ryan's speech today, there was an element of good news, which is he said very clearly that while we're going to clear out from the code a lot of special interest carve-outs, they're going to keep those that make the most sense. And we are in good company here. We said homeownership, charitable giving, and retirement savings. That was just today, before a national audience, Speaker Ryan. So that's a positive. It does -- it is inconsistent, however, in my thinking with this push to the Roth method. However, that is what he did say today.

So I think we have to be out early. I think with the California delegation we've done a couple rounds of

meetings. Tom and I have done some. I've done some with Mary Anne during one of her visits. We've done recently with Gretchen. We're going to continue to make sure the delegation is aware of our concerns.

And in one of those meetings, it was kind of our segue right now. Tom Lussier, we met with the House Ways and Means Committee Social Security subcommittee and talked about the Windfall Elimination Provision.

So with that, I'm going to end my remarks on tax reform. Of course I'll be around for questions, but I'll let Tom take it from there with the WEP discussion.

CHAIRPERSON MATHUR: Thank you.

MR. LUSSIER. Thanks, Tony. And as Tony mentioned, we actually had a very positive meeting when Gretchen was in Washington with the Majority staff for the Ways and Means Social Security Subcommittee.

We wanted Gretchen to have the opportunity to discuss with them firsthand the support that CalPERS has for a meaningful reform of the Windfall Elimination Provision. And we also wanted to hear directly from them where Chairman Brady was with regard to advancing that legislation in the current Congress.

As of this date, he hasn't introduced a specific piece of legislation. Although, he told us through staff that it remains his number one Social Security priority.

And we have confirmed that with Congressman Neal, who is his Democratic co-sponsor, and who also is now the ranking member of the Ways and Means Committee.

So we expect that at some time, and as Tony's pointed out, that the calendar for all of this is very much up in the air, given the current conditions in Congress. But the suspicion is that Mr. Brady is looking for a window of opportunity in the fall to advance his WEP reform proposal with Mr. Neal, probably in conjunction with some must-pass legislation that would carry it through the Congress.

There won't be -- as they told us, there won't be a stand-alone piece of legislation filed much before he's actually ready to advance the legislation. And we discussed why that was, and he assured us that, in no way -- and we understand this, that that in no way reflects any lack of commitment. But it does change the dynamic, because it has -- in the past Congress, we've reported to you on efforts to secure co-sponsors. We've met with a lot of California members to have them be co-sponsors. The Chairman has a very different strategy in this case.

We assured him that we were supportive and that we would stand ready to provide any technical assistance as he may need when the time is right.

While I'm discussing the WEP reform legislation, it's probably appropriate for me to simply mention that there are two additional pieces of legislation, Senate 915 and House 1205, which would fully repeal both the WEP and the GPO. I know staff at CalPERS receives communication from members. I suspect many of you do as well in support of that full repeal legislation. But unfortunately as we have for many, many, many years, it is our view that there really has -- that neither bill in either House or Senate has any hope of passing.

It is important to note that House 1205 currently has 137 co-sponsors, including 35 members of the California delegation. But having said that, again, I would underscore that these full repeal bills, frequently with two times as many co-sponsors have been filed in every Congress for nearly 30 years and none of them have ever been reported out of the Committee.

So we tell you this so that we -- you're aware that we're aware of your member's support for these bills, but we also tell you this, because we believe it underscores why it's so important for us to work with Mr. Brady, and with the other California members of the California delegation on the Ways and Means Committee to exactly advance a meaningful reform in the current Congress.

I'd now like to turn to two regulatory issues --

CHAIRPERSON MATHUR: Tom, if you could fairly quickly.

MR. LUSSIER: -- that have been of interest to CalPERS --

CHAIRPERSON MATHUR: Tom, can I interrupt you real quick?

MR. LUSSIER: Yeah.

CHAIRPERSON MATHUR: If you could fairly quickly. We need to get the agenda moving a little bit.

MR. LUSSIER: Oh, sure.

CHAIRPERSON MATHUR: Thank you.

MR. LUSSIER: I'm just going to wind down. There are two issues, fiduciary rule, which has become effective, and -- as of June 9. There is legislation to reverse the rule. It may pass the House. We don't expect it to see much support in the Senate. The other issue is the regulatory rule as it relates to Secure Choice plans that was repealed in both the House and Senate earlier this year. We wanted you to know that there has been legislation that would effectively replace the rule with a law. It has 30 co-sponsors, including both California Senators. However, we believe that without bipartisan support, it's unlikely to be taken up.

So fiduciary rule is effective. Secure Choice

will need -- folks who want to do it will need to find a way, we believe, around the process without the rules provision.

With that, I think both of us would be happy to answer any questions that there are.

CHAIRPERSON MATHUR: Thank you very much.

I think your reports were very robust, so we have no questions. Appreciate your being on the phone with us today.

MR. RODA: Thank you.

MR. LUSSIER: Thank you.

CHAIRPERSON MATHUR: Okay. So now we are going to move back to Agenda Item number 6, which approval of the 2018 Medical and Pharmacy Benefits for PPO health plans.

(Thereupon an overhead presentation was presented as follows.)

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: If we could go to the agenda, Madam Chair, members of the Committee.

This is the third in a series of presentations I have made requesting, and I will request today, that you adopt all five of the health benefit designs that I'm going to -- that I have provided in Agenda Item number 6.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Speaking to the agenda, we are going -- it continues the dialogue on the designs that I'm asking you to approve. I will focus most of my remarks on the SilverSneakers program.

We will -- if you'll turn to the agenda item itself, page three.

Carl, next slide.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: We have five benefit designs proposed. I will walk you through them and identify which plans are affected, if you -- should you approve this design.

The first is to expand the value-based purchasing design for an additional 12 medical procedures performed in ambulatory surgery centers. This applies to the PPO basic plans only, and not the Medicare plan. And for the remainder of these, these are all effective for the PPO plan, and not for the HMO plans.

The second benefit design I'm going to ask you to approve is site of care alignment for medical pharmacy, in which we want more members to get provider-administered drugs administered in less costly settings out of the outpatient hospital.

The third is a technology application for

personal device that provides both our Basic and Medicare PPO members the opportunity to seek options of care outside of the emergency room. Their health plans currently provide for 24-hour nurse line, and there's also 911 available, but we would like both our Medicare and Basic members to have the opportunity to find less expensive care settings, if warranted.

The fourth is to continue and expand our PPO purchasing tolls, which exist in our current contracts. Castlight is a tool for researching providers, in terms of benefit designs, and the costs associated with their explanation of benefits.

And the second is to continue the Welvie program for the Basic member. This is a tool that allows a member to seek alternatives to surgery. And we do know that members use this, so that they may have been advised for surgery, but they choose not to do so, and to find alternative means of recovery. We would also like to expand this Welvie product to the Medicare population.

And then the final one is the SilverSneakers program, which I would like to address in more detail for this agenda item in terms of cost benefit.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: If we go to the next slide, we have done some

fairly significant research between May and June in terms of the benefits of exercise and membership in the SilverSneakers program. What we have found -- and I would like to -- before I go through what we have found, I'd like to call your attention to an attachment 1, which lists the physiology impacts. And it's from a 2015 book written for physicians by physicians. It's written for physicians in terms of treating the older adult on the importance of the physiological effects of exercise and the benefits.

So first, the first article that we reviewed found that there is an impact on depression. That greater physical exercise does have a tendency to be associated with lower depression rates. Older Medicare members with diabetes who participated in sponsored club benefits had reductions in total cost of care at the first year, and it continued through the second year.

SilverSneakers participants are older, and interestingly enough they're more likely to be men. Now, this was a 2008 study, so perhaps the women have caught up. But they are typically -- this population is typically associated with higher costs. And in the SilverSneakers program by year two, those that participated and continued their participation had fewer admissions.

The SilverSneakers participants total health care costs were 0.2 percent, or two one hundredth -- two-tenths of a percent lower than the control group, that's for total cost of care. Whereas, the inpatient admission costs were 3.2 percent lower. And that will be the study that we have used to estimate costs.

But finally, and this is where I think this is the most important aspect of why we would want you to adopt SilverSneakers for the PPO, is that cardiovascular health, lung health, insulin sensitivity improves, strength training improves, pain relief is maintained over time.

And I'd like to point out just one notable aspect about pain relief. We've -- I've talked to, and Dr. Sun has talked to you, about low back pain. And oftentimes surgery is indicated as a treatment. But evidence has shown that when you have an acute onset of low back pain, exercise, walking, and physical therapy are more important than -- as long -- as well as non-steroidal anti-inflammatories is a much better way to treat low back pain than to go to an orthopedist, go to a primary care physician, et cetera.

So I think I think that the evidence is starting to show that these programs do work for the older American and the aging American. And I believe that they are --

would be beneficial for our memberships, for the PPO members.

Moving on to slide 5, let's look at the savings we've associated with SilverSneakers. So we used -- and this is in the agenda item, it's on page four of five. So we looked at our Medicare costs. And this is the CalPERS share of costs. This is not the CMS share of costs. So if you look at that table at the top of page four, you've got the CalPERS Medicare, what we pay out of our supplement plan, our inpatient costs are about $490 million. And then our -- this supported about 18.9 thousand patients' admissions. The average cost of admission is around 25,000.

Again, this is -- comes out of our supplement plan. This is not paid for by CMS. And if we apply a potential 1.4 percent deduction -- reduction in the number of these inpatient hospitals, that would reduce a first tier an inpatient hospital admission of about 265 patients.

Now, where did we come up with the savings?

We looked at -- the potential impact for the savings is 6.87 million per year. And if you look at the footnote, the 1.4 is based on our study. And then we applied it to the amount that we could save should approximately 265 patients not be admitted.

The SilverSneakers cost is approximately 5.7 million. And then the net -- we -- it's difficult to take the millions and put them into a PMPM due to the fact that this is a population that's actually using the benefit. The benefit is based on per visit cost, as well as an $0.80 PMPM cost.

So we've built those figures into our savings. We built them into our cost, and we would come up with an annual net savings of approximately 1.15 million.

So we believe, and we recommend, that SilverSneakers, in addition to the other benefit designs for the PPOs, be adopted.

I would now like to walk through slide 6. These are all of the costs and savings that are put forward in this agenda item. The attachments have more detail. It summarizes the detail that we presented in April and May. So it -- what we have done is simply displayed the tables that you have seen before in summary format.

And based on these -- our recommendation for these five benefits for our PPO basic plans, we would save approximately $5.5 million. There's a slight savings in terms of the additional benefits we're asking for the Medicare tools, which is about 0.15 million. And then we have -- if you look at the table below, we would anticipate our Medicare savings with SilverSneakers to be

approximately 1.15.

So between the 1.3 million, which is all of the Medicare, plus the 5.5 million, that's a little over six -- about six and a half million dollars. That's what we recommend. We believe that the benefits of these -- the benefits of these designs for the PPO justify your adopting all of the recommended changes.

Next slide, Carl.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Finally, just to show how this links to the strategic plan, these items, if adopted, address value-based insurance design, site of care alignment, and with SilverSneakers population health.

Our next steps are to -- Carl, next.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Our next steps are to seek your approval. We will produce ongoing results, and we will come back with progress reports.

That concludes my presentation. I would like you to take action to adopt our recommended benefit designs.

CHAIRPERSON MATHUR: Thank you.

Questions from the Committee.

Mr. Gillihan.

COMMITTEE MEMBER GILLIHAN: Thank you, Madam Chair.

So with respect to SilverSneakers, and I can appreciate the health benefits from increased activity and exercise. So I'm not opposed to this expansion, but I would note that we're going to spend somewhere in the neighborhood of $6 million to save a million. And because there's a lot of assumptions underlying these estimates, I'm just wondering if there's a way we can revisit this in a year to see if we -- if our continued participation in the program is justified after we have some more experience in the program

CHAIRPERSON MATHUR: I think it makes sense to have a report back on the performance of the program, and the actual savings, and reassess it then.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Thank you.

CHAIRPERSON MATHUR: Thank you.

This is an action item.

Mr. Jones.

COMMITTEE MEMBER JONES: I move staff recommendation.

VICE CHAIRPERSON BILBREY: Second.

CHAIRPERSON MATHUR: Thank you. Motion made by Jones, seconded by Bilbrey.

And discussion on the motion?

Seeing none.

All those in favor say aye?

(Ayes.)

CHAIRPERSON MATHUR: All opposed?

Motion passes.

Now, let's get down to why everyone is in the room today, Agenda Item number 5, 2018 Health Benefit Rates. Item A is the HMO plan rates. Are you going to do them together or separately.

Together. Okay.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

Good afternoon, Madam Chair and members of the Committee. Shari Little, CalPERS team member.

I'm pleased to be here today to present to you the final proposed HMO and PPO rates in Items 5a and 5b. For those of you that do not have our packet, we have published versions of the rates in the back of the room or on-line available to those who couldn't be with us today.

CHAIRPERSON MATHUR: If you're in the audience and you don't have a copy, if you could share with your neighbors, that would be great. We want to make sure everyone has access to the information.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

Thank you. It was a little bit comprehensive, so

we didn't put it up on a slide deck. There are a lot of numbers to look at.

(Thereupon an overhead presentation was presented as follows.)

CHAIRPERSON MATHUR: Um-hmm.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: So for 2018, CalPERS will be adding a new HMO offering from Western Health Advantage. We're also offering another Medicare HMO option through Anthem Blue Cross for one year. This plan was added in response to some of the feedback we received from our members enrolled in combo enrollments plans, where UnitedHealthcare does not offer a basic option with their Medicare plan. And I will refer to my colleague in just a minute on that.

But I wanted to point out that the combined weighted average for CalPERS this year in the overall program is 2.3 percent increase. It's the lowest we've had in about 20 years, so we're very pleased with that.

So if I could just take a moment to talk a little bit about our added offering, Dr. Donneson.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Good afternoon. Yes, we were asked in -- to go back and look at options for Medicare in terms of the split combo plan. And we did so, and we felt this is the best option for the Board is to use the Anthem HMO basic

plan, which has a broader coverage area combined with an Anthem traditional Medicare Advantage plan.

And then this is a one-year expansion. We will revisit it in a year with all of our contracts. We wish to anyone who might be interested in enrolling this to understand that it is for one year, as we reevaluate all of our Medicare and basic plan options for 2019 to 2023.

And we will have an extensive communication plan with our members to ensure that they understand that.

Thank you.

CHAIRPERSON MATHUR: Thank you.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

Thank you, Kathy.

So moving on. Some of the highlights. Anthem Blue Cross HMO will be expand

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

Some of the highlights. Anthem Blue Cross HMO will be expanded into Monterey pending approval from Department of Managed Health Care. We also have Health Net SmartCare that will adding -- be adding additional cities. And Kaiser expanding into Washington State.

And as I mentioned earlier, Western Health Advantage will provide coverage in El Dorado, Placer, Sacramento, Yolo, Colusa, Solano, Napa, Sonoma, and Marin

counties.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: So agenda 5a presents the final proposed rates for the HMOs, which includes Anthem Blue Cross, Blue Shield of California, Health Net, Kaiser, Sharp, UnitedHealthcare, and Western Health Advantage.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Madam Chair, we request that the Committee make a decision or action at this time.

CHAIRPERSON MATHUR: Thank you. So this is an opportunity for the Committee to make a motion to adopt the rates. Just the HMO rates.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: Just the HMO first, and the PPO next.

CHAIRPERSON MATHUR: Mr. Jones.

COMMITTEE MEMBER JONES: I move adoption.

COMMITTEE MEMBER TAYLOR: Second.

CHAIRPERSON MATHUR: Motion made by Jones, seconded by Taylor.

Any discussion on the motion?

Mr. Jelincic.

BOARD MEMBER JELINCIC: Just a question. Does that cover both basic and Medicare in this motion?

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

Yes, it does.

BOARD MEMBER JELINCIC: Thank you.

CHAIRPERSON MATHUR: Thank you.

Any further discussion on the motion?

Seeing none.

All those in favor say aye?

(Ayes.)

CHAIRPERSON MATHUR: All those opposed?

Motion passes.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: Thank you, and Item 5b for the PPOs.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Madam Chair, we request the Committee to make a decision on the PPOs.

CHAIRPERSON MATHUR: Oh. Thank you. Okay. So we need a motion also on the PPO rates.

COMMITTEE MEMBER TAYLOR: I'll make a motion.

CHAIRPERSON MATHUR: Moved by Taylor.

VICE CHAIRPERSON BILBREY: Second.

CHAIRPERSON MATHUR: Seconded by Bilbrey.

Any discussion on the motion?

This is again just for the Basic and the Medicare rates.

Seeing no discussion. All those in favor say aye?

(Ayes.)

CHAIRPERSON MATHUR: All those opposed?

Motion happened -- motion passes.

(Laughter.)

CHAIRPERSON MATHUR: Motion happens.

(Laughter.)

CHAIRPERSON MATHUR: It's only 3:00 o'clock.

(Laughter.)

CHAIRPERSON MATHUR: Okay. Well, thank you very much for this -- I mean, that was -- that seemed like a very simple vote, but it's the -- it's the result of quite a lot of work on behalf of -- on the part of our team here at CalPERS, included -- and the Board as well spent a lot of time deliberating various -- various items in closed session as well. But I just want you all to know that this is -- this is truly the result of dedication and commitment on behalf of our members from this team. So thanks again for all your efforts.

Okay.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

Thank you, Madam Chair and Board. And I just want to just mention that we're just now going to go -- our next steps will be to communicate to our Board members about open enrollment, and we will see you next month.

CHAIRPERSON MATHUR: Sounds good.

We do have one comment from the Committee
Mr. Jones.
HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:
Yes. I apologize.
COMMITTEE MEMBER JONES: Yeah. Thank you, Madam Chair. Just wanted to echo your comments and also applaud the staff, because we received those rates a month ago, and we asked you to go back and twist arms, renegotiate, and do whatever you have to do to bring those rates down. And I just want to thank you for coming back with a better position than we had in May. So thank you again
HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:
Thank you.
CHAIRPERSON MATHUR: Thank you for your comments.
All right. So now, we'll move on to Agenda Item number 7, Long-Term Care Contract Award.
(Thereupon an overhead presentation was
Presented as follows.)
HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Madam Chair, Kathy Donneson, CalPERS staff. This is Agenda Item number 7. It is the long-term care contract award.
The agenda provides information to this Committee regarding contract award 2016-8180, long-term care solicitation evaluation results.

The California Public Employees' Retirement System solicited proposals for a five-year agreement beginning in 2018 for its third-part administrator for its Long-Term Care Insurance Program

We were tasked in June to develop a competitive negotiation approach. That's June of 2016 that consisted with the Government Code section 21663. We come now before you having concluded all aspects of this competitive solicitation with a -- with successfully negotiated contracts from two firms Long Term Care Group, and CHCS.

I will now turn it over to Victoria Eberle to present all of the details of this solicitation and to ask for your award of the contract.

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HEALTH PLAN ADMINISTRATION DIVISION ASSISTANT CHIEF EBERLE: Thank you, Kathy. Madam Chair, members of the Committee, this agenda is an action item for solicitation 2016-8180. In our agenda item today, highlight the background of the solicitation, the timeline, the approach we took, the proposal content and the independent assessment, and the transition.

The CalPERS Long-Term Care Program started in 1995 and currently we have an enrollment of 128,000 active participants, and 100,000 inactive participants.

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HEALTH PLAN ADMINISTRATION DIVISION ASSISTANT CHIEF EBERLE: With this, we have four blocks of product series LTC1, LTC2, LTC3, and LTC4 which is currently under open enrollment.

The goal of the solicitation was to identify bidders who could wholly do the services of a third-party administrator for our Long-Term Care Program, and to bring to you a negotiated contract that is favorable to CalPERS at a competitive price point. The goal has been met, and I am pleased to take you through the process we took.

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HEALTH PLAN ADMINISTRATION DIVISION ASSISTANT CHIEF EBERLE: The solicitation itself, as Kathy said, has taken well over a year, and has consumed the time of at least 100 CalPERS team members across the enterprise from inception to present.

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HEALTH PLAN ADMINISTRATION DIVISION ASSISTANT CHIEF EBERLE: In 2016, phase one was released and that was the minimum qualification. At that time, we had three bidders, CHCS, Long Term Care Group, otherwise known as LTCG, and Long Term Care Partners.

In September 2016, phase two was started, and the firms were provided questionnaires to complete on their

capabilities, management plans, workplans, staffing plans, and of course our financial proposals.

The firms were also provided at this time de-identified data to help them prepare the response to the solicitation. In October of 2016, we held confidential discussions to answer any questions that bidders might have prior to their written submission.

January 4th, 2017, the submissions from each bidders were due and Long Term Care Partners withdrew from the solicitation.

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HEALTH PLAN ADMINISTRATION DIVISION ASSISTANT CHIEF EBERLE: Between the time period of January and February, we had evaluations and scored their submissions through an iterative process, which allowed us to ask questions of the bidders as they were going through to understand each bidder's offering to CalPERS.

Between January and May, the team performed reference checks, on-site visits, and an independent assessment of information technology systems. And between February and June, the competitive negotiations were held resulting in signed letters agreements from both bidders.

Each bidder's capabilities, their management plans, their workplans, their staffing plans, and financial proposals were all consensus scored. At the

conclusion of the evaluation, both bidders earned four out of five stars, placing them in a highly competitive range.

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HEALTH PLAN ADMINISTRATION DIVISION ASSISTANT CHIEF EBERLE: The summary of the stars is seen on page one of attachment 2.

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HEALTH PLAN ADMINISTRATION DIVISION ASSISTANT CHIEF EBERLE: Given the complexity of the Long-Term Care Program, the CalPERS team wanted to ensure that each bidder's information technology capable -- capabilities were agile and strong. In the end, the CalPERS team engaged the external long-term care consultants Optimity Advisors to identify and assess each bidder's information technology.

Consistent with the CalPERS team findings, Optimity concluded that both bidders had strong information technology systems, and employ similar systems in the terms of policy administration, claims adjudication, care management, and customer call center services offered.

However, to note, two distinct notices -- two distinct differences were noted. LTCG offers a full web experience via the portal that members can use. CHCS currently does not have this feature, but would build it,

if selected. LTCG also has a formal information technology business plan over three years to improve its current system. CHCS did not present a proposal in their business plan to improve systems.

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HEALTH PLAN ADMINISTRATION DIVISION ASSISTANT CHIEF EBERLE: The transition would be very different depending on which bidder is chosen. If CHCS is chosen, the transition activities would commence immediately for a negotiated go-live date of June 1, 2018. The transition plan entails migration of our current business including the 128 active participants -- the 128,000 active participants, the approximately 100,000 inactive participants, the four blocks of business we spoke earlier, but more importantly 22 years of historic data, most it in paper form.

The transition team will be comprised of a team that's made up of the CalPERS program staff, CHCS staff, LTCG staff, a project manager, and an on-site long-term care consultant to perform independent validation and verification.

We would also develop a proactive communication plan to keep stakeholders and participants aware during all phases of implementation.

If LTCG is selected, a traditional transition is

not necessary. However, technology enhancements to be implemented over three years, would be in effect, and monitored by the same type of team structure, CalPERS team member, the bidder, a project manager, an external on-site consultant to perform independent validation and verification. And, of course, we would have a communication plan just the same to make sure that all members and participants knew what was going on.

If selected, LTCG, their start date would be January 1, 2018. And although both bidders are very strong and fully capable of being successful as the CalPERS long-term care third-party administrator, there could be only one.

The competitive negotiation approach utilized in solicitation 2016-8180 consistent with Government code 21663, the CalPERS team recommends that the Long Term Care Group is awarded the contract for the third-party administrator services commencing January 1, 2018 through December 31st, 2020.

That concludes our presentation -- 2022. And that concludes my presentation.

We'll take any questions. Thank you.

CHAIRPERSON MATHUR: Thank you.

This is an action item. What's the pleasure of the Committee?

Mr. Jones.

COMMITTEE MEMBER JONES: Thank you, Madam Chair.

I move adoption.

COMMITTEE MEMBER FECKNER: Second.

CHAIRPERSON MATHUR: Motion made by Jones, seconded by Feckner.

Any discussion on the motion?

Seeing none.

All those in favor say aye?

(Ayes.)

CHAIRPERSON MATHUR: All those opposed?

Motion passes.

Again, this is another item where the team spent, as you mentioned, a hundred different people dedicating time over the course of over a year on this very important project that really does impact quite a number of our members. So thank you and all of those involved.

Okay. We are now going to move on to agenda Item number 10, State Annuitant Contribution Formula.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

Hello again, Madam Chair and members of the Committee. Agenda Item number 10 provides the State annuitant contribution rates, which are based on the 2018 health premiums, provide -- excuse me, provided in the attachment in this agenda item.

Government code section 22871 sets forth that an employer contribution for health benefits for State employees and annuitants shall be based on the principle of a weighted average of premiums for the top four health plan benefits

The four largest health plans for 2018 are Kaiser, Blue Shield Access+, UnitedHealthcare, and the PERS Choice Preferred Provider Organization.

This is an information item only, and I will take questions, if you have any.

CHAIRPERSON MATHUR: Any questions from the Committee?

Seeing none.

All those in -- or sorry, this is not an action -- oh, Mr. Jelincic, go ahead.

BOARD MEMBER JELINCIC: Yeah. I recognize that the 80/80 and the 85/80 are actually determined by CalHR. But since they do it off our data, do we have some idea what those numbers are, because I think we probably have a member or two that would be interested.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Mr. Jelincic, we are permitted to provide an estimate, but it truly -- with us providing an estimate, it really needs to come from CalHR. That's my understanding is that we can't distribute it, other than just via an estimate. Maybe --

BOARD MEMBER JELINCIC: Is that your position or can they give what they think the number is going to be, and recognizing it is, in fact, an estimate?

CHAIRPERSON MATHUR: Mr. Gillihan.

COMMITTEE MEMBER GILLIHAN: I don't have any concerns if staff presents an estimate that's their estimate.

BOARD MEMBER JELINCIC: Yeah.

(Laughter.)

BOARD MEMBER JELINCIC: And that's fine.

CHAIRPERSON MATHUR: No guarantee that it's accurate, or that it reflects what the administration is going to calculate -- CalHR is going to calculation.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So, Madam Chair, is that Board directed to go ahead and distribute that?

CHAIRPERSON MATHUR: That -- then that -- as long as -- yes, then that's fine.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Okay.

CHAIRPERSON MATHUR: Okay. Anything else on Agenda Item number 10?

We will move on to Agenda Item number 11 then, Update on Transition Care Program Pilot.

Thank you, Ms. Little.

(Thereupon an overhead presentation was

presented as follows.).

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Could we go to the agenda, please?

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Good morning -- or good afternoon Madam Chair, and members of the Committee. Today, we're going to talk about the completion of the Transition Care Pilot, which we started in 2015.

And as any really good study, we don't want to deliver results that haven't been evaluated. And Dr. David Cowling, just behind me, did the evaluation studies that we will be presenting today.

Today, I'm going to talk about why we conducted the pilot, how it was constructed, and the outcomes and lessons learned.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Thirty percent of Medicare patients are readmitted within 60 days of discharge according to one study. As you just saw in the prior agenda item, looking at it does cost us money. It's not totally paid by CMS. There are costs associated with each admission.

What other studies have found is that gaps in care exist between the hospital discharge and the first

physician visit. And usually that occurs after the patient has been discharged to home. Also, what has been discovered is if good post-acute discharge care and transition care planning is performed, readmissions are reduced.

We conducted this pilot to look at transition care from the hospital to the home, or from the hospital skilled nursing to the home to see if we could determine what needs there might be in terms of follow-up care as the patient recovers in the home, and to look at avoiding readmissions, because that is better care than perhaps what they are getting when they are discharged from the hospital.

We also wanted to know if our long-term care participant pol -- participant holders of policies, if care is delivered in a lower cost setting, such as the home with lower attendant costs associated with that care delivery would that reduce health care costs in terms of our PPO supplement plans.

So when we pick the participants for the study, we wanted to look specifically at the Medicare population. They had to be 65 years and older. We picked area hospitals in Sacramento, so eight area Sacramento hospitals, and we -- so they both had to -- they had to have both coverage for long-term care and coverage for the

PPO supplement plan.

We also looked at a participant database of members who had been readmitted or admitted in the prior one to two years. This pilot was a partnership between Anthem Blue Cross, CalPERS, Long Term Care Group, and a company called AccentCare who's provided discharge planning nurses that could go in and counsel the long-term care members who were transitioning from their inpatient to their outpatient home.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: As I said, eight greater Sacramento hospitals participated in the pilot. We used the AccentCare discharge planning nurses who actually got privileged at the hospitals to work with the discharge planners when they were admitted. Our members carried cards that said they were part of the pilot, had they chosen to volunteer to participate. And that told the -- that told the discharge planner to call the transition care nurse and assist in this supervision of that transition from hospital to home at the time of discharge. Again, this was a voluntary reprogram, and it was at no cost to the participants. And we did have some invited participants decline from the program.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: This is the evolution of our pilot. We originally looked at some of the most frail of our population -- Medicare population who had had multiple admissions, either in the prior year or the prior two years. So we took a day to set and we looked at the frailty of the member that is associated with the diagnoses, and then we looked at whether to -- how many -- whether they had been readmitted -- whether they had been admitted and then readmitted within the time period. And we found that there were, of this population, a number of them that had multiple admissions in a single year.

The problem with that data set - there were about 440 - was that it was the most frail of the population, and so over that initial period we actually lost our members. They passed away.

And, in fact, one of the members who the discharge nurse was called -- the transition care nurse was called, and the member had passed away in the ICU, and that nurse assisted the family in making preparations for their loved one.

So we thought maybe we better expand the population to all 65 and older Medicare members within the greater Sacramento area, and that was approximately 1,140.

So between February and March of 2016, you can

see from this timeline that with the initial 440 that we launched, we then expanded it to another 1,150 approximate participants. But then as we proceeded -- as we proceeded to look at the needs of this population, we actually started looking at home care case management with the membership, as well as home safety visits.

So it evolved. We had 440. We then expanded to 1150 or so. And that also included the spouses, because one of the things we have found out is that carrot home -- if there is a spouse is often managed by the spouse.

And these also our long-term care policyholders, so we wanted to make sure that if they had needs of assistance with daily living, or they wanted to know how to open a claim, or they wanted to know about adult respite because the spouse gets stressed as part of that care giving, then we wanted to make sure that they had availability through the Long Term Care Group, as well as AccentCare nurse to coordinate that care.

We also looked at patients that might have been admitted through the emergency room. So we looked at ER visits that did not lead to an admission.

So, in summary, on our timeline and our scope, it did expand. But we believe that even though the original intent was to reduce readmissions, we found out some much more valuable lessons associated with the pilot, when it

was evaluated.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: One of the things that we learned is that, one, just having Long Term Care Group and the AccentCare nurses work together, our members were -- they were actually more educated about what their benefits were. Whether they needed them now or not, they at least had a greater understanding.

Most of them in State -- in the terms of safety, a lot of what we found, through these nurses, is that safety is an issue in the 65 and older population in terms of grab bars, in terms of getting trip rugs. We had a member who kept being readmitted, because there were tripping over their rugs and falling down.

One of the -- we also diverted a house fire, when one of the participants tried to light the fireplace, and it hadn't been lit for more than eight years.

We learned that that health coordination is really more community and social services coordination. Oftentimes, members need to find transportation to the physicians's office, or they need to identify the support from the society for the blind, because of macular degeneration.

So these were the types of things in terms of

just health coordination we are finding out. Oftentimes, it's not medical care they need. Although, when we get to pharmacy it is medical supervision that they need. Often, i's community and social services.

Our greatest safety issue, in terms of readmission to the hospital, was on medication reconciliation. The greatest danger to any -- probably any person, but because this was our Medicare population, the greatest danger to readmission is Medicare -- medication interaction, and the failure to reconcile medications.

The fact that you have two seniors living in the home each having their own medications oftentimes they're mixing them up in the cabinets, oftentimes the discharge medications are inconsistent with the medications at home. So the biggest safety issue we encountered was medication reconciliation. And that is probably the biggest reason that you have readmissions from this population.

And finally prevention. As I said, we did look at preventing not just going back to the hospital, but going back to the ER. And now I'm going to turn it over to Dr. Sun to talk about the evaluation.

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DR. SUN: Good afternoon. Richard Sun, medical consultant for CalPERS. Before the program was

implemented, we developed a thorough quantitative and quality evaluation plan with the Health Policy Research Division. The difficulty of obtaining participants and the evolving eligibility criteria impacted our ability to implement that plan, including our intended primary outcome of re-hospitalization.

As you can see from the table on page three, there were 257 participants in the TCP program, that is the intervention group. There were 884 in, what we called, comparison group one who met the risk score criteria and were offered participation in the program, but who did not enroll.

Comparison group 2 included those who were not offered participation in the program. They had lower risk scores, including a lower average age, fewer hospital admissions, and fewer emergency room visits prior to the program. The small size of the intervention group causes uncertainty in the results, which do not allow us to form definitive conclusion about the impact of the intervention.

Nevertheless, they suggest that the program decreased emergency room visits compared with the other two groups. In contrast, comparison group one seemed to have greater decreases in hospital admissions, and length of stay than the intervention group.

Dr. Donneson has already touched upon the programs anecdotal benefits. I will add that as part of the evaluation, the CalPERS nurse consultant at the time reviewed the nurses notes generated by the program. She identified possible areas for improvement, including making the nurse's interactions with the families and participants more comprehensive.

In summary, we will continue to follow developments in minimizing hospital readmissions in our population health management efforts.

This concludes our presentation, and we're happy to answer any questions.

CHAIRPERSON MATHUR: Thank you very much.

Mr. Jelincic.

BOARD MEMBER JELINCIC: In page three of four, the comparison group, comparison group 1, which were the people that were eligible but declined to participate or didn't respond, you pointed out they had a greater decrease -- or a greater increase -- no, a greater decrease in admits, but even then they're still the highest group. Do we have any idea why apparently the people who declined tended to be less healthy than the people who accepted?

DR. SUN: We do not have any explanation for that.

BOARD MEMBER JELINCIC: Okay. Thank you.

CHAIRPERSON MATHUR: Thank you.

Well, despite the small sample size, I think this -- this actually did -- clearly, there are some lessons that were -- that we were able to glean from this study. And it's an important area to review, particularly given that we are -- we do provide health benefits, and we also offer this long-term care product, and ensuring that we are both efficiently using the services -- that our members are efficiently using the services, but also that they're getting the best care and having the best outcomes is clearly our long-term term objective.

So I think this kind of work and continuing on with this kind of work is important. So I thank you for your efforts on this, and let's see what the next -- what the next study teaches us.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Thank you. And I'll just stay up here.

CHAIRPERSON MATHUR: Okay. So we're going to go over now to Agenda Item number 12, the Spousal Surcharge for Contracting Agency Member Health Benefit Contributions.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Thank you, Madam Chair, members of the Committee.

In March, we reported the close-out of the 2012 to 2017 strategic plan. There are a couple of items that we were asked to follow-up on. And one was the spousal surcharge. And I just want to be clear, we understand it. It's a spousal surcharge for employers. And there is interest from all also the State employer as well as the contracting agencies.

At the time that we reviewed why the surcharge was not pursued between 2012 and 2017, in speaking to the team that worked on it, it was that there -- it's an administratively complex effort that has to be administered through an employer. It is not really -- it's difficult -- it's actually, probably according to the Government Code, impossible for us to administer the program.

And so, I -- the -- when I was asked to go back and take a look at it, the first thing I did was contact our Legal Office to ask if we could, if there was a way that the premiums could be surcharged in terms of a spouse. And it's about a spouse who has alternative coverage through a non-contracted PERS program. So somebody who might have a health plan through a federal government, be the spouse of a State or contracting agency subscriber, that's what the surcharge is for.

We do understand -- and in this agenda item, we

cite research that spousal surcharge is a method that is incorporated by other employers as an incentive for the spouses to use -- the benefit eligibility awarded through their own employer.

As we -- as our legal team looked at whether we could surcharge through the premium, they examined Government Code section 22890. And I won't get into the specifics of it of the -- how the statute reads. It's just that our Legal Office advised and we concurred that neither the State nor the contracting agencies could build a surcharge into the premium.

CHAIRPERSON MATHUR: Okay. Thank you.

So I think that -- that is -- okay. We do have a question from the Committee.

Mr. Gillihan.

COMMITTEE MEMBER GILLIHAN: Thank you, Madam Chair. Maybe we looked at the question a little too narrowly. And I don't know why we only looked at it from the public agency perspective and not the State perspective, because I think this is something we've been interested in is a possible alternative to help rein in again the ever-increasing cost of health care. As an employer, it's incredibly expensive. And it's the employers that unfortunately bear the burden -- the brunt of these costs.

So if an employer were to negotiate this with their employees or a subset of their employees, is CalPERS not able to facilitate an employer coming to the system saying we've negotiated this arrangement, and we need you to help implement it?

CHAIRPERSON MATHUR: We have our legal counsel.

COMMITTEE MEMBER GILLIHAN: Would that -- would that be contrary to Government Code?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I just want to clarify something before we turn it over to the Legal Office. We understand that the State had great interest in this. We were not trying to exclude the State by calling it for a contracting agency. It's just that when it was presented, I guess several years ago as part of that strategic plan, it was felt to be administratively expensive for both -- for all employers, including the State of California.

That it was not our intent that you should not or that the CalHR should not be included as we reviewed this. And as I expect our legal counsel is going to advise you, that whether it's the State of California or a contracting agency, the Government code applies.

So I'll turn it over to Mr. David Van der Griff.

CHAIRPERSON MATHUR: Thank you.

Mr. Van der Griff.

SENIOR STAFF ATTORNEY VAN der GRIFF: Good afternoon, Madam Chair, members of the Committee.

We would interpret that, in general, a memorandum of understanding, or MOU, collectively bargained MOU does not take precedence over provisions of PEMHCA, unless provisions of PEMHCA provide for that precedence.

So again, from our perspective, should the State negotiate this or a contracting agency, for that matter, negotiate this into their agreements, we would think that would be inconsistent with PEMHCA, as PEMHCA does not provide for that.

COMMITTEE MEMBER GILLIHAN: Thank you. So PEMHCA doesn't have supersession language that would allow an MOU to be controlling. But the truth is this system and the State changes laws all the time. In fact, this system runs an annual housekeeping bill every year to clean up Government Code.

So I would just hate that we would look for the first hurdle and use that as a reason to stop research into this, because if this was something an employer, perhaps the State, or other public agency employers are interested in, to help manage their costs to enable to keep providing benefits, I think it's something that we should help them with, if they so choose.

So I think it warrants -- I don't know. I feel

like we just found the first roadblock and called it a day. And I think it deserves a better look than that.

Thank you.

CHAIRPERSON MATHUR: Thank you.

Mr. Slaton.

BOARD MEMBER SLATON: Thank you, Madam Chair. I agree with Mr. Gillihan that, you know, I think further exploration of this from a legislative standpoint, I think, makes some sense to be able to do it. But the other question I have is what about a spouse that does have -- in other words, there it's not necessarily elected, it's provided, how do we do coordination of benefits?

SENIOR STAFF ATTORNEY VAN der GRIFF: In general, there is a in coordination of benefits provision within all of our health plan arrangements. There are -- as I say, there are provisions that do set out the procedures and how you do coordinate benefits in those situations, where, right, the spouses both enroll in their respective employer's coverage, and then it's a determination to which one is primary and which one is secondary.

BOARD MEMBER SLATON: Okay. And we don't -- we don't mandate it one way or the other, that --

SENIOR STAFF ATTORNEY VAN der GRIFF: We don't mandate in terms of the spouses, in terms of which

coverage they should enroll in is the question or --

BOARD MEMBER SLATON: Oh, I'm just -- I'm asking -- you know, there's some organizations that have where your coverage is conditional upon you don't have other coverage available to you.

SENIOR STAFF ATTORNEY VAN der GRIFF: Yeah.

BOARD MEMBER SLATON: If you have other coverage available to you then that's the coverage you should use. And I -- my guess is we don't take that approach.

SENIOR STAFF ATTORNEY VAN der GRIFF: We don't take that. Yeah, we do not take that approach. I mean, we offer -- you know, if we have the coverages available for our members, employees, either State or contracting agencies, and generally their spouses, domestic partners, and other dependents.

So we don't put a condition, if you're eligible, then you can enroll, and they --

BOARD MEMBER SLATON: So just -- just enlighten me just a little bit on how that coordination of benefits works, where is the first dollar spent in spousal coverage? Does it come out of our plans, does it come out of their plans? It depends on the situation?

SENIOR STAFF ATTORNEY VAN der GRIFF: It depends on the -- I mean, we have it explained in the evidences of coverage for each plan that we offer, and it sets forth --

I don't know what chapter and versus right off the top of my head right now, but we can certainly get back to you with that.

BOARD MEMBER SLATON: Thank you.

CHAIRPERSON MATHUR: Thank you.

Mr. Jelincic.

BOARD MEMBER JELINCIC: And I disagree with the two Governor appointees. But if, at some point, we do pursue it, one of the issues that I think has to be thought about is what happens if you have a couple where they are both CalPERS employers, but they are different employers?

And so I think that's another little -- if we pursue, that's another twist that I would encourage you to make sure you look at.

SENIOR STAFF ATTORNEY VAN der GRIFF: Yeah. And I think I would just add to Mr. Slaton's in terms of the coordination of benefits. It most likely is going to depend on which coverage the spouse uses to go for the services that they are accessing.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: The coordination of benefits is often -- often happens at the provider's office. So that's why we may not have total visibility on how it works. So I, as a calPERS member, may go. I'm the subscriber. My benefits

prevail in terms of that benefit. As a military officer, I have secondary coverage through the -- my military benefit, which could be coordinated. My husband also has that type of coverage as well as he's on Medicare, so coordination of benefits often happens at the provider's offers.

And not to make this a lengthy discussion, we don't have a great visibility on it, but certainly as if we go -- continue to explore this, we'll try to understand a little more about that.

CHAIRPERSON MATHUR: Thank you.

Mr. Bilbrey.

VICE CHAIRPERSON BILBREY: Thank you, Madam Chair. While I understand this doesn't specifically interfere with collective bargaining, we're kind of approaching there where employers and their members come to agreements and we just administer benefits.

If employers wish to have this impediment taken care of, certainly they could pursue something by legislation. But I'm not sure CalPERS is really the one that should go down that route myself. So I caution our committee members on where we're going with this item.

CHAIRPERSON MATHUR: Thank you, Mr. Bilbrey.

Mr. - Ms. Taylor.

COMMITTEE MEMBER TAYLOR: Yes, I was -- I repeat

what Mr. Bilbrey said. It was my understanding that there was some direction here from Mr. Gillihan to -- for you guys to look into some legislation. And I agree, I think that should be sought through other means. I don't think CalPERS is the appropriate place for that legislation to be sought. And I will also add that as an employee of the State of California, I don't want to see my benefits degraded anymore than they already have been. And I think it makes it difficult for us to, you know, recruit great people.

So that's my thinking on this. I just want to make sure that we -- and one other question I had was is it the same Government Code section that you were quoting that applies to the State of California as it does to --

SENIOR STAFF ATTORNEY VAN der GRIFF: No. No. There are separate -- they're identical, but separate provisions within PEMHCA.

COMMITTEE MEMBER TAYLOR: Okay. Thank you.

CHAIRPERSON MATHUR: Okay. Thank you.

That was an information item. I see no further requests to speak.

So that will bring us to Agenda Item number 13, Summary of Committee Direction.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Thank you, Madam Chair. The first action item is to come back

in a year and report back on the SilverSneakers prog -- SilverSneakers program progress back to the Committee.

The second action item is to distribute the CalPERS estimated 80/80 and 85 rates -- our 80/80 amounts. And then it sounded like we were not directed to lead the spousal surcharge open. So we only have the two items.

CHAIRPERSON MATHUR: That's right. Okay.

And finally, public comment. I have received no requests to speak. Is there any member of the public who wishes to address the Committee at this time?

Seeing none.

We are adjourned. Thanks, everyone.

(Thereupon the California Public Employees' Retirement System, Board of Administration, Pension & Health Benefits Committee open session meeting adjourned at 3:37 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 26th day of June, 2017.

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