MEETING

STATE OF CALIFORNIA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

BOARD OF ADMINISTRATION

PENSION & HEALTH BENEFITS COMMITTEE

OPEN SESSION

ROBERT F. CARLSON AUDITORIUM

LINCOLN PLAZA NORTH

400 P STREET

SACRAMENTO, CALIFORNIA

TUESDAY, AUGUST 15, 2017

9:00 A.M.

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

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. Richard Gillihan

Ms. Dana Hollinger

Mr. Henry Jones

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

Ms. Kelli Aoki

Dr. David Cowling, Center for Innovation

Dr. Kathy Donneson, Chief, Health Plan Administration Division

Ms. Jan Falzarano, Chief, Retirement Research and Planning Division

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

STAFF:

Ms. Jennifer Jimenez, Committee Secretary

Mr. Gary McCollum, Senior Life Actuary

Ms. Renee Ostrander, Chief, Employer Account Management Division

ALSO PRESENT:

Mr. Bob Cosway, Milliman

Dr. Ateev Mehrotra, Harvard Medical School

Ms. Donna Snodgrass, Retired Public Employees Association

Mr. Larry Woodson, California State Retirees

I N D E X

P R O C E E D I N G S

CHAIRPERSON MATHUR: Good morning, everyone. We are going to convene the Pension and Health Benefits Committee meeting. The time is 9:00 a.m.

Please -- first order of business is to call the roll.

COMMITTEE SECRETARY JIMENEZ: Priya Mathur?

CHAIRPERSON MATHUR: Morning.

COMMITTEE SECRETARY JIMENEZ: Michael Bilbrey?

VICE CHAIRPERSON BILBREY: Good morning.

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

ACTING COMMITTEE MEMBER GLASSER-HEDRICK: Here.

COMMITTEE SECRETARY JIMENEZ: Rob Feckner?

CHAIRPERSON MATHUR: Excused.

COMMITTEE SECRETARY JIMENEZ: Richard Gillihan?

COMMITTEE MEMBER GILLIHAN: Here.

COMMITTEE SECRETARY JIMENEZ: Dana Hollinger?

COMMITTEE MEMBER HOLLINGER: Here.

COMMITTEE SECRETARY JIMENEZ: Henry Jones?

COMMITTEE MEMBER JONES: Here.

COMMITTEE SECRETARY JIMENEZ: Theresa Taylor?

CHAIRPERSON MATHUR: Excused.

COMMITTEE SECRETARY JIMENEZ: Alan Lofaso for Betty Yee?

ACTING COMMITTEE MEMBER LOFASO: Here.

CHAIRPERSON MATHUR: We have a quorum.

Next order of business is the executive reports. Ms. Bailey-Crimmins.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Good morning, Madam Chair and members of the Committee. Liana Bailey-Crimmins, CalPERS team member.

Today, my opening remarks will focus on four topics. The first is the upcoming health plan open enrollment period, which I will highlight what is new for our members and our employers. Two, I will highlight the CalPERS Health Beliefs. I'll provide a short update on that. Third, pharmacy coverage, what's going on in the news and what it means for CalPERS. And then fourth, there is a September health care summit that will be held in Sacramento, so I'd like to talk a little bit about that.

So first order of business is the 2018 open enrollment period. It's just around the corner. September 11th is when it starts, and it will end on October 6th. During open enrollment, members may enroll in the CalPERS health program, add eligible family members, or make changes to their existing health plans.

A friendly reminder that changes made during open enrollment will stake effect January 1st of 2018. For

convenience, CalPERS members can explore, learn, and decide about their 2018 coverage options logging in to my|CalPERS. And this year, we have decided to sunset the Health Plan Chooser Tool. But instead, we've enhanced my|CalPERS to provide this functionality and much, much more.

So our members now will be able to do customized searches, which they can do plan comparisons side by side looking at monthly premiums, covered benefits, deductibles, and copayments.

In addition, effective August 28th, members will be able to access their health plan statements, and open enrollment materials.

So for our employers, we are pleased to announce the new CalPERS open enrollment webpage, which is available on the CalPERS website. It replaces the annual CalPERS circular letter that was traditionally mailed in August. CalPERS continues to strive to be green. And so our employers can now obtain all the information needed on-line in a centralized location, which includes the 2017 and 2018 health benefit summary, the health plan summary of benefits and coverage, health plan evidence of coverage, and health program guide.

The second item is the CalPERS Health Beliefs. At the July Board off-site, the health team presented

draft Beliefs statements and associated strategies. The team and I want to personally thank the Board for engaged and valuable feedback. And after reviewing the Board calendar, it was determined that the best time to hold our next workshop will be at the January 2018 off-site instead of our original September target.

Over the next several months, the CalPERS team will continue to make progress and the extra time will be used to refine the Beliefs statements, and leverage the Board, the stakeholders, and the executive team feedback.

The revised timeline again is at the January off-site. We will propose another set of draft Beliefs statements. And hopefully, we'll have a vote in Pension and Health Benefits Committee in March.

Third item is the pharmacy update. There have been numerous media stories regarding pharmacy benefit managers and clawbacks, where basically consumers are asked to pay a full co-pay, which is a higher amount than if they had paid cash. I want to assure you and our members that the contract that we've negotiated with OptumRx ensures that our members receive the lowest amount regardless of their co-pay.

If their co-pay is $10, and a cash amount is a dollar, member only pays the dollar. We also have full transparency with OptumRx. We know exactly what they pay

for their medications. And it also is a requirement that 100 percent of the rebate savings get passed on to our members.

The fourth item is there will be a September health care summit. It's right around the corner. The Gordon and Betty Moore Foundation awarded a major grant to the National Coalition of Health Care. The purpose is to establish program work and help inform, frame, and advance a constructive national dialogue about the affordability of health care.

CalPERS holds a board seat. And we are a partner with the National Coalition to hold a summit here in Sacramento on September 12th, where we'll be examining the underlying causes of escalating health care costs, and innovative ways that we can continue to have quality care and affect policy.

We will have a star lineup of health care leaders and representatives. And the summit will be held from 11:00 a.m. to 3:00 p.m. at the Citizen Hotel in downtown Sacramento. So please keep an eye out for additional information on this event.

And, Madam Chair, in closing, I'd like to take a moment privilege and announce that Rob Jarzombek has been appointed the new division chief over the Health Accounts Management Division.

For the past three years, Rob has served as the Assistant Division Chief in CSOD leading the customer contact center. In his role, he has led and increased the customer satisfaction ratings to their all-time high, while reducing wait times to their all-time low.

Rob's customer-first philosophy and leadership abilities makes him an excellent new addition to the Health Policy and Benefits Branch. I'd like for Rob to please stand and be recognized by the Board to be the new chief of the Health Account Management Division.

(Applause.)

CHAIRPERSON MATHUR: Congratulations.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Thank you, Madam Chair. That concludes my opening remarks. I'm available for questions.

CHAIRPERSON MATHUR: Thank you very much.

Any questions from the Committee?

Seeing none, we'll move on to Agenda Item 3, which is the action consent item, approval of the minutes

VICE CHAIRPERSON BILBREY: Move approval

CHAIRPERSON MATHUR: Moved by Bilbrey.

COMMITTEE MEMBER HOLLINGER: Second.

CHAIRPERSON MATHUR: Seconded by Hollinger.

Any discussion on the minutes?

Mr. Jelincic.

BOARD MEMBER JELINCIC: Yeah. I'm not on the Committee, so I can't make a motion. But on page three of the minutes, Item 12, the spousal surcharge for contracting agencies, I think we should add a line that such a surcharge would be illegal under PEMHCA.

CHAIRPERSON MATHUR: So I think that was part of the discussion was that really the biggest impediment is the law that prohibits us from levying the surcharge. So perhaps if we could just add a line to that effect consistent with the agenda item. I will direct that that be the case.

Thank you very much.

BOARD MEMBER JELINCIC: Thank you.

CHAIRPERSON MATHUR: Assuming that that is satisfactory with the Committee.

Seeing no objections. Okay.

So the motion before you is to approve the minutes as amended.

Any discussion on the motion?

Seeing none.

All those in favor say aye?

(Ayes.)

CHAIRPERSON MATHUR: All opposed?

Motion passes.

Agenda Item 4 has the consent items including the

calendar. We're going to move that workshop on health benefits -- Health Beliefs rather to January of 2018. It's currently listed in September of 2017.

Seeing no requests to pull anything off the consent calendar. We'll move on to Agenda Item number 5, which is proposed regulation for pensionable compensation under PEPRA.

Ms. Ostrander.

EMPLOYER ACCOUNT MANAGEMENT DIVISION CHIEF OSTRANDER: Good morning, Madam Chair and members of the Committee. Renee Ostrander, CalPERS team member.

Before you today is Agenda Item 5, an action item, requesting approval of the draft regulations clarifying CalPERS's interpretation of what is considered pensionable compensation for PEPRA members, and to help ensure uniform compliance amongst all CalPERS covered employers.

We did not receive any public comments or requests for a hearing during the public comment period. As a result, the final version of the proposed regulations have not changed from the version brought forward to you in March. And it aligns to the direction provided to employers in the 2012 Circular Letter. This means that no reconciliation efforts will be required by our public agencies or schools.

With your approval, and the Board's approval tomorrow, we will move forward into the final steps of the process. With the Department of Finance's approval, this final package will be submitted to the Office of Administrative Law for review and ultimate publication.

The completes my presentation, and I'm happy to answer any questions you might have.

CHAIRPERSON MATHUR: Thank you.

Any questions from the Committee?

Seeing none.

This is an action item.

COMMITTEE MEMBER GILLIHAN: I move staff recommendation.

COMMITTEE MEMBER HOLLINGER: Second.

CHAIRPERSON MATHUR: Thank you. Moved by Gillihan, seconded by Hollinger.

Any discussion on the motion?

Seeing none.

All those -- Mr. Jelincic, do you have discussion on the motion?

One moment.

BOARD MEMBER JELINCIC: Yeah. I know this is going to pass, and I accept that, but I still believe that if people do the work, they ought to get paid. And so I think the temporary upgrades ought to be part of their

compensation, and it ought to be PERSable. And if I have to make a choice between Jerry Brown and Jesus, I will take Jesus. In looking at Luke, it clearly should be paid.

Thank you.

CHAIRPERSON MATHUR: Thank you.

All in favor say aye?

(Ayes.)

CHAIRPERSON MATHUR: All opposed?

Motion passes. Thank you very much, Ms. Ostrander.

Agenda Item number 6, Proposed Amended Regulation for Normal Retirement Age.

MS. AOKI: Good morning, Madam Chair, members of the Committee. Kelli Aoki, CalPERS team member.

Agenda Item number 6 is an action item requesting approval of the proposed amendments to California Code of Regulations 586.1 defining normal retirement age.

In 2004, CalPERS adopted California Code of Regulations 586, 586.1, and 586.2 defining normal retirement age for the existing benefit formulas and bona fide separation in service to help ensure compliance with federal rules governing in-service distributions.

CalPERS defined normal retirement age as the later of the member's age when their first eligible to

retire or the member's benefit formula age. For example, for the two percent at 55 benefit formula, CalPERS defined normal retirement age as age 55. Since 2004, the legislature has added new benefit formulas to the CalPERS defined benefit plan, including benefit formulas added under the Public Employees Pension Reform Act of 2013, more commonly known as PEPRA.

This proposed amendment updates the existing regulations in compliance with federal rules governing in-service distribution by adding normal retirement age definitions for benefit formulas added since 2004, including the PEPRA formulas.

This proposed amendment also consistent with federal rules governing in-service distributions establishes the maximum normal retirement age as age 62 for members who are otherwise eligible to retire. Please note that we are not establishing a mandatory retirement age. Normal retirement age applies to working after retirement and partial service retirement programs.

These proposed amendments are consistent with existing State and federal law and will not impact any of our existing programs.

Although CalPERS already applies those normal retirement age definitions in operation, explicitly defining them in the regulation provides clarity, and

assists CalPERS team members, contracting agencies, State and school employers, and CalPERS members to ensure compliance with federal rules governing in-service distributions.

If the Board approves the proposed regulatory amendment and initiation of the regulatory process, we will request the Office of Administrative Law publish the Notice of Proposed Regulatory Action in the California Regulatory Notice Register. The Notice of Proposed Regulatory Action requires a minimum 45-day public comment period.

We anticipate bringing this draft regulation package, along with any comments received and our responses to them back to this Committee for final approval in February.

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

Thank you.

CHAIRPERSON MATHUR: Thank you very much.

A few questions from the Committee.

Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you, Madam Chair. Yeah, just a clarification on the modification from age 65 to 62.

Excuse me.

And you said that this is in accordance with federal regulations, but Social Security has a higher age. And that's -- so why is this different?

MS. AOKI: So in 2007, the Internal Revenue Service established normal retirement age rules. And they established age 62 as the allowable in-service distribution option. So the age 65 is not a maximum retirement -- normal retirement age that we've established. Age 65 is the benefit formula age for a couple of our existing benefit formulas. So we're just aligning the age 62 with the normal retirement age regulations.

COMMITTEE MEMBER JONES: But that is different than Social Security --

MS. AOKI: Correct.

COMMITTEE MEMBER JONES: -- where -- and it's under federal regulations also, right?

MS. AOKI: Correct

COMMITTEE MEMBER JONES: Okay.

CHAIRPERSON MATHUR: Thank you.

Ms. Glasser-Hedrick.

ACTING COMMITTEE MEMBER GLASSER-HEDRICK: Just a quick question. How does the reduction of the retirement age to 62 affect those individuals who are -- who their benefits are predicated on the 1.25 percent at 65, and the

1.2 percent at 67, or is there no impact?

MS. AOKI: There is no impact to the retirement benefit calculation. The retirement benefit calculation would still be using the benefit factor at the age at which they retire. The age 62 just applies to our working after retirement program, and our partial service retirement program.

ACTING COMMITTEE MEMBER GLASSER-HEDRICK: Okay. Thanks.

CHAIRPERSON MATHUR: Thank you.

Mr. Gillihan.

COMMITTEE MEMBER GILLIHAN: Thank you, Madam Chair. Yeah, I just wanted to clarify. This doesn't change any of the retirement formulas. It's merely benchmarking or pegging a point in time that we define as normal retirement costs. And for classic members under miscellaneous today, that age is 55, correct?

MS. AOKI: Correct.

COMMITTEE MEMBER GILLIHAN: And so this really is kind of aligning what we did in PEPRA on the miscellaneous side making it 62.

MS. AOKI: It's -- correct, that's for the --

COMMITTEE MEMBER GILLIHAN: The miscellaneous formula is two at 62 today, under PEPRA --

MS. AOKI: Correct.

COMMITTEE MEMBER GILLIHAN: -- is two at 55 for classic members, right?

MS. AOKI: Correct.

COMMITTEE MEMBER GILLIHAN: And so -- but this has no -- are there any fiscal impacts to the system by changing this definition?

MS. AOKI: We have not identified any.

COMMITTEE MEMBER GILLIHAN: Okay. Thank you.

CHAIRPERSON MATHUR: Thank you.

Mr. Jelincic.

BOARD MEMBER JELINCIC: Yeah, in (a)(2), the addition of, "Not to exceed age 62", I'm not sure what that addition adds. I mean, because we go on and we have (A), (B), and (C), (D) where we describe those ages. So I'm just not sure what gets added by adding "Not to exceed 62".

MS. AOKI: So we have a few benefit formulas that have a benefit formula age higher than 62. So, for example, we have a 1.25 percent at 65. So establishing a maximum normal retirement age at 62 lowers the retirement -- the maximum normal retirement age -- lowers the normal retirement age for those benefit formulas from the benefit formula age to that maximum normal retirement age.

BOARD MEMBER JELINCIC: But isn't that caught in

(A), (B) and (C), (D) -- (A), (B), (C) and (D)?

MS. AOKI: We're just adding clarification in (A) to say that the normal retirement age isn't defined as the benefit formula age at 65. That it's aligned with the maximum normal retirement age of 62.

BOARD MEMBER JELINCIC: And I thought we did that. I'm just not -- I don't understand what it adds into is really the problem. I mean, because you go on and you say in this case, it's, you know, 62; this case, it's 60; this case, it's 67; this case, it's 65; this case, it's 50. So I'm not sure what gets gained by adding that

MS. AOKI: So for the other benefit formula ages, the benefit formula age is lower, so we're -- we define the normal retirement age as the benefit formula age for the benefit formulas who has a benefit formula age below 62.

BOARD MEMBER JELINCIC: Clear as mud. I don't understand it at all.

CHAIRPERSON MATHUR: Ms. Falzarano.

RETIREMENT RESEARCH AND PLANNING DIVISION CHIEF FALZARANO: Good morning. Jan Falzarano, CalPERS team member.

So the reason we're establishing the age 62, it has nothing to do with the maximum retirement age, but it

has to do with the bona fide separation and the 60 days afterwards. So if we pick age 62, when someone reaches the age of 62, they're no longer required to have that bona fide -- 60-day bona fide separation in place. So that was the intent of the age 62, and that's what the federal government has released since 2007. And so we're just being consistent with the federal rules in applying age 62.

BOARD MEMBER JELINCIC: And I think we do that (A) through (D), and I still don't understand what it adds to (2). Although, I will say, it doesn't hurt anything.

RETIREMENT RESEARCH AND PLANNING DIVISION CHIEF FALZARANO: It doesn't change any of the benefit formulas. So the two percent at 55 would still apply, the 1.25 percent at 65 and 67 would still apply. But if someone was greater than the age of 62, they applied the 1.25 percent at age 65, and they retired at age 62, they're able to return to work as a retired annuitant without having the bona fide separation date.

BOARD MEMBER JELINCIC: I still don't understand, but okay. Thank you.

RETIREMENT RESEARCH AND PLANNING DIVISION CHIEF FALZARANO: Okay.

CHAIRPERSON MATHUR: Thank you.

Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you, Madam chair. Yeah, that's the same source of my question about the 62 is that (A). I'm wondering the Government codes that follow that statement, is that where the explanation is that you just explained? Is that why it's kind of confusing, because what you talked about you say these Government Codes. So is that where the explanation is?

MS. AOKI: Right. So the Government codes listed are the Government codes for the benefit formulas.

COMMITTEE MEMBER JONES: Okay.

MS. AOKI: So for like in (A), where it says 62, and it lists the four government codes there. Those four government codes apply to different retirement benefit formulas.

COMMITTEE MEMBER JONES: Okay. Okay.

CHAIRPERSON MATHUR: Okay. Mr. Gillihan.

COMMITTEE MEMBER GILLIHAN: Thank you, Madam Chair.

I just wanted to clarify, the bona fide retirement date, is that the term you used?

MS. AOKI: Bona fide separation in service.

COMMITTEE MEMBER GILLIHAN: Bona fide separation. Does that have any impact on the mandatory 180-day break before people can return to service as a retired annuitant?

MS. AOKI: So people are subject to 180-day break in service, but there are some -- there's some exemptions to that 180 days. So if you were to retire before normal retirement age, you would -- and you're exempt from the 180 days, you would still be subject to the 60-day bona fide separation in service.

COMMITTEE MEMBER GILLIHAN: What do you believe are the exemptions from the 180 day, the peace officer/firefighter piece --

MS. AOKI: There is --

COMMITTEE MEMBER GILLIHAN: -- or the CalHR approval for State employees to return with 120 days -- 180 days?

EMPLOYER ACCOUNT MANAGEMENT DIVISION CHIEF OSTRANDER: Renee Ostrander, CalPERS team member. There are multiple exceptions that are located in the statute, all of which you have mentioned. So there can be -- there is a resolution process. You mentioned that the State could do that. That's correct. Also, public agencies through their governing body could put forth a resolution and pass it. There is the faculty early retirement. There is the peace officer status that you mentioned.

COMMITTEE MEMBER GILLIHAN: But I guess my question is nothing we're doing in this -- in this proposed regulation impacts those requirements as they

exist today?

EMPLOYER ACCOUNT MANAGEMENT DIVISION CHIEF OSTRANDER: That's correct. They still are required -- those two are separate requirements, and they still must be fulfill both of them.

COMMITTEE MEMBER GILLIHAN: Okay.

EMPLOYER ACCOUNT MANAGEMENT DIVISION CHIEF OSTRANDER: Either the 180-day sit-out, or the resolution, but that does not impact the bona fide separation of 60 days.

COMMITTEE MEMBER GILLIHAN: Okay. Thank you.

CHAIRPERSON MATHUR: Thank you. Okay. I see no further requests for questions. So this is an action item.

COMMITTEE MEMBER JONES: Move it.

COMMITTEE MEMBER HOLLINGER: Second.

CHAIRPERSON MATHUR: Moved by Mr. Jones, seconded by Ms. Hollinger.

Any discussion on the motion?

Seeing none.

All those in favor say aye?

(Ayes.)

CHAIRPERSON MATHUR: All those opposed?

Motion passes.

Thank you very much.

That will bring us to the information items.

Agenda Item number 7, Empowering CalPERS Members with Health Care Price Shopping Tool: Promise and Reality.

(Thereupon an overhead presentation was presented as follows.)

CENTER FOR INNOVATION CHIEF COWLING: Good morning Madam Chair, and Committee members. David Cowling, CalPERS team member. I'm bringing to you today Agenda Item number 7, which is an informational agenda item.

To empower members to shop health care services, the price transparency tool CalPERS Compare from Castlight Health was offered to about 200,000 PPO members in July of 2014. CalPERS Compare is a web and smart phone application that allows members to compare prices, conduct searches find doctors, look up their deductible, look at their benefit design, and find other educational materials on-line.

Although, the availability of price transparency tools like CalPERS Compare has been increasing in the U.S., there are no studies published about their effectiveness, when CalPERS Compare was implemented in 2014.

So CalPERS established a research partnership

with Anthem, Anthem's research HealthCore, and Harvard Medical School to evaluate the effectiveness of this price transparency tool.

I'm here today with Dr. Ateev Mehrotra from Harvard Medical School, and a practicing physician at Beth Israel Deaconess Medical Center. He is quite the overachiever. He has degrees from MIT, US Berkeley, UC San Francisco, and Harvard. In 2013, he was named by Academy Health, as the Alice Hersh New Investigator of the Year.

Ateev today will discuss the evaluation of the CalPERS Compare, but we'll also put our studies in the context of where trends -- price transparency is today.

He will also provide some thoughts about where the health care community can go from here with price transparency and price shopping.

Ateev.

DR. MEHROTRA: Well, thank you very much for this opportunity to present to you. Before I begin, I wanted to give the view of the other coast and the policy community as a whole, where CalPERS has really thought to be among the few health care purchasers who's willing to take risks and try new benefit designs, and also to take -- engage in rigorous evaluation.

And so while I wanted to -- kudos to the Board as

well as the staff for doing this kind of work. This work is obviously critical for your members, but it is also really driving a lot of conversation on a national level in the policy community. So thank you for that work.

I wanted to -- in my talks, I wanted to first start with the promise and the reality of price transparency. And so on the promises well articulated --

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DR. MEHROTRA: Go one more slide there.

So this is a quote from Regina Herzinger in a book that was widely cited, where she says when consumers apply pressure on the industry, whether it's retailing or banking, cars or computers, it invariably produces a surge of innovation that increases productivity, reduces prices, improves quality, and expands choices.

Her quote really captures, I think, a lot of the interest in price transparency. We hear this a lot in the debate about health care spending. That the way that we're going to reduce health care spending in the United States is to unleash market forces, and that patients, by selectively choosing lower priced providers will reduce health care spending.

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DR. MEHROTRA: And in some work that we've done with CalPERS, we wanted to understand what's the

potential. We looked at three sets of services, laboratory tests, imaging, direct medical equipment, those are things such as getting a walker, or a CPAP machine. Why do we focus on those?

Those are what CalPERS members felt was an area of health where they thought of it more like a commodity, where quality and relationships didn't matter as much.

And what we wanted to do is create the scenario what would happen in an individual market if a CalPERS member who received care at service -- at a higher priced provider switched their care to a provider at the median? You can see here that overall across those three sets of services, the average CalPERS member was -- the spend is $767 per person per year.

And there's a remarkable savings if those patients or those members switch their care to the median. Most of the high priced providers in the markets have greater market share.

And so overall, the savings here would be 58 percent. Really emphasizing why there's so much enthusiasm and interest in price shopping. How does one drive or encourage members, employees to switch their care to lower priced providers?

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DR. MEHROTRA: And a lot of that interest has

been -- on a national scale has been in price transparency. Over half the states in the U.S. have now passed some form of price transparency law, almost all the major health plans have some form of a price transparency website, and other employers, like CalPERS, have introduced and purchased price transparency products to provide to their members.

What's the goal?

The goal of these is the first goal that's often articulated is that it's about information. It's a very complicated health care system, and people need mechanisms to understand where their -- where the spending is occurring. And also, before you get care, it's important to know how much's it going to cost you, so and your family can budget appropriately.

But I think the primary objective on a national scale in terms of the interest in price transparency is to capture those savings that I just described. Can a person be provided, a member be provided their out-of-pocket cost, what they have to pay, before they get care at a given provider, and to be able to compare that across other providers? And so that they can selectively -- the hope is that they'll selectively choose the lower price provider and prices will overall fall. That's the goal of these transparency initiatives to drive that sort of price

shopping.

Well, that was interest when we started this project. The question is what's the reality, and that's what I would like to describe to you next.

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DR. MEHROTRA: In a paper that we published last week, along with colleagues here at CalPERS, team members as well as folks from Anthem, we described what we found among the CalPERS population. Let me go into a little of depth in terms of what we did here.

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DR. MEHROTRA: We focused on the members who were provided or offered the price transparency tool. Those are the CalPERS members who are non-Medicare eligible, who are in a PPO. And we compared those to members of Anthem who were also here in California who had a similar PPO product. We used some statistical methods called propensity score weighting to address differences in those populations. And what we wanted to know was we focused on spending for a set of, what you might call, shoppable services.

You're not going to shop for a heart attack. You're not going to shop for emergency surgery. You can only -- so we focused on those services such as laboratory testing, imaging, outpatient physician services, where it

was feasible, at least, that someone would shop.

And what we wanted to do is we -- what we did, excuse me, is compare the spending for these services in the year before the Castlight tool was offered to the year after, both in the intervention and control population. What our thought was, our hope is, is that we would see a lower spending growth among those in the CalPERS population who are offered this tool.

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DR. MEHROTRA: Unfortunately, that's not what we found. We found that spending growth among CalPERS members offered such a tool, compared to this control population that was not offered this tool was almost identical.

This work that we have done has been echoed in some other work that we have also done in the same time period looking at other employers, other tools, and including employees who have high deductible health plans. And in those -- in that research we've also found similar results, that the offering of a price transparency tool has not had any discernable decrease in health care spending.

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DR. MEHROTRA: So the question is why?

There's a lot of interest, a lot of frustration

among the American public in prices. What we found was is that among those households offered such a tool, only 23 percent of those signed up for the tool, and that's despite a very aggressive marketing from both CalPERS and in conjunction with Castlight and Anthem.

And fewer than half used it for a price search. People were using it for other purposes, and very few used it more than once. Most people seemed to log on once, try it out, and then never come back again. And that is not a unique experience to CalPERS. In our other work, we found with this Truven tool, only 10 percent of the households used -- signed up for that tool and only two percent used it over time.

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DR. MEHROTRA: But that's not the point in just signing up for the tool. You've got to use it before you get care. When we looked at the these types of services, we wanted to see how often did someone log on to the tool on an app or a website, and look at price information before they got care.

It didn't happen that often. From 0.3 percent to 1 percent of all people who were offered the tool used the tool before they got care. Among those who signed up, of course, a larger percentage did, but it was still low rates. So relatively fewer searching before they get

care. And among CalPERS members -- then the whole point is that if you use the tool, you're going to switch your care to a lower priced provider.

And for laboratory tests and office visits, we didn't find that was the case. Those who searched went to a, for example, an office visit that cost nearly exactly the same as those who did not search. For imaging, we did see a difference, a 14 percent lower price was paid for -- by the -- if they searched before they got their imaging test. This is like a CT or MRI. But so few people searched, that we found no discernable impact on overall shoppable spending.

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DR. MEHROTRA: So why doesn't price transparency lower decrease spending? Few people are signing up for the tools, few people are using the tool before they get care, and when they do use the tool before they get care, searchers are often not going to a lower price provider.

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DR. MEHROTRA: But why?

Again, going back to the American public, anyone who has friends, family, people are frustrated out there with prices. It's one of the greatest concerns for the American public is health care spending. So you have this disconnect between interest and the idea. But when

offered the tool, they're not using it.

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DR. MEHROTRA: To answer this question, we've done a number of evaluations. First, we conducted a survey of CalPERS members. We also did a number of interviews with 30 plus CalPERS members, some who signed up for the tool, use it a lot, others who signed up once, and others who didn't sign up at all.

And I've also done some work on -- from my end doing a national survey of people who -- on asking them about prices and price shopping before they got care.

So what did we learn?

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DR. MEHROTRA: Let me tell you first what doesn't appear to be an explanation. There's been this concern or idea that American public, CalPERS members, they don't really care about prices when it comes to health care. Health care is too important. I'm just going to go wherever I need to go, and I -- this whole idea of price shopping is something that just doesn't feel comfortable when it comes to health care.

That is not what we heard from the CalPERS members. I'll read you a quote one CalPERS person we interviewed. He said, "It was just like getting a car. If people are out looking around trying to get the best

price, dealers are going to drop the price for you, because they want your business. I don't think health care is any different".

Another -- and I think his quote really illustrates what we heard from a lot of CalPERS members. The other concern has been, oh, the reason these price transparency tools aren't going to work is that people are going to see a higher price, so that means better care. And they're going to sort of shift their care to higher priced providers. We didn't hear that also.

Most people described to me experiences where they go to one place that's very costly, the other one is less costly. They didn't see a difference there in terms of quality differences by -- based on price.

So those don't appear to be the explanation. What does appear to be the explanation?

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DR. MEHROTRA: First, CalPERS members are not stupid, and they know that in many cases it doesn't really impact their bottom line under the current benefit design. If you go to getting a surgery and it's above the deductible, it's going to be the same amount for you, or you're going to a doctor's office, or a high cost MRI.

This's also -- we heard, you know, really difficult stories of how hard it is to get this

information, despite the access to this tool. Price data is very hard to understand. We have a complex system with facility fees, and professional fees, and all sorts of bills that come in your mailbox, an explanation of benefits. And in that system, it's very difficult for people to navigate.

And also the good thing about health care is that for most people you only need health care once in a while. But that means that when you now have a health care need, you've completely forgotten about that website or other facil -- you know, a capability that was available to you.

Also, there are limited circumstances to shop. Again, I brought up the idea of a heart attack. You're not going to shop on the ambulance on the way to the hospital. And also, in many communities, there's just one provider, so what's the point? How am I going to shop for a dermatologist if there's only one dermatologist in town, or the health plan offers -- only has one provider in their provider network.

I think that maybe the most significant barrier is the relationships with their providers. Patients tell us that I've been seeing this primary care physician for 20 years. You can tell me how much it's going to cost me, I'm going to still go to that primary care physician, or that cardiologist who they have a relationship with.

And similarly, it's about the recommendation that that primary care physician gives you. The primary -- you know patients will tell us how am I -- you know, a primary care physician told me to go to this place for an MRI, who am I going to say, oh, well, this place has a lower price is just as good. And so they really feel understandably the recommendation of their provider is key.

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DR. MEHROTRA: So let me sum up and think there is a lot of promise related to price transparency. Certainly, significant savings to be had for the CalPERS population in terms of if we -- if there is ways to encourage members to switch to lower price providers, but these tools -- or simply offering these tools hasn't seemed to work.

Well, the first is different kinds of benefit design. Currently, the benefit design is not encouraging people -- isn't sufficient. In terms of a different kind of benefit design, I am not talking about higher deductibles or cranking up the deductibles to 1,000, 2,000, or $3,000 as we see.

Myself and others who have done research on high deductible health plans have shown that those high deductible health plans are very good at reducing spending, but that reduction in spending comes entirely

from reductions in utilization. People just get less care because they're scared about the prices that they'll have -- how much money they'll have to pay.

But we find no evidence under higher deductible health plans that patients are going to switch their care from high-priced to lower-priced facilities. In other words, we don't see any evidence of price shopping.

What kind of benefit designs could you use?

The nation has been really looking to CalPERS and your experience with reference pricing, which has been quite successful, as well as tiering. And what I mean by tiering, I mean similar to what we see in pharmaceutical benefits, you would have tiering of say laboratory tests. If you go to a low-priced laboratory, you pay $0 co-payment, but if you go to a high priced laboratory facility, you have to pay $20 or $30.

And there's good evidence now that those kind of tiering networks do encourage people to switch their care to lower priced facilities.

A second recommendation relates to targeting. Right now, we've asked people to set up this website and passively wait for people to go to that website to look for this information. What we need to think about is can we target that information, targeting in terms of who it is. A small percentage of people, about 10 percent of

people -- of members make up 50 percent of spending. Can we get that information to those particular employees or members who can best use that information?

And also, can we get that information to them in a way that's more actionable? It's a difficult website, difficult network. Can we get something to something simple saying Ms. Jones, there's a lower priced dermatologist in town. Here's the number. Maybe you could consider switching there, because you might save some money. Make it easy for the patient.

And the third and last recommendation relates to how the information -- how we describe price shopping. Right now, the idea is everything you need, physical therapy visit, a lab test, an x-ray, a dermatologist. You go out there and you price shop for each of those individual services.

But another approach could be to profile practices or physician groups based on their relative price. And so a page -- we would create a benefit design to encourage people to switch to a lower priced primary care physician. And then the expectation would be is after that, the patient would receive all their care from that primary care physician's group. And there wouldn't be this idea that they would have to switch out. And so therefore, they could follow their physician's

recommendation.

So I'll stop there.

CENTER FOR INNOVATION CHIEF COWLING: Thanks, Ateev. And we're open to taking any of your questions.

CHAIRPERSON MATHUR: Terrific. Thank you very much.

Ms. Hollinger.

COMMITTEE MEMBER HOLLINGER: Thank you.

First of all I appreciate and -- the presentation. And I'm very familiar with Regina's work. I met her when I was at the Kennedy School, heard her speak. And what Regina says actually does work and is effective is when the savings ultimately can accrue to the bottom line of the benefit, the bottom line of let's say the insured.

And I think she does something where over time, to the extent that they're able to save money, they actually get a rebate, let's say, in five years. I don't know, can we do that within our benefit construct?

Do you understand what I'm saying, where money actually filters in the terms of health care savings to the bottom line of our recipients? Because Regina has found that that is effective, and that does encourage people. So where I think we're constrained is by our benefit design. And I'm not sure that would work within

our structure. Could you please speak to that?

DR. MEHROTRA: Yeah. So let me start and then maybe turn it to the CalPERS staff who obviously know your structure better.

So the first point to emphasize is -- and going back to what I said is that the way this is going to work if it benefits the bottom line of the member --

COMMITTEE MEMBER HOLLINGER: Correct.

DR. MEHROTRA: -- because you can't hope that they'll just altruistically just switch their care. They've got to do what's right for them, themselves, and their family. The idea that I think you've been -- so that's the first point. The second point is that there have been a number of initiatives out there, where people are financially rewarded for switching care.

COMMITTEE MEMBER HOLLINGER: Correct.

DR. MEHROTRA: What I mean bu that is that they'll -- let's stick with laboratory tests. If you go to a lower priced laboratory test -- sorry, provider, we'll send you a check, 25 bucks, $50 outside that doesn't have any relation to your health benefits or your deductible is a check that goes right into your -- you know, right into your bank account. These kind of rewards programs have garnered a lot of interest, and a number of employers have introduced them.

We don't know yet how effective they are, but I think it's a very promising thing that I -- you know, I think is another innovation that should certainly be tried.

Do you want to comment on whether that's feasible.

COMMITTEE MEMBER HOLLINGER: Yeah, that's -- because I believe -- I know Regina has felt that those work or -- because at least then we're incentivizing behavior and people are rewarded financially for it.

So I was curious could something like that work?

CENTER FOR INNOVATION CHIEF COWLING: That is something we'd have to research. I think our approach has been a little -- so that's kind of the carrot approach, and we've been using a little bit of the stick approach with the reference pricing, which is somewhat similar, in the sense of, you know, the immediate financial consequence of going to a non-reference priced facility is the money out of your pocket right then.

And so it's a little bit of a flip of that situation, but that's something to consider.

COMMITTEE MEMBER HOLLINGER: But most -- most of our members, at least it's my understanding, you know, once they pay their co-pay, it's not really going to impact them, correct, if they -- I don't know, how are

they incentivized?

CENTER FOR INNOVATION CHIEF COWLING:

Incentivized for right now?

CHAIRPERSON MATHUR: So the reference -- maybe describe the reference pricing approach again. That would be helpful.

CENTER FOR INNOVATION CHIEF COWLING: So for Reference pricing, so right -- we have reference pricing for five procedures right now. And so if you choose the reference pricing facility, you pay your regular co-insurance and deductible co-pay. But if you go to a non-reference pricing facility, you pay -- there's a fixed amount. And if that amount is above the reference price, that all of that funds come out of your -- you pay that amount.

COMMITTEE MEMBER HOLLINGER: Right, right, right.

CENTER FOR INNOVATION CHIEF COWLING: So -- and in that way, it's a financial incentive not to go to those non-reference pricing facilities.

CHAIRPERSON MATHUR: There's a financial penalty to going to the higher priced --

COMMITTEE MEMBER HOLLINGER: Right. Right.

CENTER FOR INNOVATION CHIEF COWLING: That's what I meant by it's kind of the stick approach, rather than the carrot approach --

COMMITTEE MEMBER HOLLINGER: Right, the carrot.

CENTER FOR INNOVATION CHIEF COWLING: -- which is financially rewarding.

COMMITTEE MEMBER HOLLINGER: Right, and -- which I think would make people -- encourage people more to shop. Okay. Thank you. Appreciate it.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: And, Madam Chair, I just would like to also point out we have had several sessions on the value-based insurance design. And so we are looking at ways of -- within, you know, meeting the law of PEMHCA, of ways that maybe the co-pay tiering, other ways we can incentivize to ensure that people go to the doctor when they need to go to the doctor, but also rewarding them in ways that follow our statutes.

So we will be bringing back to the Committee opportunities. Kathy will be doing a presentation before the end of the year on how we could actually apply value-based insurance design within one of our PPOs, specifically PERS Select.

CHAIRPERSON MATHUR: Great. Thank you.

Thank you.

Mr. Lofaso.

ACTING COMMITTEE MEMBER LOFASO: Thank you, Madam Chair and thank Drs. Cowling and Mehrotra for your work.

Two questions, one more narrow than the other.

In the second paper you all put up there, the June 2017 one from the American Journal of Medical something, AJMC, whatever it is, and that's the one about the quote qualitative survey of the CalPERS members, and it's of course a very small sample, but there's some commentary in there suggesting that some of the members who use the Castlight tool, though their behavior didn't lead to some measurable cost reductions, they were using it for other purposes evidently because they were, you know, concerned about their own spending below their deductible.

Obviously, these speaks to the question of, you know, when there are stakes for the -- for the enrollee or for the member. Can you comment on that and whether that -- whatever you observed in those behaviors, again small sample, tell us for opportunities for targeting or whatever your other next steps are?

DR. MEHROTRA: And so I think it's a really important point, which is that if we judge the offering of the Castlight tool in terms of the metric of did it drive people to price shop, it doesn't seem to have worked. But the other goal of often these price transparency initiatives is to try to be an information source.

And we did find, and we did hear from the CalPERS

members that they really valued that. That they were able to, in a more intuitive way, track their spending, and to look ahead of time or after they got care, how much did that cost me?

And so that was something -- I appreciate you raising that, because from that perspective, you could describe the Castlight tool, from what we heard, it was a success. And I should emphasize that a large fraction of the use of the Castlight tool was for those types of purposes versus price shopping.

ACTING COMMITTEE MEMBER LOFASO: Appreciate that.

CHAIRPERSON MATHUR: Okay. Thank you.

ACTING COMMITTEE MEMBER LOFASO: Oh, no, just -- I have one more question.

CHAIRPERSON MATHUR: Okay.

ACTING COMMITTEE MEMBER LOFASO: Just a -- it's a bigger one just in the spirit of the research. We had a number of these studies. They all are a little inconclusive and about choice in the health care marketplace. Can you put this -- this research in the context of other research? Is this confirming other research? Is this substantially different than other research?

DR. MEHROTRA: The work that we've done on price transparency has been confirming other work. I'm aware

now of a number of other groups that have tried to -- have assess different price transparency tools. And to a T, they're all finding similar findings.

ACTING COMMITTEE MEMBER LOFASO: Appreciate it. Thank you.

CHAIRPERSON MATHUR: Thank you.

Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you, Madam Chair. Yeah, Dr. Mehrotra, yeah, I was just looking at Ms. Herzinger's comment about when consumers apply pressure on the industry, regardless of what industry it is, invariably it produces a surge of innovation and price.

So my question goes to the great concern about the addiction crisis ravaging our country on opioids. And I was wondering, calling up on your research, whether or not you have come across any efforts that are being made between the plan sponsors and the providers of these services to begin to deal with this problem on national basis?

DR. MEHROTRA: Yeah, it's an important point. In terms of my own research, we haven't really seen any efforts in terms of consumerism related to the opioid crisis and how those are intersecting right now. I feel like those are almost on different parallel tracks.

Specifically, to the CalPERS members, I don't know if you want to comment.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Mr. Jones, so as a part of our overuse of ineffective or medically unnecessary, we are looking at opioid use. And so we are working with the integrated health IHA SmartCare of California. And so we have a measure that we will be measuring specifically CalPERS members, and being very conscious of overuse and ineffective.

So there is a measure looking at potentially the duration that a member has been on opioid use, and then also looking at milligrams. So at some point, we can look at our population and effect change to ensure that we're targeting providers that over -- are overprescribing, when there's other pain management opportunities for our members. So we are tackling it, but it's not through that research. It's through SmartCare of California.

COMMITTEE MEMBER JONES: Okay. Thank you.

CHAIRPERSON MATHUR: Thank you.

Mr. Lind.

BOARD MEMBER LIND: Thank you.

One of your points is around physician recommendation being a key. And based on my experience, that is probably the primary issue here why people don't go to lower cost providers.

Has anyone ever looked into finding ways to use carrots or sticks with primary care physicians around how they're reimbursed based on where they send people?

DR. MEHROTRA: Yeah. So there's -- it's a very intuitive idea, which is why are we asking the patient to do this? And, you know, they're not -- they didn't go to medical school. They didn't go to nursing school. Why don't we have the physician, who is the ordering provider, have information to prices, and see maybe that's a mechanism to drive lower priced care.

There have been a number of trials where people -- physicians have been shown price information when they -- in their order entry screens in their offices, and to see whether that would change ordering behavior.

Somewhat surprisingly, those studies have found no effect. In other words, there's been, at most, minimal change in terms of what tests are ordered or what services are provided. I would emphasize though, that we're not -- maybe the tools have generally been within your own system, so maybe more concrete.

Let's say I worked at UC Davis. I would open up my computer screen. I wanted to order something, a lab test for you, and it would say here is what we're reimbursed for that laboratory test. It doesn't have the

information about what my patient is going to have to pay for that. And I also want to emphasize that it's within my system. It doesn't say if the person went down the street, it would cost less.

And I should say that health systems with the consolidation that we have, physicians are very leery of referring out. In my own medical system, if I started systematically referring my patients outside my own Beth Israel system, I'd get a phone call pretty quick. And so I think that is a aspect of that, which I do want to emphasize.

But just going back to your original question, the idea of giving price information to providers or physicians and the hope that that will drive patients to lower priced care hasn't so far been effective.

BOARD MEMBER LIND: Thank you.

CHAIRPERSON MATHUR: Thank you.

Mr. Bilbrey.

VICE CHAIRPERSON BILBREY: Thank you, Madam Chair. So on slide 13 you mentioned labs, offices, imaging, what other -- is there other areas that -- on the tool that you -- that comparisons of prices, pharmacy, et cetera that we --

DR. MEHROTRA: Yeah. So we did not look at pharmacy spend, but we did -- when I -- in terms of

these -- these are the things we focused on, because what we'd heard is these are places where people -- and we saw use of the tools in these areas. So we have not looked in the pharmacy area.

VICE CHAIRPERSON BILBREY: But does it have that option on the tool?

DR. MEHROTRA: They do have that information. You want to comment on, because it's a little complicated in terms of how -- we didn't really focus on that at all.

CENTER FOR INNOVATION CHIEF COWLING: So, yes, the pharmacy information is on the tool. So you can find -- you know, you can search for your drug, and that will show up with the price options for the tiering on the pharmacy. I was going to emphasize as well that the other things that HealthCore looked at, which is Anthem's research arm, was the variety of reference pricing procedures as well.

And in that case, we didn't see much difference in the terms of the prices, because a lot of it -- all of that effect had already occurred. Our members had been educated already about the reference pricing. And so there wasn't a lot of searches, or usage -- or we didn't see a lot of differences in the tool between those two prices.

VICE CHAIRPERSON BILBREY: In regards to

pharmacy?

CENTER FOR INNOVATION CHIEF COWLING: No, that was in terms of the -- actually we have not looked at pharmacy in terms of evaluation of pharmacy for this project.

VICE CHAIRPERSON BILBREY: So pharmacy and pharmaceuticals being are highest cost factor, and our medical -- medical field right now, and what's affected our rates, why have we not done a little more research in members being able to see the differences in pricing, especially for generics as opposed to...

CENTER FOR INNOVATION CHIEF COWLING: So the tool offers that service, but we have not evaluated that.

VICE CHAIRPERSON BILBREY: Have we -- and I don't recall this. I was trying to remember back. Have we had a demonstration of how the tool works here before to the Committee? I don't remember.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: (Nods head.)

VICE CHAIRPERSON BILBREY: How long ago was that?

CENTER FOR INNOVATION CHIEF COWLING: The tool was introduced in '14 -- 2014, and it was somewheres around that time period.

VICE CHAIRPERSON BILBREY: It may not be bad for us to revisit it before we make a decision next year.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: And also, now that we have 12 new procedures, there will be additional usage. And then the one things that Ateev was talking about is ambulatory surgery centers. So as we're expanding site of care, our members are able to find those locations fairly easily by using the tool.

So maybe not price shopping, but are there other value-add opportunities that we could use Castlight moving forward. But definitely bringing back that, bringing back a demo, and then also talking about that before we go into the next 2019 cycle.

VICE CHAIRPERSON BILBREY: All right. Thank you.

CHAIRPERSON MATHUR: Thank you.

Mr. Jelincic.

BOARD MEMBER JELINCIC: I have four questions actually, two for the doctor, two for staff.

On slide 4, imaging. Our spend is 436. We could save 254 by getting to the median. When I do that math, it says that the median price is actually 182, if I'm reading that right? If I take what we're spending, what we could save, it leaves the median price?

DR. MEHROTRA: Yeah, it's a little bit -- I mean, so you'd have all these different services that we included in there, you know, and the median price for a chest x-ray versus an abdominal CT and so forth. They're

all very different.

And we also just -- I want to emphasize, we did this per market. So we look in Sacramento. And we'll say, okay, what are the -- is the chest x-ray price? There's the distribution. Some people are paying $36 and some people are paying $98. What's the median there? We move people in Sacramento to that median price, and we do the same thing for each of the different markets. And it's a little bit more narrow than just the larger area.

So I don't know if you can -- this imaging -- this is a per seer, per member spend, as opposed to the actual price for the individual service.

BOARD MEMBER JELINCIC: Okay. But if we could get to the median, we would save the 2 --

DR. MEHROTRA: $254.

BOARD MEMBER JELINCIC: Which says, you know, that it ought to be 182, given all the constraints. But so we're actually paying about two and a quarter times as much on imaging than we're -- if we were at the median? Is that actually what I'm reading here?

DR. MEHROTRA: I don't know if two and a quarter. It would be 254 divided by 436. So a little bit less than that for imaging in that case in the math. But I guess the point overall - I'm totally with you - which is that if you could wave a magic wand and switch people from a

higher price to the median, there would be tremendous savings for the CalPERS population.

BOARD MEMBER JELINCIC: Okay. And the other question was on slide 12, but you don't have to go there. You talked about people who used the system once and then didn't use it again. Do we have any idea what's driving this one and done?

DR. MEHROTRA: My instinct from the interviews, as well as some of the survey responses - and I'd love David to jump in also on this - which is that the marketing was very successful in encouraging people to log on to the tool. And I think that people in that circumstance -- because a lot of that first log on was during that aggressive marketing period.

And they thought, oh, they tried it out. Let me see what are my last health care services, and then I think they forgot about it.

BOARD MEMBER JELINCIC: Okay. And then the two questions for staff. The -- Dana asked about the reference pricing. If somebody has already reached their maximum out of pocket, they're not particularly impacted by the reference pricing, are they?

CENTER FOR INNOVATION CHIEF COWLING: They are. Actually, the reference pricing -- the amount above the reference pricing that you would pay doesn't go towards

your out-of-pocket max.

BOARD MEMBER JELINCIC: Okay. So if you're -- if you've already hit the out-of-pocket max, you might still have to pay the additional?

CENTER FOR INNOVATION CHIEF COWLING: That's right.

BOARD MEMBER JELINCIC: And then in the agenda item itself, you said that the service is $0.62 a member, per month, so, you know, seven and a half bucks a month times how many members? I mean, what's the total dollar that we're spending on the administration?

CENTER FOR INNOVATION CHIEF COWLING: Some quick math says about, what is that, $2 million per year.

BOARD MEMBER JELINCIC: Okay. Okay. Thank you.

CHAIRPERSON MATHUR: Thank you.

Mr. Gillihan.

COMMITTEE MEMBER GILLIHAN: Thank you, Madam Chair.

Following up on the last question from Mr. Jelincic, I just sort of question what we're getting for our investment here. I understand that there's potential, and there's promise, but we're spending a couple million dollars and with no sort of measurable benefit. So -- like so many things in our health care program, I think we really need to assess what we're getting for our

investment. And this doesn't seem like a good return on investment at this point.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Madam Chair, I'd like to point that definitely when we made the decision related to Castlight, that's why it's so important we make decisions as Board members, that the team research provide this information back to you, so that we can make future decisions, so instead of just making the decision and we never hear back.

So you will see more of this coming forward. Obviously, we've made the decision for 2018, but we will definitely be teeing up a demo, more additional analysis, and then it will be a decision moving forward, if we continue with this in 2019.

CHAIRPERSON MATHUR: And I think what we've discussed is we're aware that the timing this year was not optimal in terms of our decision making, but that we will endeavor to make the timing match better, so that we can make the right decision at the right time.

All right. Thank you.

Mr. Slaton.

BOARD MEMBER SLATON: Thank you, Madam Chair. I want to add my two cents on that same issue of value received.

So you mentioned the anecdotal information of

someone saying that like going out and buying a car, if you shop around, you know, the prices will come down.

I think that's great in theory. But when someone faces the decision of having to make a medical decision, and they're not a trained doctor, I think that analogy starts to fall apart pretty quickly when the subject changes from the theory to the practice.

And I think that the -- you've made the point of the network issue, the networks that we have that tend, over time, to get narrower and narrower as we get price pressures. That the ability to -- and from my own personal experience. You know, when the doc says go here, and this is in our group, there's zero friction to that. And, you know, that means the results get fast, and it gets passed through the computer system. And so you're not trying to go from one computer system to another computer system.

So I come back to the issue of if we're facing the pressure of practices, doctors groups, and medical groups, and we're on top of that facing -- and you mentioned the friction of actually using the site -- and that's why I think it would be very instructive for us to see again how difficult is this to find out pricing?

I think it's great for people to go back and look at their history, and see what their spend is, and what

they've done. But I'm not sure that was the purpose -- the original purpose of putting this in place. Am I correct --

CENTER FOR INNOVATION CHIEF COWLING: (Nods head.)

BOARD MEMBER SLATON: -- that the reason for doing this in the first place was the ability to impact cost?

CENTER FOR INNOVATION CHIEF COWLING: You're correct.

BOARD MEMBER SLATON: Okay. So I think that this certainly bears looking at. And I really appreciate your presentation and staff that were willing to come forward and say, look, sometimes we don't get the results that we expect, and that's just and honest look at it.

So kudos for that.

CHAIRPERSON MATHUR: Well, I would agree with you that this is -- I think this really exemplifies good practice that, you know, we put in an initiative, a pilot, and we then assess whether it has the desired effect or the -- and we're not always going to hit the mark. But I think it's -- it really says something about CalPERS that we're willing to try things, and then we're willing to take a hard look at it and see whether it achieves the objectives, and then make an educated decision about whether to continue.

So we will have more of this. We will have further discussions about the value of this tool for our membership, and continue to look at other options as well to reduce costs.

Thank you very much for being with us this morning.

DR. MEHROTRA: Thank you.

CHAIRPERSON MATHUR: Okay. Well, that brings us to the end of this agenda item -- oh, sorry, before I -- before we leave this agenda item, we do have a member of the public who wishes to speak.

Ms. Snodgrass, if you'd come forward. You can take your seat here to my left. And if you could identify yourself and your affiliation for the record. You'll have three minutes of which to speak.

MS. SNODGRASS: Hi. Good morning. I'm Donna Snodgrass, Director of Health Benefits for the Retired Public Employees Association.

And my comments and questions changed several times during this.

(Laughter.)

MS. SNODGRASS: So what I was going to ask and say has changed now, and -- because it boils down to how do you get your provider laboratory doctor vendors to sign on to the lists that can be searched for the lower cost?

Where does that information come from to you, or to the program? Do I talk to the judge or to the --

(Laughter.)

CHAIRPERSON MATHUR: Well, I'm sorry, so the questions is whether you're doctor is included in the Castlight?

MS. SNODGRASS: How do we get the information to go shopping? Where does the shopping list of providers come from?

CENTER FOR INNOVATION CHIEF COWLING: That comes from Anthem.

CHAIRPERSON MATHUR: So this is not available through all the plans.

CENTER FOR INNOVATION CHIEF COWLING: That's correct.

CHAIRPERSON MATHUR: It's only available through the PPO plans.

MS. SNODGRASS: Okay. So Anthem has a list and what the labs will cost if you use them in different areas?

CENTER FOR INNOVATION CHIEF COWLING: Correct.

CHAIRPERSON MATHUR: On the Castlight tool.

MS. SNODGRASS: Okay.

CENTER FOR INNOVATION CHIEF COWLING: Yeah.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: And I was

just going to say, Donna, we'd be happy to send you the link and additional information that you could share with your retirees on how they can go out and get that list that you're talking about.

MS. SNODGRASS: Well, I think I have that down. I just -- I had -- I was missing that piece where it came from. Do they pay a fee to be included in our shopping list or --

CENTER FOR INNOVATION CHIEF COWLING: No.

MS. SNODGRASS: Okay. Now, just a comment is that this would be a valuable tool if we had enough in the PPOs that would drive the cost down in the regional areas, like the greater San Francisco Bay area. That's where I see the most value for this tool.

My members in Los Angeles, San Bernardino, Riverside are not going to have anything to do with this, because it's already a lower cost down there, depending on -- especially my State retirees, they're going to pay the same whether they use this tool or they don't, so that we're not going to take the time to do that.

But if we could dial this in to use -- like, I'm going to give an example that was given to me by a very valuable CalPERS staff member, right now for a hip replacement in the San Francisco area, it would be less expensive for PERS and the insurance, or whoever pays the

bill, to fly the patient plus one person to Los Angeles, let them spend a week, go to Disneyland in a wheel chair, and then fly them back home to the Bay Area. It would cost less than to have that surgery done in the Bay Area.

So I don't know if that helps or hurts, but this would be a valuable tool to drive the costs down, if you could get the members to go south comfortably to have the procedures done. And then if they started losing business, but then what would that disrupt? What kind of tsunami what that cause up there. That's just my comments.

CHAIRPERSON MATHUR: Okay. Thank you very much for your comments.

Okay. That brings us then to Agenda Item number 8, Risk Adjustment of CalPERS Health Plan Rates History and Experience.

(Thereupon an overhead presentation was presented as follows.)

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Good morning, Madam Chair and members of the Pension and Health Benefits Committee. I would like to introduce the CalPERS team members that will be making the presentations today. To my left, I have Gary McCollum, who is the CalPERS Health Actuary. To his left, I have Bob Cosway from Milliman Consulting. He is also an

external consulting actuary. And I am Kathy Donneson, Chief of the Health Plan Administration Division.

I would like to, before I -- we go through our presentation, remind the Committee of what were the goals of risk adjustment when it was implemented in 2014. We did that. We asked the Board to allow us to implement to increase our choice of health plans, to help us manage our cost trends, for data, transparency, and to better manage our disease and population health.

So those were the original goals of risk adjustment when we implemented in 2014.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I've got to get the pressure-sensitive touch down here.

Today, we're going to -- I'm going to give you the background of risk adjustment. We're going to talk about the history, the how, and the why, and the what as we came forward to ask you to implement risk adjustment -- risk-adjusted premiums. We want to talk about our CalPERS team experience over the last nearly five years of risk adjustment. And then through Mr. Cosway, we'll talk about the risk-adjustment market.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF

DONNESON: What is risk adjustment?

It's an actuarial tool used to assess the risk of a population -- an insured population to determine levels of health or risk within that -- levels of sickness or health within that risk pool. So it's an actuarial tool that compiles the amount of risk in a population that is handled by our various health plans.

So what we do is within that pool, we measure each health plan's risk, that is CalPERS members who are part of that health plan against the aggregate average of the pool. And then we determine, through our premiums, if a health plan has a sicker population than one that has a healthier population, to manage risk transfer payments from the healthier population to the sicker population.

The way risk adjustment works, whether it's CalPERS or any other methodology, is it looks at each individual member's risk based on their age, their gender, and the diagnosis codes as a measure of their health. But it also considers the geographic location where those members live in terms of the cost of that geographic region. It considers whether they are single, or whether they're married as a couple, or whether they are families.

So each of those components are part of the evaluation of not just the risk pool, but the pool -- but the risks associated with each health plan that has

members of that pool.

When we set the risk-adjusted premiums, what we do in April every year is we take the unadjusted premiums, and we look at the -- what the premiums are, and what might be negotiated in terms of the unadjusted premiums. And through the risk-adjusted methodology, we assign risk scores to each health plan in May and June, and therefore determine the risk-adjusted premiums.

Now, I'd like to say I am the messenger not the actuary. That's why I have two next to me. So any questions about methodology deeper than that explanation, I'd like you to direct the questions to my experts.

So in 2018, when we set the premiums, the first phase of risk adjusting the premiums occurred at that time. So risk adjustment is phased over a period of time. Phase one starts with the original adjusted premium, and then phases two, three, and four proceed throughout the year and the following year as claims and experience is updated for the pool and for each plan.

The history of risk adjustment goes back to January of 2012 when this Committee heard about the 21 health initiatives that were going to be part of the 2012 to 2017 strategic plan. Later, in 2012, Assembly Bill 2142 was passed, which allowed the Board to implement risk adjustment. So it updated the Government Code.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: As part of our planning for 2014 to 2018 procurements, we included risk adjustment as a methodology that we were going to ask our plans to implement. And our plans were not -- they were not -- they were a part of all of this. They had the opportunity to meet with the staff at the time, to talk about the risk-adjustment methodology, and then actually to negotiate the premiums in 2013 that would be risk adjusted for 2014.

So we went through our procurements. We explained risk adjustment. We provided the opportunity for the plans to participate in 2013. And finally, in 2014, the final methodology for risk adjustment, including the plans input was solidified.

We also provided a very comprehensive report in September to the State legislature on risk adjustment specifically. And that report can be found in Agenda Item 9c of September of 2016.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I'm going to now turn the part of the presentation over to Mr. Gary McCollum who's going to talk about the challenges of risk adjustment.

SENIOR LIFE ACTUARY McCOLLUM: Thank you, Kathy.

Good morning, Madam Chair, members of the Board. Gary McCollum, CalPERS team member.

As Kathy mentioned, CalPERS has been using a four phase risk-adjustment process. So just as a quick reminder, phase one is implemented or performed during the rate-setting process. And that's when we take past claims experience to estimate the risk of the population, and the enrollment for the upcoming year in order to determine the rate development -- or, excuse me, the rates for that upcoming year.

Now, we moved to phase two just after the beginning of the plan year, when we get the open enrollment results and see how the enrollment changed during that open enrollment period.

And this phase two is used to establish the basis for what we call the monthly transfer amounts that are done behind the scenes to transfer the appropriate funds between the plans. And I want to remind you that the total dollar adjustment within the system is cost neutral.

Now, six months later in the fall of the plan year, we do phase three. Now there, we update the risk sores for the members to a newer period, and we also update the enrollment for any adjustments that have been made during the year. And that then changes the risk transfer amounts for the remainder of the year.

And then finally, in the fall of the following year, after we have six months of time for the claims to come in during that plan year, we conduct the final reconciliation. And that's based on the actual enrollment, and the actual claims for that full policy year, with claims paid through June 30th of the following plan year.

So now we have now had four years of experience with risk adjustment. And during those years, we've learned a lot, and we've had a lot of challenges along the way.

So briefly, those challenges. First, we've had issues with data submissions from the health plans. The risk scores, if you recall, were derived from the diagnosis codes that are contained within the data. And the ability of the health plan to obtain and then submit complete and properly coded data can lead to risk scores that do not completely or accurately reflect the true risk of the population.

Second, in October of 2015, the diagnosis coding system changed from ICD-9 to ICD-10. And that required significant testing by us to verify that the provider coding procedures, and also the computer system changes were all working correctly, and as they were supposed to.

And then third, there had been a significant

amount of inter-plan migration during each of the open enrollment periods that we've experienced. And this presents a lot of difficulties in aligning the risk scores at the time when premiums were set, along with the risk scores of the final enrolled population.

But there have also been positive aspects. We can't just dwell completely on the negatives. First, we are receiving more data from the carriers than we did prior to the implementation of risk adjustment. In 2014, with the advent of the additional plans, we have given our members more health plan choices. We believe that risk adjustment is at least partly responsible for the low premium increases of the last few years. And then finally, each year we are obtaining more information on the morbidity risk within each plan. That helps us in our methodology.

So that -- with that, I will turn it back to Kathy.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: To be honest, we experienced a difficult start with risk adjustment. We implemented risk adjustment simultaneously to imple -- as we implemented six new HMO plans. And I do want to remind the Committee that the pools that are risk adjusted are separate for the PPO and

the HMO plans, and that risk adjustment does not apply to the Medicare population, nor does it apply to the association plans.

As Gary described, the difficulties with its implementation related to the items that he described post open enrollment migration, ensuring that diagnosis coding was properly applied across all plans. And then as he mentioned the conversion of ICD-9 on to 10 for which that was actually one of the easiest items to test. So the conversion was stellar in those -- in the respects of the challenges of risk adjustment.

But I would like to also reassure you that between 2012 and 2017, we did have significant multiple tests of the risk-adjustment model and the phases, both internally with the actuarial staff, as well as externally with validation, and assistance through Milliman Consulting.

And as Gary said, it has given us a more complete view of the CalPERS population health, both in the plans and in the pools. And as we worked over the last four years, and I am certainly appreciative of the actuarial expertise, both internal to CalPERS and external to CalPERS, to ensure that what we did as risk adjustment -- as we managed risk adjustment in the premiums, to be fair and equitable.

And you'll note that in the budget we have spent upwards of $500,000 over the last four years to ensure that equitableness and fairness was sustained throughout this process.

We will be conducting a separate evaluation of risk adjustment, as we go through 2018 into 2019. And we will come back to you with a series of presentations on how we're doing between now and December.

And now I'd like to turn it over to Bob Cosway who will talk about the state of the market for risk adjustment.

MR. COSWAY: Thank you, Kathy.

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MR. COSWAY: My name is Bob Cosway. I'm with Milliman. I've been with Milliman for 36 years. And I've -- we've worked with CalPERS as part of your actuarial consulting pool for at least 12 or so years, probably more.

With respect to risk adjustment, we started working with CalPERS, I believe, in 2010, 2011. Prior to, and since that time, staff has developed a very good working knowledge of risk adjustment and a lot of expertise. And we view our role as being an outside resources to CalPERS staff to keep them up to speed with the state of the art in risk adjustment.

We feel well qualified to do that. I think your staff is in good hands. Milliman actuaries have been instrumental in the Society of Actuaries, sponsored studies of the different risk adjusters in terms of predictive accuracy. We've developed our own risk adjusters. So we have people that know that level of detail about the challenges and how they're developed.

One of the big uses of risk adjustment is with Medicare Advantage plans. Milliman actuaries submit about 45 percent -- or work with about 45 percent of the bidders, so we're very knowledgeable on the -- you know, the use side of risk adjustment.

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MR. COSWAY: Just to kind of repeat what Kathy and Gary have said, and -- there really are two different aspects of risk adjustment that are often done together, but sometimes an employer may do one or the other. And one is at the front end, and one is sort of at the back end.

And the front-end one is risk adjustment can be used to change the public facing or the published premiums for the various plan options. And the theory is that with -- sometimes if each of the options is studied on its own, based on its own experience, you might find a plan is much more expensive, not because it's got lower copays, or

a different network, but because it, over the years, has attracted a sicker population. So it costs more per person solely because people who have illnesses are attracted to it.

And then the question would be, well, if you look at an average member who is choosing between plans, is it fair and equitable to -- maybe they like that plan, but it's so expensive. And it's not expensive because sort of its innate features. It's expensive because it just happens to be appealing to sicker people.

So one of the primary goals of risk adjustment is to make the prices that your members face, or premiums, more equitable, based on the value of the plan and not based on who else happens to like that plan.

And then the back end is the goal is to pay your various health plans and vendors fairly, namely based on the value of the plan, and reflecting the actual health status of those members, and not an average health status or an approximation.

So those are the two goals that, in my mind as an actuary, kind of underlay what CalPERS adopted back in 2014.

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MR. COSWAY: With respect to the first part, PERS Select and PERSCare represent a very visible demonstration

of what I'm talking about. Prior to 2000 -- in 2013, prior to risk adjustment, for an employee only, PERS Select's premium was $463 a month, PERSCare was $1,029 a month.

Now, PERSCare is a more valuable plan. It has lower cost share and deductibles, et cetera, but it's nowhere near, you know, a 2-to-1 relationship. It's more like your 17 percent. So since -- so the effect of risk adjustment has been to bring those two premiums closer in line. So now in 2018, of course, there's been trend since then, but you'll notice the key thing here is that the PERS Select premium is $661, PERSCare is $776. And that published relationship reflects much more accurately the true relative value of those two plans.

And so that has been successful in terms of making it -- giving your members choices that -- where the prices actually match the relative value of what they can choose.

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MR. COSWAY: CalPERS has been among the leaders in employers adopting risk adjustment, but government-sponsored plans have been taking the lead before then, and continue to expand. And so we wanted to describe that and give you a little perspective.

So other entities that risk adjust are Medicare

Advantage, the exchanges, here Covered California in this State, some other health -- State health plans do that, University of California has done that, and Medicaid in most states does risk adjustment.

Let me just describe briefly how that affects the front end or the premiums that individuals pay in these programs.

In Medicare Advantage, the purchase is made by an individual beneficiary, independent of their employer. It's an individual choice. And in Medicare Advantage, the premium that any individual pays is intended to reflect the average Medicare health status. So all the prices are set based on the same health status for all of the options. And that same being an average health status.

Under the Affordable Care Act, Covered California in this State, the premiums that an individual sees when they go on to choose their plan are intended to reflect the average marketplace health status in the State. So all of the plans' premiums are sort of right-sized, so that they're -- they don't reflect the population in those particular plans, but they reflect an average health status.

Other State employee health plans - the State of Washington Health Care Authority has had a history much like CalPERS, so it does it very similar - are currently

going through a change, which staff will be looking at, because they face many of the same challenges that CalPERS has.

And other states do it, but it's not as obvious, because as an example if a State has one vendor that provides the various PPO options like a high, medium, and low PPO, that vendor may sort of, behind the scenes, adjust the premiums to reflect risk adjustment, and give those to the State, and so the State doesn't have to then do an explicit adjustment. Sometimes it's hard to spot, because the carrier can do that risk adjustment behind the scenes.

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MR. COSWAY: And finally on those same programs, just to look at the back end, is how risk adjustment affects the amounts that the plans receive. Medicare Advantage, each carrier, each plan ends up getting an amount that's based on their bid, and their actual risk scores.

Affordable Care Act similar, but in Medicare Advantage, it's not a zero sum, as Gary described. If every carrier has a higher health status, then the total payments to those carriers will be -- that's the risk to the federal government. They'll pay more.

All the others do it on a revenue-neutral basis.

So under the Affordable Care Act, Covered California plans -- effectively at the end of the year, money is moved around among those plans with no new money in or out to reflect risk adjustment.

Other State employee health plans, in our experience, is similar, that there's no new money in or our, that each carrier's payment is basically based on their bid. And CalPERS -- again each carrier gets a payment based on their bid, and then at the end of the year, instead of using an expected risk score, it's based on their actual risk score, but again with no -- with money moved between the plans, but no -- not net new money coming from CalPERS.

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MR. COSWAY: So I hope that's been helpful from the outside market perspective.

CHAIRPERSON MATHUR: Thank you. Are you all ready for some questions?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: We are indeed, Madam Chair.

CHAIRPERSON MATHUR: Terrific.

Mr. Jelincic.

BOARD MEMBER JELINCIC: The risk adjustment for the HMOs I think is fairly clean because everybody has got the same benefits. You know, they have their own

networks, but the benefits are the same.

PERSCare historically was extremely expensive, in part because it was the only plan we offered with no cap. And so if -- when you start approaching the cap, we administratively moved you to PERSCare. And the people who are approaching the lifetime max tend to be people who are sicker. So, I mean, in some ways, we helped create that problem.

The -- when we look at the PPOs, and recognizing their difference in design, how comfortable are you with the risk adjustment we're doing? I mean, I've seen the back numbers, so I mean we clearly are, you know, moving money around. But how comfortable are you with that in light of the difference in designs?

SENIOR LIFE ACTUARY McCOLLUM: I think the risk-adjustment process has worked adequately and well for the PPO program. If you remember, or if you realize, if you take PERS Choice as the base, you might say, the difference between PERS Choice and PERSCare is strictly a benefit differential. PERSCare is a richer benefit and should cost more because of that.

The difference between PERS Select and PERS Choice is primarily a network differential. There is a small benefit differential in that PERS Select has some tiering in their hospitals, but primarily it's a network

differential, in that the network that PERS Select uses is a lower cost more efficient network than PERS Choice.

So you have these two differentials between the three plans, and the premiums, for the most part that are risk adjusted, reflect those cost differentials that exist between PERS Select and PERS Choice, and then between PERS Choice and PERSCare.

BOARD MEMBER JELINCIC: So you're comfortable with the adjustment we're making within that group?

SENIOR LIFE ACTUARY McCOLLUM: Yes, sir.

BOARD MEMBER JELINCIC: Okay. Thank you.

CHAIRPERSON MATHUR: Thank you.

Well, really appreciate this overview of the history of risk adjustment. I know there's more to come. I see no further requests to speak at this time, so if you have any concluding remarks or --

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Just as the Board has made, timing is critical.

CHAIRPERSON MATHUR: Yeah.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: And so we are bringing this and several other discussions, as Dr. Donneson had talked about, between now and December to talk about risk adjustment and seeing if there's any adjustments that need to be made before the 2019 cycle.

CHAIRPERSON MATHUR: Terrific.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So we're -- what I side earlier about timing, it is true with this agenda item as well.

CHAIRPERSON MATHUR: Okay. Terrific.

That brings us to Agenda Item 9, which is summary of Committee direction. I don't think there was any -- oh, you found two. Okay. Go ahead.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: I have, Madam Chair, two. One is to amend the minutes regarding spousal surcharge and adding some language regarding being compliant with PEMHCA on the statute based on Mr. Jelincic. And then also I took it down as bringing back a Castlight demo as a Board directive --

CHAIRPERSON MATHUR: Yes.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: -- before we need to make a decision for the next 2019 cycle.

CHAIRPERSON MATHUR: Terrific. Okay. That sounds good. Thank you.

So that brings us -- oh, sorry, Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you, Madam Chair. Yeah, this is just a piece of information. I attended the California School Employees Association annual conference last week. And I sat in on the CalPERS presentation on getting ready for retirement. And I would just like to acknowledge Richard, I think it's, DePaola.

He did an outstanding job he answered all the questions to the satisfaction of that full room. So I just wanted to acknowledge his outstanding performance.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: On behalf of Donna Lum, thank you.

(Laughter.)

CHAIRPERSON MATHUR: Thank you. Thanks very much, Mr. Jones.

That brings us to public comment. We do have one member of the public who wishes to speak. That's Larry Woodson. If you could please come forward, take the seat to my left, please identify yourself and your affiliation for the record, and I will allot you four minutes to speak.

MR. WOODSON: Good morning. I'm Larry Woodson, California State Retirees. Madam Chair, Board members, thank you for the opportunity to comment this morning. My remarks regard CalPERS recent move to paperless direct deposit statements. In spite of stakeholder objections, CalPERS required members who wanted to continue receiving direct deposit by mail to return a postcard by June 1, which was at the bottom of its one and only flier to members. Otherwise, they are automatically opted into electronic notification and had to log on my|CalPERS.

We expressed concern at that time that older

members with limited computer skills or no computer at all might be adversely affected by this approach, and that one mailing was inadequate.

The new paperless policy was put into effect July 1. Staff reported to you and stakeholders that about 33 percent, or approximately 150,000 members, requested continued mailing by mail. But there was no mention of any implementation problems. However, I'm here this morning to tell you there are some implementation problems. I start with myself. I mailed my postcard requesting continued mailing a couple of weeks before the deadline, and I never received a July or August notice in the mail.

So I emailed management staff at CalPERS advising them of my problem, and asking if others were experiencing similar problems to see how wide spread it was. I copied our president, Tim Behrens, and our VP, Stephanie Hueg, on the email. And Tim responded that he, too, had sent in his card well ahead of time and had not received mailings for July or August either. And Ms. Hueg responded that she had just gotten complaint from a member with the same story.

So CalPERS management promptly responded that they would investigate. And at last Thursday's stakeholder briefing, they addressed the issue and

reported that there were a number of postcards that arrived after the deadline, so they were not processed. They were not able to identify my or Mr. Behrens' card. They couldn't say how many cards actually had been received after the deadline, and were not processed.

And I requested that they make an attempt to contact retirees who had sent in their cards and not had them processed. And we were told that the bar codes on each postcard that contained the member information can only be read by their contractor, and the contract had expired.

The solution we were given was to have members just call in and request mailings, and they would be restarted. And, of course, we don't know who to tell that to, and we don't know how many cards were not processed, how many came in late, or how many maybe were mishandled. So it shouldn't really be the stakeholder group's responsibility to fix that.

After the meeting, I called my 87 year old father-in-law who is a retired CHP, doesn't own a computer, doesn't want to own a computer, and he filled out his card and sent it in the day he received the flier from CalPERS, and lo and behold, he has not received the mailings either.

So we did not -- I realize four is not a large

number, but four out of four is problematic. We didn't miss the deadline. We went through the extra hoop required of us, and the system failed.

We request two things: One, that CalPERS identify through their contractor who mailed the cards and simply processed them. And I was approached before the meeting, and the staff said they intend to contact people, hopefully to process the cards. And my last request is to communicate to all retirees so that they have another opportunity to request mail direct deposit, because we don't know if the problem is they were late, or that they were mishandled.

Thank you.

CHAIRPERSON MATHUR: Well, I thank you, Mr. Woodson, for raising this issue. And obviously, we do want members who wish to have a paper copy mailed to them to receive such a copy. So I under -- my understanding is that there are about 1,000 members who've experienced the same issue, and that we are going to work to resolve that and to ensure that each member is reinstated as getting the paper copies. So we -- that is our commitment to you, that that will -- that will be effected.

MR. WOODSON: That would be great. Thank you.

CHAIRPERSON MATHUR: Thank you.

Any requests from the Committee?

Seeing none, that brings us to the end of our agenda, and we are -- we are adjourned.

(Thereupon the California Public Employees' Retirement System, Board of Administration, Pension & Health Benefits Committee open session meeting adjourned at 10:41 a.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 21st day of August, 2017.

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