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, NOVEMBER 14, 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 Mr. Matthew Saha

Mr. Rob Feckner

Mr. Richard Gillihan

Ms. Dana Hollinger

Mr. Henry Jones

Ms. Theresa Taylor

Ms. Betty Yee, represented by Mr. Alan Lofaso

BOARD MEMBERS:

Mr. J.J. Jelincic

Mr. Bill Slaton

STAFF:

Ms. Marcie Frost, Chief Executive Officer

Ms. Liana Bailey-Crimmins, Chief Health Director

Mr. Matt Jacobs, General Counsel

Ms. Donna Lum, Deputy Executive Officer

Mr. Brad Pacheco, Deputy Executive Officer

Ms. Mary Anne Ashley, Chief, Legislative Affairs Division

Mr. Forrest Grimes, Chief Risk Officer

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

STAFF:

Ms. Renee Ostrander, Chief, Employer Account Management Division

Ms. Jennifer Jimenez, Committee Secretary

Mr. Anthony Suine, Chief, Benefit Services Division

Dr. Richard Sun, CalPERS Medical Consultant

ALSO PRESENT:

Mr. Richard Averett, Local Government Services Authority

Mr. Tim Behrens, California State Retirees

Ms. Kristin Cofer-Larsen

Mr. Gary Collier, California State Retirees

Dr. Kelly Pfeifer, California Health Care Foundation

Mr. John Prince, OptumRx

Ms. Donna Snodgrass, Retired Public Employees Association

Mr. Larry Woodson, California State Retirees

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

P R O C E E D I N G S

CHAIRPERSON MATHUR: Good morning, everyone. We're going to bring the Pension and Health Benefits Committee meeting to order.

First order of business is roll call.

COMMITTEE SECRETARY JIMENEZ: Priya Mathur?

CHAIRPERSON MATHUR: Good morning.

COMMITTEE SECRETARY JIMENEZ: Michael Bilbrey?

VICE CHAIRPERSON BILBREY: Good morning.

COMMITTEE SECRETARY JIMENEZ: Matthew Saha for John Chiang?

ACTING COMMITTEE MEMBER SAHA: Here.

COMMITTEE SECRETARY JIMENEZ: Rob Feckner?

COMMITTEE MEMBER FECKNER: Good morning.

COMMITTEE SECRETARY JIMENEZ: Richard Gillihan?

COMMITTEE MEMBER GILLIHAN: Here.

COMMITTEE SECRETARY JIMENEZ: Dana Hollinger?

COMMITTEE MEMBER HOLLINGER: Here.

COMMITTEE SECRETARY JIMENEZ: Henry Jones?

CHAIRPERSON MATHUR: He's here.

COMMITTEE SECRETARY JIMENEZ: Theresa Taylor?

COMMITTEE MEMBER TAYLOR: Here.

COMMITTEE SECRETARY JIMENEZ: Alan Lofaso for Betty Yee?

ACTING COMMITTEE MEMBER LOFASO: Here.

CHAIRPERSON MATHUR: Thank you. We do have a quorum. And please note for the record that J.J. Jelincic and Bill Slaton are also in attendance.

All right. Agenda Item number 2, the Executive Reports. Who's up first?

Ms. Lum.

DEPUTY EXECUTIVE OFFICER LUM: Good morning, Madam Chair, members of the Committee. Donna Lum, CalPERS team member. I'm pleased to share a few updates with you this morning as related to customer services and support.

First off, I'd like to introduce to you our newest Division Chief in Customer Support. Don Martinez was appointed as the Chief of the Member Account Services Division, which includes oversight of our Branch Administrative Services, as well as our Service Credit Purchase Teams.

Prior to his appointment, Don served as an Assistant Division Chief here at CalPERS for about eight years, primarily in our health program, as well as in customer service. And some of you may recognize Don from previous work that he did with this Committee as related to the online health statements.

Don is an Emeritus -- an APEX Emeritus having been awarded the Emeritus -- the prestigious award twice in his CalPERS career. And as many of you know, APEX is

our highest level of recogni -- formal recognition here at CalPERS. Don holds a Bachelor's Degree in Business Administration, as well as a Master's in Public Administration. And at this, I'd like to ask Don to stand and please join me in welcoming Don to his new role.

(Applause.)

DEPUTY EXECUTIVE OFFICER LUM: So as many of you know, open enrollment is a very busy time for our customer contact center. And open enrollment ended in early October. What I wanted to do was just share with you the team's performance, specifically within the context -- the customer contact center. And I think what it will do is it will demonstrate their dedication and commitment, in serving our members and our business partners throughout the open enrollment process.

From a statistic perspective, the team answered more than -- answered three percent more calls this year than they did last year. The abandonment rate -- and the abandonment rate is the number of calls when a member calls in, either they hang up the phone or they're abandoned in someway dropped by two percent. We had a significant jump in our customer service level, seven points, and that is that we answered seven percent more calls within our established service level, which is answering 80 percent of the calls in 60 seconds or less.

And we also reduced our call wait time by 46 percent this year. The average wait time for our members calling in for open enrollment was one minute and 27 seconds.

But lastly, I wanted to share with you that there was an interesting statistic that we saw this year, in that there was a three percent increase in the number of online transactions, health change transactions that were performed by our retiree groups. Retirees are the only ones that are able to make changes online, and we saw a three percent increase. And I think that's a positive move in the right direction as we continue to evolve into our member self-service.

So with that, I just wanted to say that I'm very proud of the team, they accomplishments that they had, and this is really critical work for CalPERS, as we round out our open enrollment

The last time we met, I shared with you an update on all of the work that our team members across the organization performed as related to the devastated hurricanes that were occurring at the time. And just on the heals of the hurricanes, we had again another natural disaster that impacted a great number of our members that reside in the Sonoma County area. And what I'm referring to are the raging fires that took place not so long ago.

At the onset of the fires, our team members throughout the Information Technology Branch, as well as our Operations Branch, and the Customer Service team members worked very quickly to try to identify those members that were in the impacted zip code areas, for which we knew that mail disruption was occurring and it was indefinite.

We identified about 280 members that were impacted -- that were receiving paper warrants that were potentially going to be impacted by the closure of the mail service during this time. Our teams very quickly reached out to all of these members in an effort to ensure that the November 1st pay warrant would be received timely.

We were able to receive -- to reach out to a great many of them. As with the hurricane a number of our members did transition over to direct deposit. And for those that we weren't able to reach, and there were only 57 out of the 280, we did continue to -- our efforts to see what could be done with them.

Our contact center was provided with a lot of information to ensure that any of the members that were impacted that had issues or questions or needed replacement warrants procedures were in -- are in place to help to expedite those.

So I just wanted to again reiterate that there's a great amount of work and effort that our teams are doing to ensure that our members are minimally impacted during these devastations.

And then lastly, I'm pleased to say that after a number of years and iterations of working with stakeholders, and across the organization. Our pensionable comp regulations were approved and published on October 27th. It seems like it's been a long time coming. We had a lot of team members that collaborated on this. And again, I would also like to express my thanks and appreciation to all the work that went into this. And Madam Chair, that completes my report.

CHAIRPERSON MATHUR: Thank you very much, Donna. And your reports seem to just be getting better and better. You keep reporting improvements, and just how much our members -- our employees step up to support our members. So I really -- we really value the work that your team does. Thanks so much.

All right. Ms. Bailey-Crimmins.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Good morning, Madam Chair and members of the Committee. Liana Bailey-Crimmins, CalPERS team member. I would like, during my opening remarks, to provide three highlights. The first is related to the 2017 Education Forum. The

second, it's been while since we've talked about Affordable Care Act. There's a lot going on in D.C., so I'll provide you an update on what's going on there, and then lastly provide the Committee and our members information related to the CalPERS Away From Home Care Program.

So the CalPERS health program's mission is to provide superior service in the delivery of affordable quality health care. And at the Ed Forum, it's a wonderful opportunity not only to meet employers and interact with them that do business currently with CalPERS' health program, but also to meet new employers that may be interested in contracting with us in the future.

The CalPERS team members got to experience interacting with them via a panel to talk about affordable health care. And as a reminder, every year CalPERS must earn employer's business when it comes to health care. And we do this through three ways. We do it through innovation, partnership, and leadership. When it comes to innovation, it's looking at being Innovative in relation to our benefit design, so that things such as reference pricing, pharmacy medical, and also looking at other ways to fix pricing, it allows us to reduce the cost of care to our members.

And when it comes to the partnership, we see ourselves as partners when it comes to working with the employers and the members to improve the overall health status of an employee, because we believe having healthy employees living long productive lives is a good thing for us and the system.

And then from a leadership perspective, being the second largest purchaser of health care in the nation when it comes to public service, we get to use our purchasing power and our leverage in order to turn the market. And so that is specific in relation to overuse or medically unnecessary procedures.

We continue to look forward to using Ed Forums as a way to provide ongoing education and outreach to our business partners.

And when it comes to ACA replacement, there's been a lot going on in the Hill. Our team continues to monitor what's going on in Washington D.C. related to legislative, regulatory, and administrative changes that may impact CalPERS. So various congressional efforts have been underway, specifically not only for ACA repeal, but there also has been one to stabilize. And when that -- we looked at that, both of those efforts did stall out this past couple months. And the last notable repeal effort was a Graham-Cassidy plan. And that would have rolled

back key provisions of the ACA, but obviously that was not put up to vote for the Senate.

Another effort the Alexander-Murray Bipartisan Health Care Stabilization Act of 2017 would have restored cost sharing subsidies terminated by the Executive Branch. It would have provided more flexibility for State waivers, allow catastrophic coverage for all, and allow interstate insurance companies, and redirect consumer fees for State outreach. And at this time, this has not gone up for a vote.

These efforts do not appear to affect CalPERS directly, but we continue to monitor to see if these proposals have any downstream effects to our members. Also, earlier this month, the IRS updated a series of FAQs on the employer share responsibility requirement for large employers that have 50 or more employees to offer affordable, minimal essential coverage to their full-time employees and their dependents. If any of our employers are interested in learning more, they can go and find this information at the www.irs.gov website.

And lastly, I would take -- would like to take a moment and provide additional information to you and to our members regarding the Blue Shield Away From Home Care Program. First and foremost, I'd like to make sure everyone is aware for 2018, CalPERS will continue to

provide a traveler benefit program for members living and/or traveling outside of their home state. The program is known as the Anthem Blue Cross Guest Program which is a fee-for-service HMO offering. It's for students, families living apart, and travelers.

It's an important note that guest benefits are similar, but not identical to the home state services and service will be based on the host state guidelines.

So we've been asked several questions about what happened to the Away From Home Care Program. So just from a timeline perspective, I'd like to bring to your attention, in May of 2014 during the rate development process, CalPERS instructed its health plans to remove additional cost of the travel benefit from the rate proposals. If a health plan wanted to keep such a program as a selling point, they were free to do so, but the condition that CalPERS would not pay additional administrative service fees.

Blue Shield and Anthem Blue Cross decided at that time to keep the program, and we received no additional invoices in 2015 and 2016. In April of 2017, CalPERS received a very large invoice for the Away From Home Care Program in relation to the 500 families that were participating.

Prior to open enrollment, we informed the plans

that they must adhere to the original directive. And consequently Blue Shield updated their 2018 evidence of coverage that they were removing the program, but Anthem Blue Cross agreed to continue these services.

I would like to acknowledge that CalPERS and Blue Shield should have done a better job communicating this change to potentially impacting members. CalPERS had found out that Blue Shield had not notified the members in a timely Manner, other than the evidence of coverage. We escalated that inquiry. They immediately sent out a letter.

In addition to Blue Shield, we sent out our own personal letter to the impacted families. We sent out one to the 500 families. We also sent out another letter to new subscribers that were potentially impacted, because they didn't know of the change. We also extended open enrollment, because this happened at the very end of open enrollment by 30 additional days to provide families an additional time to find out more information about the guest program and register that if they were interested.

So for any families at this point who want to obtain additional information regarding the Anthem Blue Cross guest program, I would encourage them to please contact 888-CalPERS. Again, again 888-CalPERS.

Madam Chair, the concludes my opening remarks,

and I am available for any questions.

CHAIRPERSON MATHUR: Thank you, Ms. Bailey-Crimmins. We do have a couple of questions from the Committee.

Mr. Jelincic.

BOARD MEMBER JELINCIC: I went to the CalPERS Educational Forum. And as you are probably aware, I tend to go congregate with employers. But I met a couple of people that I'd like to mention Danny Gilley and Brenda Fimbres. And they are with Chaffey College, which is in Rancho Cucamonga. They are one of our newest health care employers.

They learned about the program at the 16 Forum, which says something about our marketing. But by June of this year, they were actually -- had their people enrolled, and they were very, very complimentary about the staff and its cooperation, maintaining a sense of humor, not getting upset when they asked the 15th question in the same day, especially since three -- it was the same question three times from three different employees. But they said our staff was just absolutely great. And I thought I would pass that on. I hope you'll pass it on to your staff.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Thank you.

COMMITTEE MEMBER JONES: Thank you.

CHAIRPERSON MATHUR: Thank you, Mr. Jelincic.

Ms. Taylor.

COMMITTEE MEMBER TAYLOR: Yes. Thank you, Madam Chair. I just had a follow up on the last part of what you were talking about Ms. Bailey-Crimmins, the -- so Blue Shield -- I guess where I'm a little concerned is Blue Shield gave you the invoice for '16, or was it for just this past year, and that's when you guys --

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: We are reconciling those invoices currently to determine which year and current -- it was over multiple years.

COMMITTEE MEMBER TAYLOR: Okay.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: They just -- they said it was an IT system glitch, and that was why they had not billed us.

COMMITTEE MEMBER TAYLOR: Okay. And when the decision came down to -- for us not to pay for the Away From Home Program, but if they still wanted to offer it, was that something that got brought -- it could be, I don't remember, but got brought to the Board.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: It was discussed from my predecessor during the rate development process with the Board, correct.

COMMITTEE MEMBER TAYLOR: Okay. And so now Blue

Shield is no longer offering that, but you're giving -- and that just came out?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: It was -- it was updated in the 2018 evidence of coverage. So that won't out September 11th to the members, but they didn't take additional steps. They -- we can't always assume that members read the evidence of coverage, so we should -- we're holding the plans accountable to provide more proactive communications in the future.

COMMITTEE MEMBER TAYLOR: Okay. That's awesome, because I don't have Blue Shield. But as a member, I didn't even hear about this until just very recently. So you are -- you are extending the open enrollment to what day?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: We extended it an additional 30 days. So open enrollment ended October 6th, but we extended it to November 9th.

COMMITTEE MEMBER TAYLOR: For them

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: And we've had 22 families take advantage of that extension, and that personal outreach that we've made.

COMMITTEE MEMBER TAYLOR: Okay. Good. And we made the personal outreach because Blue Shield did not could so?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Correct.

COMMITTEE MEMBER TAYLOR: Okay. I appreciate that. I really appreciate that we were proactive in that, and I thank your staff for helping with that.

And so in the future -- right now, so Blue Cross is offering it. In the future, do you have anything in place in case this occurs again, or just did you make it clear to Blue Cross, hey, if you do this, we're going to -- you need to make sure you're notifying the members.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So two-fold. One is, you know, any program is willing -- you know, as we were stating through the original 2014 decision, if a program would like to have a traveler benefit, absolutely do so. Use it as a selling point, because we do see where college students and people travel, and family members live outside the home. So using that as a benefit that tracks more members, absolutely that's something that we encourage.

We also are upping our communication to make sure not only that we're holding that plans accountable for proactive changes to their networks, but we are also sending out our own communications through our Public Affairs and Stakeholder Relations to make sure the word gets out, so there is no surprise in the future for any significant change to a benefit design such as this.

COMMITTEE MEMBER TAYLOR: Okay. Great. I

appreciate it. Thank you very much.

CHAIRPERSON MATHUR: Can you just clarify, you said Anthem Blue Cross is continuing to operate the -- continuing to offer that in the HMO product?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: It's a fee-for-service HMO offering. So -- and in it's based on the services that are available in the host state. So California and New York may be a little bit different. But even though it's an HMO offering, it is a fee-for-service interaction.

CHAIRPERSON MATHUR: Okay. All right. Thank you.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: You're welcome.

CHAIRPERSON MATHUR: And again, I just want to echo the comments of Ms. Taylor, that your team really jumped into action when this came -- became apparent that there was a problem, and addressed it very quickly and holistically. And I really respect and appreciate the work of your team on this.

Thank you.

Okay. That brings us to Agenda Item number 3, which is the action consent item approval of the September meeting minutes.

COMMITTEE MEMBER TAYLOR: Move approval.

VICE CHAIRPERSON BILBREY: Second.
CHAIRPERSON MATHUR: Moved by Taylor, seconded by Bilbrey.
Any discussion on the motion?
Seeing none.
All those in favor, say aye?
(Ayes.)
CHAIRPERSON MATHUR: Motion passes.
CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Madam Chair?
CHAIRPERSON MATHUR: Yes.
CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Can I just point out --
CHAIRPERSON MATHUR: Yes.
CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: -- that Consent Item number 4f, there is a change in title.
CHAIRPERSON MATHUR: Thank you.
CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So it states that its Health Plan Trend Report, but in the agenda item it says that's health care cost trends. They're the same identical --
CHAIRPERSON MATHUR: It's the same thing --
CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Yeah.
CHAIRPERSON MATHUR: -- it's just slightly different wording. Okay.

So I've had no request to pull anything off of Agenda Item 4, so we'll move on to Agenda Item 5, State Legislative Proposal, Technical Amendments to the Public Employee's Retirement Law.

Mr. Pacheco.

DEPUTY EXECUTIVE OFFICER PACHECO: Good morning, Madam Chair and members of the Committee. Brad Pacheco, CalPERS team.

This month, we're presenting a number of legislative proposals in this committee and later in our Finance and Administration Committee that support two key goals in our five year strategic plan. These include policy and technical changes in law to strengthen the long-term sustainability of the fund, and continue our efforts to reduce complexity and costs across the enterprise.

Today, before you are six changes in concept that we believe, as proposed, are technical in nature to support our goals. Marry Anne Ashley, our Chief of Legislative Affairs will briefly outline our recommendations. And we have members of our program area here to answer any question that you may have.

We are seeking approval of our recommendations so that we can move on to the next step, including finding appropriate authors in the legislature. So I'll turn it

over to Mary Anne.

LEGISLATIVE AFFAIRS DIVISION CHIEF ASHLEY: Good morning, Madam Chair, members of the Committee. Mary Anne Ashley, CalPERS team member.

I'm presenting Agenda Item 5, which as Brad noted, is the State Legislative proposals for 2018. This is an action item. So we are seeking Committee approval to pursue legislation to make minor policy, technical, and clarifying changes to sections of the Government Code that would affect program areas administered by CalPERS.

There are six provisions to be included in our annual housekeeping, or omnibus, bill. And the analysis of each provision and the background information is included in your agenda items for your reference.

The proposals that we are making would make changes that would clarify the definition of final compensation for purposes of concurrent retirement, clarify a limit on compensation earnable, based on group or class of employment; clarify the term of disqualification for disability and accidental disability retirement; allow contracting agency delegation of authority to determine disability and industrial disability; clarify conditions for reevaluating the status of disability and industrial disability, and reduce the number of contract options for retiree one-time death

benefits.

As mentioned, these proposed amendments are minor policy and technical changes that we feel would be appropriate to include in our annual housekeeping, or omnibus, bill. And we are seeking Committee approval to move forward and pursue legislation to make these changes. And we are happy to answer any questions.

Thank you.

CHAIRPERSON MATHUR: Any questions from the Committee?

Ms. Taylor.

COMMITTEE MEMBER TAYLOR: Thank you, Madam Chair.

I just had a quick question on the first one, clarifying that when the final compensation of a CalPERS member applying for concurrent retirement is based on compen -- what exactly does that mean?

(Laughter.)

EMPLOYER ACCOUNT MANAGEMENT DIVISION CHIEF OSTRANDER: Good morning, Renee Ostrander, CalPERS team member.

So what it's referring to is those individuals who have reciprocity. So they're with us in maybe another county system, or another State system, or a city where we have a reciprocal agreement. It is just ensuring -- we already have it. We already have this in practice, but

it's just clarifying the language to ensure that -- to make it clear that we can apply our laws to the pay that they earn there when we're applying it to our retirement benefits.

So when they have -- when they have pay that they earn at another reciprocal system, oftentimes there is pays in there that CalPERS does not recognize as compensation earnable or for PEPRA members pensionable comp.

And so this allows us to be able to further clarify that we should not be including those items. We should be treating them as members of our own system for purposes of that portion of their retirement.

COMMITTEE MEMBER TAYLOR: Okay. So then if they have, for example, over time as pensionable compensation but we do not any more, then we're saying that we're not going to recognize that?

EMPLOYER ACCOUNT MANAGEMENT DIVISION CHIEF OSTRANDER: That's correct.

COMMITTEE MEMBER TAYLOR: Okay. Well, that's helpful I think in a way. And then one of the concerns that was brought up by our member employers yesterday was that the -- they pay -- they may have somebody that's retiring, and I think they mentioned a specific amount for $45,000, And then they work for the State of California,

and then they're responsible -- and retire from the State of California, and now the member employer is picking up a further tab that has to do with CalPERS. Is that part of that or --

EMPLOYER ACCOUNT MANAGEMENT DIVISION CHIEF OSTRANDER: So there's a couple of things you could be talking about. One is just the natural course and progression that people have increases in pay. And so there is a liability that comes with that. But what you could be referring to is something that I believe came up, that excess liability piece, possibly --

COMMITTEE MEMBER TAYLOR: Possibly, yeah.

EMPLOYER ACCOUNT MANAGEMENT DIVISION CHIEF OSTRANDER: So -- okay. So -- and I think that's later today. It's an agenda item later today for proposed regulations that are coming forward. And so that is when an individual works at an agency, and then they move to -- they move from agency B to -- agency A to agency B. And at agency B, they receive a significantly higher salary, and so it brings what is called an excess liability to employer A.

COMMITTEE MEMBER TAYLOR: Right.

EMPLOYER ACCOUNT MANAGEMENT DIVISION CHIEF OSTRANDER: And so these proposed regulations that are coming forward to you I believe in --

COMMITTEE MEMBER TAYLOR: Finance and Administration.

EMPLOYER ACCOUNT MANAGEMENT DIVISION CHIEF OSTRANDER: -- Finance and Administration. So those describe through those proposed regulations how we will administer that. It's the last piece from PEPRA.

COMMITTEE MEMBER TAYLOR: Awesome. Perfect.

And then my last question, and I appreciate your help here --

EMPLOYER ACCOUNT MANAGEMENT DIVISION CHIEF OSTRANDER: No problem.

COMMITTEE MEMBER TAYLOR: -- the reduce the number of retired one-time death benefit payment options that public agency and school employers my contract for in the future. Could you explain that for me? Just to -- I don't understand.

BENEFIT SERVICES DIVISION CHIEF SUINE: Sure. Good morning, Madam Chair, members of the Committee. Anthony Suine, CalPERS team.

Ms. Taylor, that's referring to the contracted lump sum death benefits that are available to our employers to contract for. So currently, we have six different options. And this is an effort to reduce complexity, because they're so close in number. So we have 500 and 600. We have 2,000, 3,000, 4,000 and 5,000.

COMMITTEE MEMBER TAYLOR: Okay.

BENEFIT SERVICES DIVISION CHIEF SUINE: So we want to get down to three contract options to simplify that process. And everybody who currently has whatever is in our law today would maintain those. And then going --

COMMITTEE MEMBER TAYLOR: Forward.

BENEFIT SERVICES DIVISION CHIEF SUINE: -- into the future, there would be the option of a 500, a 2,000 and a 5,000 lump sum benefit.

COMMITTEE MEMBER TAYLOR: I appreciate it. Thank you very much.

CHAIRPERSON MATHUR: Thank you.

Mr. Gillihan.

COMMITTEE MEMBER GILLIHAN: Thank you, Madam Chair. Well, I'm prepared to support the proposal today to move forward with the legislation.

Just for the record, I want to state that my support at this stage does not state the administration's position on future legislation.

CHAIRPERSON MATHUR: Okay. Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. I would second that. And I just want to -- regarding Ms. Taylor's comment about the two employers of an individual retiring, I had marked that up on the Finance Committee report, and I was going to ask the same question, so be ready.

CHAIRPERSON MATHUR: So this is an action item. Does someone want to move it?

Was that a motion, Mr. Gillihan or was it just an expression of support.

COMMITTEE MEMBER GILLIHAN: It's a statement.

CHAIRPERSON MATHUR: Okay.

COMMITTEE MEMBER TAYLOR: I'll move the item.

CHAIRPERSON MATHUR: Okay. Moved by Taylor.

COMMITTEE MEMBER HOLLINGER: Second.

CHAIRPERSON MATHUR: Seconded by Hollinger.

Mr. Jelincic.

BOARD MEMBER JELINCIC: Yeah, I had a couple of questions. One deals with the compensation earnable based on a group or class of employment. I mean, one of the things I found interesting is you're talking about people who were in their unique class or group. And yet, you're talking about giving them the average for that unique group. And so the average is going to be actually what they got. So I'm not sure what it solves. I mean, if there's only one person in the group, the average for that group is what the person got.

EMPLOYER ACCOUNT MANAGEMENT DIVISION CHIEF OSTRANDER: So what the raw currently provides is exactly what you're -- or I shouldn't say what -- what some have tried to argue in court is what you are saying. What we

have found in the cases that they agree with our position, CalPERS has consistently taken the position, and it's been supported in court, that if you are in a group or class, then you are -- a group or class of one, then you are limited to the group that is similarly situated to you.

And so what they have tried to argue is that, well, I'm part of this other group, but I received a raise that's different from everybody else in my group. So since I'm in that group, I don't have to receive -- I don't have to be limited.

Like I said, the courts have supported us in limiting them to that amount, but we want to go back and we want to just clarify the language to further support the position that we have put forth.

BOARD MEMBER JELINCIC: Good luck crafting the language.

(Laughter.)

EMPLOYER ACCOUNT MANAGEMENT DIVISION CHIEF OSTRANDER: It actually only takes a couple of words.

BOARD MEMBER JELINCIC: Okay. Clarifying the -- who can apply for disability, that is an ongoing tug of war. I have no problems with saying if you've been fired, you know, you're not eligible, but that's very different than saying you can't apply.

I mean I could apply for disability. I wouldn't

get it approved. So I think it's important that the language say that you're not eligible, not that you can't apply. Because until you apply, we don't know that you're not eligible. So I would just, as you play with that language, I would encourage you to make that. And then on the -- reducing the number of options, I'm not sure how that saves any work at all, because quite frankly, when somebody dies, you have to look up who the employer is, and what that benefit is. And people only die once, so you only have to look it up once. And whether there's 15 or 20, or 3 different options on what the answer is, it doesn't reduce any work, as far as I can see. So maybe I'm missing something.

BENEFIT SERVICES DIVISION CHIEF SUINE: Going forward to educating our employers, it would simplify that effort about what the available contract options are. So it's not only for our internal staff, but it's in educating our employers and what options are available.

And then when our teams do talk to members, if there's only a limited number of options available, it makes that discussion easier.

BOARD MEMBER JELINCIC: Except, you're still going to have to look up the member and see who their employer, and there is a number for that employer.

BENEFIT SERVICES DIVISION CHIEF SUINE: You are

correct.

BOARD MEMBER JELINCIC: So I'm not sure -- not sure of the problem we're solving. I mean, it seems to me that what you've just said is, well, we can have a sentence that is eight words shorter when we're educating employer, because the list is shorter. But I'm not sure that that really does anything, and in fact reduces the employer's options, and I'm not sure what we gain by it.

Okay. Thank you.

CHAIRPERSON MATHUR: All right. Thank you.

There is a motion before the Committee.

Any further discussion on the motion?

Seeing none.

All in those in favor say aye?

(Ayes.)

CHAIRPERSON MATHUR: All those oppose?

Motion passes.

That brings us to Agenda Item number -- thank you very much. That brings us to Agenda Item number 6, Review of Pension and Health Benefits Committee Risk Profiles.

CHIEF RISK OFFICER GRIMES: Good morning, Madam Chair, Committee Members. Forrest Grimes, CalPERS team. The purpose of this item is to present the updated risk managing profiles, dashboard, and heatmap for your review.

The risk profiles were updated to be more clear

and the risks were scored by leader and executive teams. The Pension and Health Benefit Committee oversees benefit administration, page one of attachment one, and health administration, page seven of attachment one.

Impact increased in health administration due to the political environment, which is really no surprise. So with that, I'm just going to turn it over to you for comments and questions. Thank you.

CHAIRPERSON MATHUR: Thank you.

Mr. Jelincic.

BOARD MEMBER JELINCIC: Yeah, I have just one question. Are attachments one, two, and three the same as we're seeing in Finance and Admin and --

CHIEF RISK OFFICER GRIMES: Yes, they are, Mr. Jelincic. They are, so you could kind of compare and contrast them all at each Committee.

BOARD MEMBER JELINCIC: Okay. I just wanted to make sure the attachments were the same. Thank you.

CHIEF RISK OFFICER GRIMES: That's the case.

CHAIRPERSON MATHUR: Thank you.

I see no further requests. I do think that this is an appropriate reflection on number -- on the information -- sorry, was it -- the increase in risk. I'm sorry, I'm not seeing -- whichever page it was on, but I do -- I do think that was -- that's an accurate reflection

of the current state, so I appreciate the executive flagging that.

CHIEF RISK OFFICER GRIMES: And I would like to follow up that really our team doesn't feel that there is anything that we can or should be doing, other than what we are doing. There's just really uncertainty.

CHAIRPERSON MATHUR: Yeah, just continue to monitor the environment and what's happening in Congress.

CHIEF RISK OFFICER GRIMES: Yes.

CHAIRPERSON MATHUR: Okay. Thank you.

CHIEF RISK OFFICER GRIMES: Thank you.

CHAIRPERSON MATHUR: Oh, Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you, Madam Chair. Are there -- what kind of situation would occur where we should be doing something?

CHIEF RISK OFFICER GRIMES: Regarding the health risk?

COMMITTEE MEMBER JONES: Yeah. Any of -- I know that the others are coming through Finance, but the same question applies.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS:

Currently, the inherent risk has gone up, because that's as if we do nothing. And so at this point, we believe our mitigation strategies are keeping that under control.

We're just continuing to monitor. If their Cadillac tax actually does hit in 20 -- you know, in 2020, we will be having a conversation with you on what that impact would be. If there's other types of changes, you know, we've talked about the ecosystem, between the Medicaid, Medicare, and commercial market. We've seen where there's been these shifts in taking subsidies away.

As we start to shift more individuals to emergency rooms and the overall cost goes up, the commercial market ends up bearing the brunt of that, which then would impact us. So it's kind of a watch and monitor, but it's an active watching and monitoring from our seat.

COMMITTEE MEMBER JONES: Okay. Thank you.

CHIEF RISK OFFICER GRIMES: Madam Chair, can I follow up on that quickly?

CHAIRPERSON MATHUR: Please.

CHIEF RISK OFFICER GRIMES: Mr. Jones, I think more generally the next steps in this iterative process are really developing key risk indicators that tie to our strategic plan objectives. And so I think as you see the program mature, and this is one of our, I think, best and final steps that you'll see in coming months, you would be able to actually see things changing perhaps, and it would give you an early warning so that you could more readily

contemplate potential action.

And so that's really a next step that we're going to be pursuing. And I think it's going to be a really good one.

CHAIRPERSON MATHUR: Thank you. Well, that's it on Item 6.

That brings us to Agenda Item 7 --

CHIEF RISK OFFICER GRIMES: Thank you.

CHAIRPERSON MATHUR: -- curbing the opioid -- thank you very much -- curbing the opioid epidemic in California. This is clearly a very -- an issue of now. Every day in the press, we see items on new busts of Fentanyl rings, et cetera, and the terrible toll it's taken on public -- on the public, on people all over this country, including the State of California.

So really happy to have you with us today. Thank you for joining us. And with that, I'll turn it over to you, Dr. Sun.

(Thereupon an overhead presentation was presented as follows.)

DR. SUN: Good morning, Richard Sun, CalPERS team member. Prescription opioids can be very useful, for example, in the treatment of chronic cancer pain, but they also be overprescribed. CalPERS has made efforts in reducing the overprescription of opioids.

One measure is to join the Smart Care coalition -- Smart Care California Coalition. CalPERS was a founding member, along with Department of Health Care Services and Covered California. And another method is by putting opioid measures into our strategic plan. And at tomorrow's enterprise performance reporting update, you'll hear about our proposal to replace the single opioid measure with two measures, one on dose, and one on duration.

To put these efforts into context, we've asked Dr. Kelly Pfeifer with the California Health Care Foundation to talk about curbing opioids in California.

At the foundation, she directs the high value care team. This team supports policies and care models that align with patient preferences, are proven effective, and are affordable. The team focuses on maternity care, end of life care, and the care of population with complex behavioral health and medical conditions.

Prior to joining the foundation, Kelly served as the chief medical officer for the San Francisco Health Plan.

Dr. Pfeifer.

DR. PFEIFER: Thank you. It's been an honor to be invited to speak. And I have to say it's also an honor to work with Dr. Donneson and Dr. Sun. In the world there

are talkers and doers, and these are doers who gets things. So I'm always learning from them.

In my neighborhood, there's a coffee shop that has a sign Lord give me coffee to change the things I can change, and wine to accept the things I can't.

(Laughter.)

DR. PFEIFER: And I always think at the California Health Care Foundation, our mission is to work on the coffee problems in health care. These are the problems where a little bit of resources, and partnership, and energy, and commitment and time, can make an impact.

--o0o--

DR. PFEIFER: I'm a family doctor. And I always start these talks by admitting that I am part of the cause of the opioid epidemic. I was trained in the era when we've truly believed we were helping suffering people by giving opioids for conditions that had never received opioids, by prescribing at doses that had previously only been seen in hospice.

I, honestly, feel we were sold a bill of goods. We -- there was false advertising that made us think that opioids were not addictive when used in chronic pain. And I think all of us need to step up and take responsibility for our part in the epidemic. And that's why I always start this talk this way.

I got my wake-up call when a young woman looking like this picture was -- died with my prescription pills in her hand. I got a call from the coroner and realized, in a very profound emotional way, that the ways I thought I was helping her, I was harming her.

But I also have many patients who look like this woman who turned their lives around. And so I was able to experience firsthand what happens when you treat addiction like a chronic disease, that could be managed by a primary care provider with a combination of medications and behavior health treatment. And it's just, I think, one of the best antiburn-out options in medicine to see people move from chaos to recovery.

--o0o--

DR. PFEIFER: You know, one of the things that we really did not understand 15 years ago was how easy it is to get dependent or addicted on opioids. And there was an amazing study that came out looking at thousands of health insurance claims showing that every single day you take opioids beyond three days, you increase your risk of long term use by one percent.

That's a phenomenal statistic, because I think many of us have gone -- had minor surgery, or had a tooth extraction and got 30 of percocet. Well, if you actually took those pills for 30 days, your chance of continuing to

use opioids one year later is 30 percent, which is an astonishing number.

If you didn't take those pills, they'd be in your medicine cabinet exposing teenagers to the risk of addiction. So we've really learned a thing differently about not just the risk of opioid addiction but the risk of opioid dependence and how it's a dose response, that every day you take them increases your risk.

So again, it creates a real policy opportunity for thinking about how we treat acute pain and the importance of only using opioids for short durations.

The issue is urgent. It's easy in California to get complacent because our average looks reassuring. We don't look that bad compared to the rest of the U.S. But it's an important fun fact to know that half of California list south of Wilshire Boulevard in L.A. So the average -- California average is not that meaningful.

So there are parts of California that are as hard hit as Ohio. And so that's why in California we're taking this very seriously. A group of experts got together and projected nine different scenarios of what it will take to drop opioid deaths in California. And it was actually very sobering, because if we don't change anything about what we're doing, it's anticipated we could have another 650,000 overdose deaths in the next decade in the U.S.

That's equivalent to a 9/11 disaster every two weeks.

On the other hand to drop that death curve is going to take systematic efforts in three fronts. Lowering prescribing. We've tripled the amount of opioids we prescribed in the U.S. in the last 15 years. So dropping it by even 50 percent is not unachievable. We need to make sure addiction treatment -- effective addiction treatment is available for all who need it.

And we need to make sure, until we get to that place where the supply is down and the demand is down, that we're stopping the overdose deaths with harm reduction. That's things like you've probably heard about Narcan a nasal spray that if it's available at the time of an overdose, you can save a life.

--o0o--

DR. PFEIFER: So how do you change a problem this difficult across a state as complex as ours?

And it really breaks down into four steps and I wanted to review them with you. Having a clear vision and goal. If our focus is laser focused on opioid deaths, we make different decisions than if we were for example trying to stop all opioids, which no one would suggest.

We need to pull multiple levers at once, which really reflects how influential CalPERS can be in this epidemic. We need to build partnerships. And then

ultimately use data to hold ourselves accountable.

--o0o--

DR. PFEIFER: And, you know, getting to this clear vision. I think about another epidemic, where we stigmatize the population who's dying, we block them from access to schools and health care, we blamed them for the condition until two profound things changed in the AIDS epidemic, which plummeted the death rates. You can see it escalated, escalated, and then there was an abrupt drop.

And it was really two things that are Similar to what's happening in the opioid epidemic. One is there's a big anti-stigma campaign. You know, Rock Hudson came out and suddenly people with AIDS were people we loved and cared about. And we're seeing the same shift in the opioid epidemic.

And the second is that effective medication became deployed everywhere. And so AIDS was no longer a death sentence. And again, that's something that needs to happen in addition where we need to remove the barriers, so anyone who is ready to seek treatment can access it. And that will take regulatory change, government change, plan change, provider change. It's really going to take a shift.

--o0o--

DR. PFEIFER: And so to illustrate that, I'd like

to do a little thought experiment. What would have happened if Prince had a heart attack? The plane would have downed. He would have been in a hospital where not only would he be given treatment to save his life, but he'd be given medications to stabilize his heart condition, so that it would prevent another heart attack. That hospital would be paid differently based on how they did on giving the medications needed to prevent another heart attack.

If he ran out the door to leave against medical advice, a nurse would chase him in the waiting -- back into the waiting room saying you are at such high risk of death, you can't leave.

Now, on the other hand, what happened, which happens across the country all the time is he came with an overdose. What -- its -- and I think a lot people don't understand about over -- of overdoses and Narcan is when you wake up after an overdose, every cell in your body hurts. You're put into the worst possible withdrawal and all you can think about is that you are going to die, unless you get something to make you feel better.

And that's, I think, something that's not understood about addiction is that after awhile people don't get high from the medications, they're really just trying to keep from getting sick, and that awful feeling

of withdrawal when you feel like you're going to die. So, of course, he left against medical advice.

And what would have happened if that we treated the disease of addiction like we treat cardiac disease? Instead of just saving his life, the emergency department would give a dose of a medicine to stabilize the brain chemistry, because in long-term addiction, brain chemistry changes. And that's -- that overwhelming feeling of I'm going to die, I'm craving, I'm in withdrawal, everything hurts can be stabilized by medications.

And we're seeing that happen in emergency departments. We're -- not only are they saving the overdose, but they're giving a medicine called Suboxone, stabilizes the brain and then the patient can have an informed conversation about what do you want to do about treatment. Let's connect you to treatment.

If we had hospitals that were held accountable for preventing the next overdose, we'd e treating people very differently, because to be honest, the risk of dying after one overdose death is higher than the risk of a missed heart attack. One in 10 people will die within a year when they've had one overdose.

And that's a system problem. We like to blame the patient for it, but if we aren't treating the underlying condition of addiction, it shouldn't be a

surprise that people continue to go back to their drug. So the California Health Care Foundation and CalPERS are working on how to make sure that every point of care, you can have access to effective addiction treatment.

--o0o--

DR. PFEIFER: And that's the real power of being purchaser, because in Smart Care California with the three public purchasers we're able to influence plans and providers. We're able to organize all of our work in coordination with other local agencies, and local coalitions. And I'm going to be going through a couple of these examples briefly.

So in your packet, you can see that we've put together a call to action for all health plans to launch a system-wide opioid initiative. And by that we mean not just changing the formulary, because I wish there was one action which could turn this around, like the iPhone app that would change everything. But unfortunately, it's going to take multiple actions coordinated together.

And that's why you'll see in your packet, there's a body of work for health plans to do around preventing new starts, so new populations don't become dependent. There's work around identifying pain patients who are at high risk of death, because they're in high doses, or they're in opioids and sedatives together, which is a

lethal combination.

There's work about making sure addiction treatment is streamlined and accessible. And there's work around making sure that Naloxone is available to anyone who needs it. And so that when we -- when we're encouraging payers and providers to launch opioid safety initiatives, these are the four categories that we're really pushing, because if you just address one, you're squeezing the balloon and we'll push the problem somewhere else.

So we're really focusing on this mantra of prevent new starts, manage people at high risk of overdose because of pain, treating addiction, and stopping the death.

--o0o--

DR. PFEIFER: CalPERS put out, along with the other Smart Care California folks, put out a survey to the plans of all these four areas, what are you doing and what are you not doing, and what's a priority. And so we got some really good data about -- about what the plans are doing, and now we're working on next steps about how to help the plans work on these four main areas that are needed to curb the epidemic.

--o0o--

DR. PFEIFER: This can be successful. One of our

prime examples of success is Partnership Health Plan that launched a system opioid initiative in their plan. They dropped overall prescribing by 75 percent. They dropped total high dose users. And these are people who are taking the equivalent of 20 or 30 Norcos a day, all in one tiny pill, because, you know, one small little 80 milligram OxyContin is equivalent to around 25 Norco. They're were able to drop them to safer doses again 70 to -- by 79 percent.

So what -- they didn't do this simply. They didn't multiple interventions at once. And it was really a partnership between the plan and the provider community where the plan said, we've got a problem. We need to fix this. You know, providers what do you need to help you identify these high risk patients and taper them slowly over time to lower doses, because people with chronic pain on high dose opioids, like people with addiction, have sometimes permanent brain changes. They may never be able to get off opioids, but they can get to safer doses.

--o0o--

DR. PFEIFER: You know, very briefly, there's other statewide work going on that we're coordinating in Smart Care California with a Statewide Opioid Safety Workgroup. This is a group led by the Public Health Department that has over 60 agencies and organizations

participating, so that in a state as complex as California, we're coordinating all of our work together.

--o0o--

DR. PFEIFER: And personally, one of the most inspiring things we've seen over the couple -- last couple years are opioid safety coalitions. When the California Health Care Foundation started this work a couple years ago, we saw some best practices in Marin and San Diego, where a public health department or a medical society brought all stakeholders together, including law enforcement, and said we have a problem in our county, here's the data, what are we going to do. And they all focused on prescribing addiction treatment and Naloxone.

Now, there are 35 counties across California representing well over 90 percent of our population that have local coalitions, where all stakeholders are getting together working on this in synchrony. And we were coordinate -- we're basically bringing this network together so that everybody can share ideas. So what's happening in Ventura, people in Plumas county can learn from.

--o0o--

DR. PFEIFER: And finally data. If you've never gone on to this website, I would really encourage you to do so. It's phenomenal. It was put together by the

Public Health Department. You don't have to remember this crazy link. You can Google California opioid overdose surveillance dashboard. And you can find pre-packaged reports by county or State or you can go and play with the data yourself and look at graphs and tables and numbers. But it tracks overdose deaths, emergency department visits, opioid prescribing, and buprenorphine or Suboxone prescribing.

Again, because Suboxone is easy to track - it's available in the database - it has a marker of how easy access we have to all types of addiction treatment. And what you'll see on this dashboard, in some ways we can pat ourselves on the back, because unlike the rest of the U.S., California in the last two years has stabilized our overdose deaths. That's not enough. We need to drop them, but we aren't -- they're not going up, except for that one line item that you can see, which is fentanyl. So that one chart where we're seeing the deaths go up, as Madam Chair said, is fentanyl. And we've -- we're just seeing the tip of the iceberg, and we're going to have to solve that problem if we're going to stop the epidemic.

--o0o--

DR. PFEIFER: So, in summary, I again am so honored to be in front of you, because CalPERS and Smart Care California have phenomenal ability to impact the

epidemic by working systematically with your plans, with your members, and in coordination with the rest of the state to work on preventing new starts, managing pain more safely, treating addiction and stopping the deaths. So I thank you for your time.

CHAIRPERSON MATHUR: Thank you so much. What a chock-full presentation that was. And clearly, there are -- as you say, there are many levers to be pulled.

You mentioned fentanyl. And, you know, obviously we have created some measures aimed at reducing the diag -- the prescription -- prescribing of -- and shortening the prescribing of opioids. But I am concerned that that will then drive members to the streets to buy fentanyl and other drugs heroin, et cetera. How -- how is -- how are you and the Health Care Found -- California Health Care Foundation looking at that issue and preventing that transition to what can be very inexpensive but highly potent and highly deadly illicit drugs?

DR. PFEIFER: I'm really glad you brought that up, because we won't -- you know, we learned with the opioid epidemic, we can aim to do good and create harm, and we can do the same thing here. So I think there's really two populations to think about. One is the chronic pain population, who are on opioids. If doctors respond by firing their patients, or saying I don't treat opioids

anymore. I don't use opioids any more, we're going to, as you say, see more people driven to the streets. Because again, it doesn't matter if you got the medicine in by OxyContin or by heroin, your brain has changed in the same way, and it's really hard to function if you're cutoff completely.

So a piece of the work is helping providers understand how to safely taper people to low doses. It's also understanding that not everyone needs to stop. If you've got someone who's on low dose and doing okay, it's better to leave them alone, because you'll do more harm than good by forcing them to go off opioids.

And that's why again we're laser focused on who are the highest risk and focusing on them, not trying to stop opioids in all situations altogether.

But we will never turn this epidemic around until it's easier to get treatment than it is to get heroin, if it -- it needs to be cheaper to get treatment than it is to get heroin. And France is a great example. They dropped their opioid deaths by 80 percent, because they made Suboxone and other treatments freely available. They stripped away regulations. Insurance companies made -- had zero co-pays or zero charge, and they actually augmented what they paid doctors in primary care to treat addiction.

So again, there's a lot of barriers for primary care docks like myself to start treating addiction. It's hard. We weren't trying to do that, but if -- if we are paid better to do that, you'll see more doctors willing to do it.

But again, it's going to take changing how we think about addiction from being a siloed specialty problem to be another chronic disease that we can treat in primary care. And I think purchasers have a great opportunity to influence that.

CHAIRPERSON MATHUR: Thank you.

Mr. Jelincic.

BOARD MEMBER JELINCIC: Yeah, on slide 4, where you talk about bending the curve, there's a number of lines passed, you know, 15, what are the different lines?

DR. PFEIFER: These are nine different scenarios that academics across the country put together and they did a variety of assumptions. So the first assumption was nothing changes, it's exactly the same. And then the other lines have different assumptions. It might be worth going into this stat news, because it's fascinating. Because you can actually hover over -- like, let's look at the blue line, what's that assumption? And maybe we stop overprescribing, but addiction treatment is hard to get as it ever was.

So each of those lines is a different scenario. And the one at the bottom is that we go all out on all fronts.

BOARD MEMBER JELINCIC: Okay. Thank you.

CHAIRPERSON MATHUR: Thank you.

Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you, Madam Chair. Yeah, I see the dashboard included in the material here and you also mentioned about the webpage for information. Is there a helpline number that can be shared that people can call when they have questions or concerns? Has that been established yet?

DR. PFEIFER: So a helpline to understand the data or and helpline to get treatment or --

COMMITTEE MEMBER JONES: Yeah, about the use and treatment more or less.

DR. PFEIFER: So that's a really good question. I don't -- I'm not aware of a statewide way to get access to treatment. I think this SAMHSA website has treatment locators, so people can go online and find out where treatment is on their own in their neighborhood, in their region. If you have questions about the data, there's a place on the data dashboard where you can email the creator John Pugliese and he's the most responsive person I've ever seen. If anyone has any questions about the

data, he answers right away.

Did I answer your question?

COMMITTEE MEMBER JONES: Yeah, you -- it's not available yet. It's -- yeah, that's the bottom line. Okay. Thank you.

CHAIRPERSON MATHUR: Thank you.

Ms. Taylor.

COMMITTEE MEMBER TAYLOR: Thank you, Madam Chair. I find it fascinating that we're not paying physicians to treat it. And is that something that the group is working towards changing? I don't know if that's a federal issue or a --

DR. PFEIFER: Well, if I could clarify it takes time to treat addiction. So I can see someone in 15 minutes for a cold, or an allergy episode, but to get people started on addiction treatment takes a lot of time and effort. And so typically, the most effective way to do it is do it by team, where you have a behavioral health therapist, you might have a case manager, you might have a doctor who needs to see people more frequently.

So what France did is they recognized it took more work and more time. And so they pay doctors at an augmented rate over just the general primary care rate.

COMMITTEE MEMBER TAYLOR: Okay. And then you also mentioned that the I guess -- I don't know what we

would call it, the medicine that helps get off is also expensive. Is that at issue?

DR. PFEIFER: Well, there's three different medications that can be used to treat opioid addiction. The general term is called medication-assisted treatment, because the concept is if you -- with opioid addiction, unlike other diseases, if you try to do drug-free treatment, where you don't get any medication, only six percent are sober a year. Where if use effective medications, it's more like 70 percent.

So one of the things that we've talked with CalPERS about, at Smart Care California is how do you make sure that Suboxone and other treatments are very accessible to members, so that they either have low copays, or no copays, or that the cost share is less. And that would -- I don't know where CalPERS is on exploring that option, but I know it's something that's been discussed.

COMMITTEE MEMBER TAYLOR: Yeah. And is that an Option that's being discussed with Covered California, and --

DR. PFEIFER: Absolutely. Removing copays and cost sharing for addiction treatment is on the health plan checklist that we've created. It's been done legislatively. I think in New York and Massachusetts,

there was actually a law passed saying that you can't -- you've got to remove all authorization barriers for addiction treatment, and you can't have this cost sharing. But in California, we're hoping to do that voluntarily, that we'll be able to influence plans to remove any barriers, so again it's cheaper to get treatment than it is to get heroin.

COMMITTEE MEMBER TAYLOR: If you aren't able -- I don't know how far along you are in trying to convince plans to move that. If you aren't able to do that, would that then be something your group would do is move it in legislation?

DR. PFEIFER: We have -- we've talked about legislation at Smart Care California. And I think there's some ambivalence, because sometimes you have unintended consequences when you legislate medical care. So I don't -- I don't want to answer for the group. I think right now, I think there's been a lot of momentum and a lot of willingness by -- from plans to take this on. I've been incredibly impressed about how plans are prioritizing this. And so I still believe that we can do this voluntarily with encouragement through Smart Care California.

COMMITTEE MEMBER TAYLOR: Okay. Thank you.

CHAIRPERSON MATHUR: It might be worth asking Ms.

Bailey-Crimmins and Dr. Sun if you've been having conversations with our plans, and what the status of those conversations are.

DR. SUN: Oh, absolutely, we've had conversations, especially around the survey results. And we will be talking more with the medical directors in the future about this.

CHAIRPERSON MATHUR: Okay.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: And also at the quarterly business reviews we have with the plans. We had one with Kaiser recently, and they know these measure are things that we're looking at, and their high dose has gone down significantly. So it's on the radar. We're holding them accountable and looking at not necessarily no opioids, but specifically focusing on the high dosage, which is where we put our members at risk.

CHAIRPERSON MATHUR: Is it something we perhaps would want to consider a measure around the treatment side? Because right now we have sort of the reduction in use size -- side, but not so much the treatment side.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: We could definitely consider that. I know every year the measures are up for discussion. So we would be happy to consider that.

CHAIRPERSON MATHUR: I might suggest that that

would be something worth talking about a little bit more.

Okay. Mr. Slaton.

BOARD MEMBER SLATON: Thank you, Madam Chair.

So I want to just focus for a moment on the problem of new people coming into addiction, rather than those who are already addicted. And I know my wife recently had shoulder surgery, I had recent knee surgery, and, you know, we got a prescription for 30-day supply. And I think we used it for about 48 hours and that was it, and then it's probably sitting in a drawer some place. Luckily, we have nobody else around to grab that.

My question is why would we be paying in our health care plans for 30-day prescriptions for these kinds of opioids? It seems to me that, you know, maybe it's three day supply or a five-day supply max. Why would we permit that in our plans, and is that something that at least on the entry point that we could make a fairly simple change in our plans that might have an impact? Could you comment on that?

DR. PFEIFER: It is -- it's very similar to the last comment that some states have legislated that, which I think can be problematic. But what I've seen plans do successfully, including partnership, which is the example I gave, is that they say if you want to get more than X number of days, you know, five or seven days, that you

need a prior authorization. And that would dramatically change behavior, because it's very difficult, as I imagine you know, to get doctors to change.

Certain surgery groups have actually called their patients and found out how many do you actually use? They found out it's almost never more than three days, and then they voluntarily changed it. But again, I think the health plans can be very powerful by saying we're just not going to pay for it, unless you give us a reason, because, in general, after you've had surgery, if you still need opioids at seven days, you probably should see your doctor to find out why.

BOARD MEMBER SLATON: Right. So then the question is from staff, could we do that, and what would be the ramifications, and what would be the process?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So several things. It's -- obviously, we're concerned with addiction for the member's health status. We're also concerned that the cost to the system is sitting in a cabinet. It's not doing anybody any good.

BOARD MEMBER SLATON: Sure.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: We are looking at -- recently, we began talking to the plans of providing like Liquid morphine, instead of actually giving the pills. They're actually transitioning to more like a

800 milli -- Ibuprofen -- 800 milligram ibuprofen.

So we're seeing as a purchaser we do have a lot of influence at the table on what plans do in relation to prevention, so that we don't get people addicted in the first place. And I'm sure Dr. Sun could even talk about specifically what him and his pharmacists are doing with the plans.

DR. SUN: Sure. Well, Melissa Mantong and I have been working with plans. And OptumRx, and Blue Shield, and Kaiser all have programs to try to reduce the duration of initial treatment.

BOARD MEMBER SLATON: But we don't have a restriction on what we're willing to pay for at this point?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Not at this time.

BOARD MEMBER SLATON: Okay. Well --

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: We leave it up to the providers, but we do have -- we need to be working with them to have a prevention program. It's hard to get between the provider and the member on the care, but we can look at medically necessarily. And then based on that --

BOARD MEMBER SLATON: Yeah. I mean, we do that in other areas of coverage in terms of --

DR. PFEIFER: Limiting to seven days from the health plan is on the health plan checklist. And I have seen the plans that Dr. Sun is talking about implement those restrictions. It's a -- you know, it's a big lift for the plans, but I've seen more and more plans moving in that direction. And I think continuing to have Smart Care California push plans to implement those items on the checklist including a seven day limit, including dose limitations, we're seeing a lot of movement.

BOARD MEMBER SLATON: Well, I would encourage the Committee to consider doing this and moving forward on it. Thank you.

CHAIRPERSON MATHUR: Thank you.

Mr. Jelincic.

BOARD MEMBER JELINCIC: You talked about Kaiser. And, you know, Kaiser tells us all the time how they have this electronic record keeping, and they are best practice, and they are doing continuous research, and yet, you said they've had this problem. What's the basis for their problem, and what are they doing to fix it, since they cover a whole bunch of our members?

DR. PFEIFER: California Health Care Foundation commissioned a paper to understand what health plans are doing well. And Kaiser was actually one of our model case studies, along with Blue Shield and Partnership HealthPlan

all three did major opioid initiatives.

The advantage, of course, with Kaiser is that because they hire their own docs, they can build in into their electronic record hard stops. So unlike a health plan that has to use tools of prior authorization, they're able to just say you can't prescribe this unless you see a specialist, or you can't prescribe above this dose. So Kaiser has published its results. They've had dramatic drops in opioid prescribing. And they -- they're starting to look at outcomes like emergency department visits and hospitalizations. Look, we see Kaiser as one of the leaders in this effort.

BOARD MEMBER JELINCIC: How did it get out of hand at Kaiser in the first place?

DR. PFEIFER: It's like all of us, if you -- I think it flew under the radar hat Kaiser and the rest of the health care system didn't realize how bad this epidemic was progressing, until it started to get a lot of attention. And they looked at their data and they said vicodin is the number one drug we prescribe in Kaiser. It actually was the number one drug across the U.S., and they were shocked by that. And so as soon as they looked at the data that galvanized them to action.

BOARD MEMBER JELINCIC: Okay. Thank you.

CHAIRPERSON MATHUR: Thank you.

Ms. Hollinger.

COMMITTEE MEMBER HOLLINGER: Yeah. Thank you. Appreciate the study. Just a quick question. Have we perused the prescription database search and see which doctors are potentially overprescribing?

DR. PFEIFER: So the database by law can't identify doctors or individual patients. It can only be used in the aggregate. I know that individual health plans - again, it's part of the checklist of best practices - are looking for outlier prescribers.

COMMITTEE MEMBER HOLLINGER: Right.

DR. PFEIFER: And then using the tools of the pharma trade. So, you know, the pharmaceutical detailing where beautiful people in fancy suits would come visit me, and give samples of pizza, that are using those same techniques to try and change opioid prescribing and get -- it's called academic detailing, because it's pushing best practices as opposed to pushing brand name drugs. But that's one of many techniques that health plans are using to -- because the health plans have their own data that they can identify --

COMMITTEE MEMBER HOLLINGER: Right.

DR. PFEIFER: -- but at the State level it's prohibited. So the Department of Justice is using this database in a law enforcement capacity to look for pill

mills and fraud. But at the health plan level is the only other way to identify these outliers and trend -- either see if they're fraudulent and get them closed down, or see if they're people like me well meaning, but not doing the right thing, and then get us back to good practice.

COMMITTEE MEMBER HOLLINGER: Got it. Okay. Thank you.

CHAIRPERSON MATHUR: Thank you.

Mr. Jelincic.

BOARD MEMBER JELINCIC: Following up on Dana's point, we've looked -- have we looked at our own data warehouse to -- and I assume that identifies who the actual providers are. But have we looked at that database that we control to identify potential problems that might need to be worked with?

DR. SUN: No, we have not identified providers through our health care decision support system.

BOARD MEMBER JELINCIC: They're not providing -- they're not identified in our database?

DR. SUN: They are identified. We have not used the database in that way.

BOARD MEMBER JELINCIC: Okay. Thank you. I would like to encourage you to at least think about it. If we can identify where the outliers are, we can hopefully help some of our members.

Thank you.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: And just as a reminder, Mr. Jelincic and the Committee, I know it's not today, it's tomorrow, we are going to be talking about the health measures. We -- instead of just prescriptions in general, because not all prescriptions are treated equal, CalPERS is looking at two, which morphine milligram equivalents looking at high dosage, because that is important, and duration. So looking at is it three days, seven days, and figuring out with plans how -- because one prescriber could actually prescribe one opioid, the patient be done, and then actually prescribe another opioid. And so we're looking at the total duration. So we're trying to figure out ways.

So there are things that we are going to be holding our plans accountable for, who will also be holding the providers and the prescribers accountable for as well.

CHAIRPERSON MATHUR: Thank you. Well, clearly your presentation sparked quite a lot of interest and discussion from the Committee, and I really appreciate your being with us today. Thank you.

DR. PFEIFER: Thank you. Again, it's an honor to be here and it's also an honor to work with this team. Like I said, there's talkers and doers, and they're doers.

And they've already made a lot of progress. So I appreciate the time.

CHAIRPERSON MATHUR: Thank you. Okay. That brings us to Agenda Item number 8, OptumRx.

(Thereupon an overhead presentation was presented as follows.)

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Good morning, Madam Chair. Today John Prince, the OptumRx CEO, and I are here to address the September Board directive, which was to work with the CalPERS retiree stakeholders to take action to improve the OptumRx experience.

I'm pleased to report that we have held several productive meetings with the retiree groups. And areas of concern have been addressed, and we've established both short-term and long-term actions to bring about changes that they have requested.

--o0o--

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: To date, these improvements have been achieved, and they're in four different primary areas.

--o0o--

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: The first the retirees had asked us to evaluate the current formulary. We've all agreed that the new formulary that we have under OptumRx has new viable medications like for

multiple sclerosis, and we don't want to go backwards.

So what we did promise the retirees is that we were going to compare the current formulary against the 2016 formulary, and make any adjustments that were necessary. We are expected to complete this analysis by the end of this month.

And then when it comes to customer service, CalPERS actually reviewed and listened to 200 members -- CalPERS members, recorded calls. The average call was seven minutes. There was one call that went up to an hour. We are working with OptumRX on those results to contain to improve the customer service that we expect as an extension of us to our members.

In addition, the retirees had talked about specifically like contact agent's extension, so when we have the same issue that arises, the person that just helped us on the customer service line, that we would have their extension, so we could go back to them versus feeling like we had to get back in line. So they are working on that. They will be providing that soon.

And then also from a Medicare perspective, Medicare can be very complex. So one of the things that OptumRx and us have talked and were pursuing is that when people call in, they can specifically hit a number saying they're, you know, calling in for Medicare, and they will

have a subset of CalPERS contact agents that are trained specifically on Medicare.

The other is denial rights. When we spoke, we looked back, starting mid-August, the denial rate was as high as 33 percent. And so behalf -- on behalf of our members, we are meeting weekly, including we have a dashboard that we are looking at at those denial rates. I'm pleased to report that over the past few weeks, it has gone down to an average of 14 percent. In fact, we've seen it as low as 9.76.

But don't think that we aren't -- we're taking the foot of the pedal, we're still continuing to keep our eye on the ball and continue to get those rates down even lower.

In fact, one of the things we were finding specifically with our retirees, there is a CMS rule related to 72 hours. The prior authorization comes into this system approximately Wednesday or Thursday, it will automatically hit -- because it's based on calendar days, not on business work weeks, it will automatically receive with 72 hours over the weekend a denial without anybody doing anything about.

So we are actually working with our stakeholder groups, with Optum, and potentially talking to CMS to see if there's things that can be changed, because that

actually skews the numbers, and so we're seeing what we can do there.

The other thing is related to our most vulnerable population of 85 and older, Social Security had put in place, which we are also looking at doing, where someone is 85 years old and been on the same medication for 20 years, it's not a population that you normally mess with, unless there's some -- you know, CMS comes out and there's some, you know, risk to that member, we are looking at trying to get that down, so they will not be having to change their medications unless it's medically necessary.

And then from a technology perspective, technology is how we interface with our vendor partners. And so since we have last met, they did -- OptumRx did experience a major data center outage. They lost all power, which obviously brought down all their mission critical systems. We've also had members discuss that and come to us to say that their web portal was not up.

Again, that's the face of the company, and so we are working with them to put mitigation steps in place, so that they are keeping these systems from a high availability perspective, so they're -- they are available when our members need them.

And from a final update, as with any migration effort, CalPERS has high expectations of our vendor

partners. In fact, we have built in accountability metrics. You've asked about the contract, both OptumRx and CalPERS acknowledged that the migration could have gone smoother. And so therefore, OptumRx has issued CalPERS a $1.5 million check to be brought back into the system to adjust, because they didn't meet the contractual obligations listed. And OptumRx has also submitted a correction active plan and is currently addressing that with CalPERS.

So with that, I'd now like to turn it over to John Prince, the CEO of OptumRx who will provide you more details on exactly what they're doing in relation our members issues at hand.

--o0o--

MR. PRINCE: Thank you, Liana.

Madam Chairman -- Chairwoman and also and also members. I'm John Prince. I'm the CEO of OptumRx. I started in that role in April of this year. Prior to that, I was the Chief Operating Officer for all of Optum, so both the operations and technology. We take service very seriously in terms of our excellence. We all also know that we are extension of the CalPERS brand and experience, and so are very focused on making sure we're hitting those expectations across our organization.

What I'd like to do today is spend a few minutes

talking about where we're at right now, what are the actions that we've taken, and what are the additional actions we're going to take through the balance of the year until next year to make sure we're delivering that experience that is you expect.

--o0o--

MR. PRINCE: In terms of overall, we have 18,000 people in OptumRx, 3,000 of them are here in California and over 100 of them are focused specifically on CalPERS. We've been working on creating very dedicated sites, so that as part of the experience we have them in Costa Mesa, and Cypress, and San Diego that we're working to make sure that they're working more closely together in terms of the execution.

--o0o--

MR. PRINCE: In looking broader around how the experience happens in the pharmacy space, we try to balance four key areas. One is focus on having excellent pharmacy benefits, second is around the long-term sustainability and value of the plan, third is clinical safety and effectiveness, and lastly, but most importantly, is the member experience.

And what we've been working with with CalPERS over the last few months is making sure we have that right balance. And as I walk through the examples of the areas

that we'll talk about as you do this balance, you have to balance all those attributes to make sure you're making the right choice, both for the organization and for the member.

The level set, I wanted to walk through a couple of key statistics just so you have the background of what we do on behalf of CalPERS each day. These are the statistics as of September 30th, so nine months of the year. We've actually served 544,000 members. We've fulfilled six million prescriptions. We've answered over 566,000 calls, and we also have gone through a market check. And as part of that, we came out of there without any contract adjustments. And so that the rates that we're providing as part of the contract are still market relevant.

--o0o--

MR. PRINCE: In terms of the feedback that we received from the organization. We it received very specific feedback, and it was a great partnership in terms of both hearing from management and from member focus groups, from the Board itself around where we could do better. And we take it very seriously, and we've actually addressed the root causes of that, had to develop action plans to go after it. And I'm going to talk to you next about what we're doing.

--o0o--

MR. PRINCE: As Liana mentioned, the focus is really on three broad areas. First is around the member experience, second is around the formulary, and third is around prior authorization. And I'm happy to answer any questions about some of these areas, because I know that if you don't live with them each day, they might be -- you might have questions.

--o0o--

MR. PRINCE: So what I'd like to do is talk through what are we doing specifically in each of these areas and then this is the impact for the CalPERS members.

So maybe to start off with the formulary. I know there was a lot of the discussion in the meeting a couple months ago around what was on the formulary and what was not. A lot of work has been done in conjunction with CalPERS management about evaluating the old formulary, what we have today, and making decisions.

And when you go through that process, there's clinical decisions, there's cost effectiveness decisions, and also there's understanding around member expectations. And a lot of the member expectations, as Liana mentioned, is for individuals that are over the age of 85 that have been on medication for a long period of time, is it really necessary in there CMS guidelines around should we make

changes or not?

So we've made a couple of significant changes. One is we've removed the member pay difference for Medicare participants. That makes the difference between brand and non-brand removes that penalty. We've down-tiered select products. So for example, Synthroid and other medications from the old plan, we've actually made them tier 1, so it adjusted the member out of pocket.

And we've also made expansion to the Walgreens 90 preferred network, as looking at addressing some of the access questions that people had around -- throughout the State of California. Did they have enough geoaccess to do -- to get to their medications?

What that means for CalPERS members is that lower out of pocket cost. And so are very targeted and focused on that. But in terms of formulary, this is an ongoing process, so we did this evaluation, but we're going to continue the dialogue around formulary. There's always medications that are coming out, new clinical information that's knowledgeable, in making sure we're continuing to do that evaluation.

The member experience, which we've also gotten a lot of very specific feedback on, we've done a lot of work on, and continue to do that. A couple of examples about what we've done is we've continued to the secret shoppers.

CalPERS came in, did 200 secret shoppers. We're continuing to do them on ourselves to make sure we know that the experience we're delivering is what we want. We're doing additional one-on-one training between the supervisor and the front-line person to make sure we're delivering the experience and expectations that CalPERS wants.

We've also focused on some of the gaps between when somebody calls in and they need to do a prior authorization of how can we make that connection more effective. And so allowing that when they're on the phone, having real-time chat and other capabilities, so if they need support from somewhere else, they don't need to transfer the person, they can actually get it solved real-time.

And then lastly is we're working on implementing the opportunity that Liana mentioned, which is, as somebody calls in, they're a complex Medicare patient that they can actually then get to that same person next time, so they don't need to explain their story.

Even though, we have good notes, I think when you are at a certain age and you have a connection with somebody that you want to reach them again and talk about your issue, and start addressing that from a technology standpoint to make sure we can deliver that. All that

results in a better experience for the member.

The last area is around prior authorization. And so as you look at prior authorization, prior authorization there's a reason why we do it. And so it gives you -- and the numbers is we do about 4,000 prior auths for the commercial, and for the Medicare program per month. So that gives you sort of a number around it. Usually, it's done with a balancing clinical appropriateness, about will you prescribe the right medications, ensuring we're following CMS guidelines. So Medicare has specific guidelines for their beneficiaries around what we prior auth. And also looking at clinical appropriateness and upholding member experience.

And so based on evaluating prior auth program, we've made several changes. First of all is for individuals that are over age 85, that vulnerable population that we've removed those prior authorizations, and making sure that we are handling them in a more -- in a different way.

Second is we're looking at introducing more proactive prior authorization. So we're introducing a program where we're looking out more proactively and saying okay a prior authorization is coming due. Usually a prior authorization is only 12 months, so if that is the case, proactively reaching out to the member and to the

doctor to make sure we address it up front. And then we're in the process of consolidating our prior authorization group, so that they're more centralized. They can be managed better. And then co-locating a few of those with our customer service. So they actually are co-located in the same pod in a group to improve the interaction between those individuals. All the objective is really to improve the execution on behalf of CalPERS member.

So that gives you a perspective of what we're doing. It's a continuous process. So these are examples of it. We actually are working with CalPERS management of other areas that we wanted to continue to introduce through balance of fourth quarter and into next year, continue to improve the experience for members.

--o0o--

MR. PRINCE: The next few pages I think you've already seen the results. And so I don't want to spend a lot of time going through it, but you see overall, from a customer service standpoint, improved. What you'd expect in the customer service is about a three to four percent transfer rate. And so we made the changes in our operations to make sure we're executing for that.

--o0o--

MR. PRINCE: In terms of the prior authorization,

we've had significant results and improvements. Even though this data stops on October 15th, I can report that the next two data periods continue the trend in terms of our improved execution, as well as the appeal process.

And so good progress on that, I know it's off topic, because we just had it in the last one, but I do want to report that we're very focused on the opioid area in terms of our own risk management program. We introduced the -- our nationwide opioid risk management program to CalPERS in September this past year, which means that we're following CDC guidelines on short-acting 7 day, 30 day, chronic, and acute, and actually is prior auth. So you actually will see prior auths go up as part of that, but it's actually to help address from opioid standpoint, in terms of clinical effectiveness.

--o0o--

MR. PRINCE: So I could conclude in terms my comments is that we're very focused on our experience for CalPERS. You have my commitment as the leader of that organization around how we're executing for CalPERS. You are a very important client from our standpoint. We're doing everything we can to work around how we execute even in a better way. And I'd say that you're making us a better organization. So again, I'll turn it back to Liana.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Thank you, Mr. Prince. I just want to acknowledge, I know obviously you weren't here during the transition, but being a prior chief operation officer, you have really taken everything that we've worked together on at heart.

So it's at the core of what you bring is the operational background. We've made a lot of progress. There's still a lot of progress to be made. And I look forward to continuing to work with you on this.

Madam Chair and Committee, this concludes our presentation. We're happy to answer any questions.

CHAIRPERSON MATHUR: Thank you. I do have several members from the Committee and a few members of the public who wish to speak. Would the Committee rather speak first or hear the public first?

Okay. I think the Committee has comments they want to make first.

Mr. Feckner.

COMMITTEE MEMBER FECKNER: Thank you, Madam Chair. First of all, Mr. Prince, I want to thank you for being here today. I realize that you weren't the beginning of this problem, but the problem exists nonetheless. So we thank you for coming today and sharing with us what you've done so far.

I don't want to dwell on the past. I want to

dwell on going forward and continuing this partnership between us and you, and with Optum, as well as our members. They have lots of questions and concerns, and we hope that you're going to open to helping us solve those. It's been a -- it's been a rocky road, but I think that you've made some good inways here and I'm appreciating the fact that you've come before us and shared with us the changes that you've made. And it looks like a very positive direction, so I thank you.

CHAIRPERSON MATHUR: Thank you, Mr. Feckner.

Mr. Bilbrey.

VICE CHAIRPERSON BILBREY: Thank you, Madam Chair. Thank you also. I think you also for coming today. I'm not sure my fellow Committee members share some of my thoughts, but I -- while I'm happy you're here and things are improving, we shouldn't have to have you here today at all.

The issues we've had are -- have been unacceptable. At time, I truly wonder, and I think many of our members wonder can you truly handle our business?

The migration -- it was stated the migration could have gone smoother. I think that's pretty much and understatement, in listening to the members -- hundreds of members that we've been listening, many of us as Board members about the serious service issues they've had.

And technology, it's still baffling to me how a company the size of yours has some sort of technical -- technological issue in which it goes down. I mean, that's a threat to our members, and that's very serious. And I would expect that you would have some strategic plans or some type of plans in place like we do, that if something goes down, we have to be accessible, so -- but I appreciate the actions that are taking place.

And we are very concerned about how confident we are going forward. But what I heard today, I think we are on the right track, and I thank you for being here.

MR. PRINCE: Thank you, Mr. Bilbrey. Appreciate the comments. I don't want to be here in this circumstance. I would rather be here talking about the great value that we're delivering for the organization. We are. But our member experience is not up to what it needs to be. And we serve 65 million people. We actually do it very well across the organization. We could have done our initial implementation with you better, and we will continue to drive a better experience from you. And so you have my commitment to drive to that. We're very passionate about our Net Promoter Score, and how we're actually driving that type of culture through our organization and continue to improve.

The data centerpiece was shocking for an

organization that is as sophisticated as ours. For IT people it is a tier 3 data center. Tier 3 data centers are not supposed to go down. They've got, you know, multiple backups, in terms of what went down, and so it was a special cause in terms of that.

As a result of that, we've actually taken significant action to address that, and have been working with the technology staff at the State and CalPERS to make sure that we understand what happened, what we're doing. High availability is a critical priority from my standpoint.

Just to tell you how important it is from my standpoint, is that I stopped all of our development for the fourth quarter to make sure that we are addressing our high availability and our business continuity plan, because it should never happen. It should have been 20 minutes in terms of downtime.

To let you know, members still got their medications. So even though our system went down, we do have policies and procedures in place, so that somebody can go to a retail store, and still get their medications on that specific day, but it was still unacceptable.

I'm sorry.

CHAIRPERSON MATHUR: Thank you.

Mr. Gillihan.

COMMITTEE MEMBER GILLIHAN: Thank you, Madam Chair. Mr. Prince, first as one of the Committee members that requested your participation in this hearing, I do want to thank you for being here. I know you could have sent somebody else to sit on that seat right now, and maybe wish you had. I don't know. But we do appreciate you being here.

You know, this Committee doesn't always agree on the issues. And, in deed, the full Board doesn't always agree on issues. But there's one thing that I think does unite us and that's the care our members get. It's very important to everyone of us. And I think you're going to continue to hear that in the comments here.

And I certainly appreciate the work you've been doing and that you've done with staff. It looks like, as Mr. -- as President Feckner said, that we're on the right track, and that's good. But I have to say, it shouldn't have come to this. You knew what you signed up for when you bid on this contract, and what doing business with CalPERS is going to be like. And our members and our retirees shouldn't have to come before this Board and tell us these terrible stories about the treatment they were getting, or the lack thereof, and the way their concerns are being handled by your company.

So I hope going forward that you've learned to

listen to your customers, and particularly our members, and treat them with respect and dignity they deserve as human beings.

So thank you.

MR. PRINCE: Thank you.

CHAIRPERSON MATHUR: Thank you.

Ms. Taylor.

COMMITTEE MEMBER TAYLOR: Thank you, Madam Chair. Mr. Prince, I do appreciate you being here as well. And I am very happy with the progress that you're making with our team. I think one of the things that I have a concern with is -- you said just a minute ago that you serve 65 million people. Before we came on board, and we asked for this kind of service, and we had to actually hear from our members on a daily basis about the lack of service, the lack of customer service, the lack of care they were receiving, it makes me concerned about your other members that you were serving.

So it -- it -- the thought -- and I'm hoping you're making this a bit -- you know, making these changes throughout your organization, because it concerns me just as a person that this kind of behavior was going on prior to our getting here, and our signing up with Optum, what were you doing with your other members?

Just as a person that really concerns me. The

fact that we, again as Mr. Gillihan and Mr. Feckner had said, we heard stories from our retirees, from our members. I heard people coming up to me constantly my own members asking what's going on? I can't get pre-authorization.

I'm very happy with the progress you're making. I reiterate what Mr. Gillihan and Mr. Feckner said. I'm a little disappointed that we even had to get here. And I certainly hope that you are implementing these changes throughout the organization so that your other 65 million people that you serve are not in the same situation, or receiving the service that we were initially receiving.

MR. PRINCE: Ms. Taylor, our focus as an overall organization is really around two fundamental things, value, and the experience and quality for our members and the clients we serve. And so from my top of my organization of how I actually approached it, that's what I'm focused on. So that second piece, which is on experience and value, and quality is extremely important to us.

Just to give you a little backdrop drop so that you don't feel that we're unable to -- we're not up to the task to handle CalPERS. We actually implement every year about three and a half to four million new customers. We do that exceptionally well. Our retention rate across our

book of business is 98 percent, which is the best in the entire industry. I think retention rate is the best way to say do people think you're delivering a great value?

I think our experience in our quality of our -- of how we delivered to you could have been much better. We're fixing it. We actually have a significant effort we have been working on since taking over around stepping up how we deliver experience across our organization.

And I think you'll see that from other external sources, whether it's JD Powers, are the ones that we've actually improved our execution in the ratings that are coming out, and in terms our execution, not just for CalPERS, but across the organization.

CHAIRPERSON MATHUR: Thank you.

Mr. Jelincic.

BOARD MEMBER JELINCIC: On the formulary issue, you're making progress, and I have some sympathy there. Obviously, I've heard from members whose drug moved from preferred to non-preferred and they're copayments went way up. I will also acknowledge that nobody who went the other way and had moved from non-preferred to preferred called me to complain, but you're making progress.

What have you learned from the secret shopper program?

MR. PRINCE: Good question. So Mr. Jelincic, in

terms of what we learned from the secret shopper program, I think that while people might be reading from the script, they're not actually getting to the intent or the spirit of actually the experience. And so I'm lesser -- less focused around people answering the questions wrong versus not actually giving the service experience. I also think there's a level of ownership that is not being -- I mean, ownership by the call center person, that they're not always actually owning the issue, and actually empathizing from a -- and then actually delivering that experience.

And so those would probably be two areas where I would say that we need to do better as result of those secret shopper.

BOARD MEMBER JELINCIC: And obviously, you're making improvements on the prior authorization. But what was the problem initially that it was so high?

MR. PRINCE: I think the -- you know, when you enter a new program, you're balancing the components around making formulary changes, what you want to do from clinical effectiveness and CMS, that we had moved too far in terms of balancing the CMS, the financials versus the impact on the member.

And so there's a balance in there around that. And they specifically, for people that are the vulnerable

population that we needed to make changes there. And so that was the importance of the partnership with CalPERS management around -- as an organization who's implementing on their behalf that we needed to adjust what we are doing.

BOARD MEMBER JELINCIC: And you've obviously made some progress on the percent of calls transferred. There's a big drop there in June. But part of the description is that the service representative is advising them were told about the parameters for transferring calls. So are you -- did you change why transferred calls or were they just not understanding that they shouldn't be transferring calls? I mean, what was there?

MR. PRINCE: I think part of it, when you enter into a new program, is do people really understand the CalPERS benefits, and really feel confident to answer a question. And when you are a call center person, the east thing to do if you don't feel confident about something is you transfer it somewhere else and not own the issue. So this is back to the secret shopper feedback, is that that's an important thing for a customer service agent to say do I own the issue, do I feel confident in solving it, and do we -- and are we giving them the support.

And so a lot of also what you don't see in the data here is we're also changing our technology behind it,

so with pop-ups and other things, so that the agent can actually answer the question better.

BOARD MEMBER JELINCIC: And a broader question. Obviously, when you first started there were some major problems. You wrote a check for it. You're making improvements. But broader question, what went wrong in the first place? What did -- what did you not anticipate or what did you make bad assumptions about?

MR. PRINCE: Well, without being here, so it's hard to actually do a retrospective. I've actually been here. This is my fourth trip to Sacramento since I've joined, not just for today, but in terms of it. So my perception is actually 98 percent of it actually put it -- went pretty well, in terms of you don't see those components on it. But when you look for a change of this magnitude, I'd say most of it actually went very well.

I'd say that we did not understand the culture as much of CalPERS in the experience that CalPERS was hoping for from that culture and the membership experience, that we -- as you balance the four elements, we didn't -- we didn't learn as much from that. We didn't execute as well for that.

BOARD MEMBER JELINCIC: So the biggest problem was, if I heard you correctly, is just not understanding the culture of what you were walking into?

MR. PRINCE: I'd say yeah. And then also making sure we setting up our people to execute against in that culture. So that they were actually executing more in a transactional way versus, I -- think, there's an expectation in CalPERS around a sense ownership, in terms of what you're looking for, which we weren't delivering for, and that resulted in some of the numbers.

I'd -- also, I'd say that we weren't thinking as much end to end around our experience. And so I think that's just separate from just -- for CalPERS is that I think we could have been much better in terms of how we that about the end-to-end experience for you.

BOARD MEMBER JELINCIC: Thank you.

CHAIRPERSON MATHUR: Thank you.

Mr. Lofaso.

ACTING COMMITTEE MEMBER LOFASO: Thank you, Madam Chair. Thank you also, Mr. Prince, for being here. I agree with other Committee members in the various expressions of it shouldn't have happened.

I guess I still don't fully understand all of what you're telling us about prior authorizations. So I want to ask you how long does a prior authorization take, or how much work is involved, or how many person hours? You say 4,000 prior authorizations. I don't know what that number means.

MR. PRINCE: So a prior authorization, think about it as if you were prescribed a drug that there was -- needed to be a prior authorization. And so what would happen was that there would be an interaction between the OptumRx team and your doctor's office. And there might be both ways how the doctor would want to interact, but there might be a -- unfortunately, most doctors' offices want a fax. We have electronic ways of doing it, but typically, it is done by fax.

And so either we'd -- they'd fax in information. It would be evaluated, put into a form on a system, that actually will look at the clinical effectiveness. Actually, there is a decision tree around whether --

ACTING COMMITTEE MEMBER LOFASO: Can I interrupt you?

MR. PRINCE: Sure.

ACTING COMMITTEE MEMBER LOFASO: There's some of these things I understand. I asked you how long does it take?

MR. PRINCE: Oh how long it takes, it might be, you know, total time, most of them get done in like eight hours in terms of the actual person time might be an hour.

ACTING COMMITTEE MEMBER LOFASO: Okay. I mean, the reason I ask is the experiences I'm aware of relative to the transition of the migration from the prior PBM are

there was an expectation that individuals would have their medication regimens continue until they were able to sort of slog through a new process under a new set of rules and a new formulary, hopefully with the intention of continuing their regimen largely as is after they adjusted.

That, as I understand, is fundamentally what didn't happen. And the metrics, I don't understand what those mean relative to that. Because I understand what it means if appeals are down, and denials are down. But I don't know if that means those individuals ultimately slogged through the system and got their regimens continued, or if they just had to give up somewhere?

I mean, the reason I asked the question the way I did is most people view prior authorizations as a grueling process, where you might not get through it, and if you're doctor isn't at your side, and some physicians don't want to get involved with it.

So the metric I didn't see was how many people got through the process of transition such that their medication regimen was ultimately not disrupted. That's the one sooner or later I'd like to see.

MR. PRINCE: Right. I think that's -- that's a great metric. We could actually get it for you, because one of the key metrics I look at is ultimately a

continuation of medication treatment. And so that is one of the core elements that I look at across the -- especially in the specialty business, which is usually the high cost, but also the most complex patients to making sure that they're getting their continuation of medication treatment. So we -- actually, we measure that across the book of business in terms of managing that.

Our goal is not to make the prior authorization process complicated. It's actually to go through a decision-tree process. We're actively working on how to make that process part of the doctor's experience. So we offer physicians multiple ways to actually do that electronically. So we actually have offered multiple trees and methods for somebody to actually go in and do it automated, so that it actually would go straight through and actually authorize it.

One of our biggest investments that we're doing in this organization is to embed that technology into a doctor's electronic medical record, so that as they're doing the prescribing, this is actually solution has been rolling out. It's called pre-check my script, and allows somebody to actually check does it require prior authorization, and actually complete it in their EMR as they're going through their prescription.

So our investment and our focus for the future is

we're actually making that process seamless to the doctor. So what happens when the patient is actually in front of the doctor, they can see those information, and actually move forward. So that is our intent about where we're going. As an organization, that's where most of our investments are.

And to clarify the eight hours, it was not because it's just a -- you know, it's a relaxed overall time. It is an hour. But when you go back and forth, there's a lot of back and forth, and saying, okay, did you get the information? Did I fill it out right? I mean, there's a -- it's not the ideal process today. We recognize that, in terms of the elapsed time, and that's why we're looking to automate that going forward.

ACTING COMMITTEE MEMBER LOFASO: Appreciate that. Hope you can produce that metric.

MR. PRINCE: Okay.

ACTING COMMITTEE MEMBER LOFASO: Thank you, Madam Chair.

CHAIRPERSON MATHUR: Thank you.

Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you, Madam Chair. Yeah, I concur with my fellow Board members, Mr. Gillihan and President Feckner, so I'm not going to repeat what they said, but I absolutely concur with what they

said.

And as you might have expected that this problem started small drip, drip, drip and pretty soon it reached a critical mass where people were complaining, et cetera, in order to get the attention to begin to try and address the problem.

And there's another drip, drip coming, and I'm going to ask you this question. But I don't want you to respond until the discussion on this issue is done, but I would like to hear your response on this issue of clawback.

We're beginning to get drip, drip pieces of information about the clawback, where a customer is prescribed a medication, and the pharmacy benefit manager negotiated a co-pay. And the pharmacy is reimbursed, and the benefit manager claws back a profit. And because your firm was mentioned in an LA Times article, and that's why I'm raising the question, so -- but I don't want the answer now. I want to wait and complete all the other issues, and then I would like your response in that area.

MR. PRINCE: Okay.

CHAIRPERSON MATHUR: Okay. Thank you.

Mr. Saha.

ACTING COMMITTEE MEMBER SAHA: Thank you, Madam Chair. I want to just actually ask you a quick

question -- a couple quick questions. But first the -- you'd mentioned in your presentation about the denial rate. It moved from 33 percent to 14 percent, is that right?

MR. PRINCE: Correct.

ACTING COMMITTEE MEMBER SAHA: And can you elaborate on why that was such a dramatic decrease?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: We believe a lot of it had to do with education, explaining that prior auths, remember the whole 72 hours, trying to get those in Monday, Tuesday or Wednesday has obviously sent the right message to the right providers. So that's helped. And then obviously looking at the formulary and speeding up the process, so that they don't have to get into a prior authorization situation in the first place.

So it's been multiple facets, but overall I'd say it's probably the CMS piece that we've just worked through. We still don't think that someone getting a prior auth on Thursday should get a denial automatically, because they didn't fit within the 72-hour window. So we still need to address that at a federal level. And we will be putting our signature behind getting that changed, if we can, in any manner possible.

ACTING COMMITTEE MEMBER SAHA: Okay. And just really quickly, the second question that I had, or you had

mentioned, I guess, that prior customer service representatives, if a member calls in and they have a customer service representative that if they call back at this current point, they don't have the opportunity to have that same service representative you said. I was kind of unclear if that is the current system set up and it's trying to be resolved where they call back and they get the same person for continuation of service or is that currently how it is or not? Are you working on it, or where are you?

MR. PRINCE: We actually are implementing that, so that as you go --

ACTING COMMITTEE MEMBER SAHA: And why is that -- why is that -- to a point that I think was made earlier about how your other millions of customers and how those are handled, I guess it's surprising to hear that that's not a part of something that you currently offer or offered prior to signing the contract, I guess, with CalPERS. So when would that be expected for members that they can have that kind of advantage?

MR. PRINCE: I believe we're within the last -- within a couple months of actually getting it fully implemented to that you -- well, the first piece is go off the call tree that actually say Medicare, so you get a group that's dedicated that knows the Medicare with

CalPERS specifically. And then we're actually implementing the technology done -- I can give you the exact data around when the technology will be implemented.

In terms of overall, we'll continually evaluating around -- usually, actually our whole goal is first-call resolution. So from an overall service about how we service all of our customers, we have high goals around fist call resolution. Everybody's contract is a little different. I mean, there's actually a lot of uniqueness around the CalPERS benefit.

And so what we've learned in our last many months around how we execute is we need to do more and more dedicated teams that are commingled to make sure we continue to deliver the experience you're expecting.

ACTING COMMITTEE MEMBER SAHA: Sure. And I understand. Boy, I think it really speaks to what I think everybody on the -- pretty much everybody on the Board has mentioned that it's -- it seemed like a really readiness failure. It's really to kind of prepare because you're unaware of what the level of customer service, I think, that the members are expecting. So -- but thank you for coming.

CHAIRPERSON MATHUR: So I think one of -- what you've heard is that, number one, this Committee and the Board recognizes that you being here, your engagement, to

date, it really indicates a commitment to this relationship, and we really appreciate that and respect that.

Clearly, there is -- there are -- there have been some concerns. And one of the driving concerns for me, and I think was expressed by some of my colleagues is that it took our own members elevating key issues for Optum to become aware of them. And so that raises a question in my mind about how you monitor, track, assess, your own performance, the performance of your team, and how is that operationalized in such a way that moving forward we won't have to have, you know, a number of high profile cases come before us, you know, brought by our member groups, which we are so grateful to them for highlighting these issues, but they shouldn't have had to -- it shouldn't have risen to that.

So I guess how are you going to ensure that that does not occur again? How are you going to monitor your own performance and ensure that these types of issues are nipped in the bud early before they become really serious?

MR. PRINCE: Sure, Madam Chairman -- person. In terms of just the overall focus, really two things that we're focused on. One is changing our performance metrics, so we actually worked with CalPERS around what are the metrics you're using that are more proactive to

making sure we're identifying those issues sooner, as well as adding additional metrics in terms of our performance score cards, around how we look at ourselves daily, weekly, monthly, quarterly. So a metric is one piece. The second one is better engagement with the member groups.

I think we've not been plugged into the member groups candidly until the last couple months. And so we've actually been engage -- figuring out how we actually can use them as user groups to actually get better feedback, both on what is going not as well, but also in terms of as we continue to enhance the program about how we can use them more effectively to get their feedback.

CHAIRPERSON MATHUR: Okay. Thank you. Well, before I turn to public comment, which there is some, I would think we should come back to Mr. Jones question around clawbacks. Are you prepared to address that as well?

MR. PRINCE: Sure. Mr. Jones, in terms of the clawbacks, maybe just to be clear on our position, that way pharmacists should also be always offering the member the lesser of any amount in terms of by the plan design. And so our contracts have been very explicit around that whenever a situation is, that the member should get the lesser of the plan design, what can be offered by the

retailer in terms what they pay out of pocket.

COMMITTEE MEMBER JONES: So you --

CHAIRPERSON MATHUR: Sorry, Mr. Jones, let me get you back up.

There you go.

COMMITTEE MEMBER JONES: So you are certifying that that's the case, in your -- at Optum?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Mr. Jones, I can state that in CalPERS' contract with OptumRx, there is no clawback clauses.

COMMITTEE MEMBER JONES: Okay. Okay.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: They're not permitted. Our members, when they show up will get the best price.

COMMITTEE MEMBER JONES: Yeah, because the -- I mean, the articles that I'm looking at here, it's --

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: At the national level, but we -- actually, once those articles came out, we did go down and have a conversation with John and his team, and we clearly do not have a clawback clause. And so if the cash price for the same medication is cheaper than the co-pay, our members will pay the cash price.

COMMITTEE MEMBER JONES: Okay. I'll take that.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: And if

any member is not experiencing that, please let us know.

CHAIRPERSON MATHUR: Okay. Thank you. So we do have a few members -- excuse me -- of the public who wished to speak on this item. Tim Behrens, Larry Woodson, and Donna Snodgrass.

And I'm going to allow four minutes per speaker.

MR. BEHRENS: Madam Chair, members of the Committee. Tim Behrens, President of the California State Retirees. I'd like to thank you for letting me give you some public testimony this morning.

At the September 19th Pension and Health Benefits Committee meeting I gave public comment regarding continuing problems our members were experiencing with OptumRx for pharmaceutical drug services, including much higher costs, pre-authorization difficulties, poor customer service, prescription denials, and many denials of appeals. Larry Woodson, our Health Benefits Committee Chair and other stakeholders presented individual member's personal stories of their bad experience with Optum.

Well, at this time, I'd like to thank the Board members for your responses to our comments. You offered many statements of support, concern, and direction to the staff to address these problems.

Since that time, stakeholder group's support representatives met with CalPERS management and health

team members, and top Officials from OptumRx to give additional input and hear what actions are being taken by CalPERS and Optum to improve services under this $4.9 billion contract.

I'm happy to share with you that since September 19th, we have begun to see significant improvements in the many areas we identified as problematic. Mr. Prince's presentation this morning showed some graphic representation of those improvements. We believe things are trending in a positive direction and appreciate the efforts of CalPERS staff, as well as Optum in making corrections.

And again, I want to thank the Board members for your support and direction. We are hoping that these trends continue, and the positive changes become more systemic. And, at this, time Mr. Woodson has some additional feedback for you from members who have recently contacted him.

Thank you very much.

CHAIRPERSON MATHUR: Thank you, Mr. Behrens.

Mr. Woodson.

MR. WOODSON: Good morning. Larry Woodson, California State Retirees. Madam Chair, members of the Board, thank you for the opportunity to comment. I concur with Mr. Behrens and thank each of you for your supportive

comments at the September 19th meeting regarding the concerns we raised and member hardships we shared in dealings with OptumRx. And October 9th we had a productive meeting with Liana Bailey-Crimmins and her staff, as well as Optum's chief medical officer and their account executive, and then the same Optum reps attended our retiree roundtable last month, and reported actions that you've heard this morning that they've taken to address the many shortcomings we've experienced. And I too believe that things are trending in the right direction.

Since September 19th, I have received only one member complaint, which is unusual, and which has since been resolved to his satisfaction, and a number of positive emails and phone calls from members, some of whose stories I shared with you in the last meeting. One member reported receiving a call from Optum -- and Optum representative who was most helpful, was able to reverse the prior denial of a drug that she desperately needed. I shared her story with you in September.

Another reported being contacted by Optum and being refunded $280 for overcharges. Another reported a $300 refund, was quite happy. Also, members have been reporting calls from CalPERS staff who were helpful in intervening with Optum, and resulting in positive

resolutions. So we are seeing encouraging trends. We will continue to monitor.

That said, we do want reassurance that the positive trends are not just ad hoc changes to individual member complaints, and represents systemic long-term improvements.

To that end, I have requested a list of the drugs which are undergoing formulary change to our members' benefit, including, for example, moving to lower tiers. We were told that information would be provided in December. It sounds like maybe even at the end of this month.

We do remain concerned because PBMs, as a whole, are some of the least transparent and least regulated for-profit companies in the health care industry. And recently, it's come to our attention that there are multiple lawsuits in at least a dozen states against PBMs and prominently OptumRx for the practice that Mr. Jones already mentioned called clawback.

And in short, that involves PBMs setting customer copays with network pharmacies, which are significantly higher than what the drug costs the pharmacy. The pharmacy then takes a small profit and the rest goes back to the PBM.

There are gag clauses in many of these contracts

with the pharmacy and the PBM that prevent the pharmacist from telling the customer he could get the same drug at a fraction of the cost, if he chose not to use the PBM insurance.

And I did provide all of you with several articles that give greater detail on that practice. Four states have passed legislation -- anti-clawback legislation.

And so we don't know if this practice has, in part, been applied to our members, but it is of concern. We've heard this morning that it's not being followed here. But really the CalPERS contract itself would not -- I don't think would likely be the vehicle that would prevent it. It's really the PBM's contract with the network pharmacies where that practice is initiated. And I'm not sure how CalPERS would even know.

Finally, because of the lack of transparency for PBMs, CSR encourages CalPERS to endorse AB 315 by Assemblyman Wood, which CSR has endorsed, and which would require PBMs to be licensed in California and would place some reporting requirements on them for greater transparency.

Again, we thank you, the Board members, on this Committee for your support. We thank CalPERS staff and Optum staff for their recent efforts to help our members.

Thank you.

CHAIRPERSON MATHUR: Thank you, Mr. Woodson.

Ms. Snodgrass.

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

I'll start this morning by saying thank you to this Committee and the -- and the Board for listening to us, and for staff for working on the issues and including us in the conversations. They really did take the time to listen to all of our concerns, not just what we spoke here. They asked for more documentation, and the did a very good job.

We haven't resolved all the issues yet. There's some items that are still working to be insolve -- resolved. But at least they haven't been set to the side and ignored.

A good mid-benchmark for me is, like Larry said, is that since September I've only received one phone call -- one negative phone call. And prior to that, it had become a full-time job. And I didn't retire to take a fuel-time job, so --

(Laughter.)

MS. SNODGRASS: In my world though, no news is good news. Earlier, during the presentation from Optum,

you mentioned one-on-one training with supervisors and employees. And I have one situation. It's the one negative call that I have had since September, where I believe the -- there is a personnel problem with a supervisor.

And I don't want to name names. I've already spoken with Dr. Curtis about the individual, and I'm willing to speak further about that with the entire situation. But it seems like this particular person, as it was mentioned, didn't own the issue. They pretty much were blaming other staff down the ladder, and making excuses, but finally got cornered and had to fess up. But that's not good, if you've got somebody, even in middle management, doing that.

So I would like to pursue that privately and get that resolved. There's not need to make, you know, a public issue with one person.

I have some CMS questions, and not here today. I don't want to take up the time today, but would it be possible to have a meeting with myself or anybody else who wants to come along so that we can learn more about how CMS interacts and interfaces with our, in my case, my 100/90 formula.

If I were to be denied through CMS, doesn't the secondary insurance, shouldn't that cover that, rather

than getting caught in the CMS web?

I'm confused about it. If I'm the only one confused, I'm very happy to just talk to somebody on the phone and get it over with. But I have a feeling I'm not the only one confused with this CMS stuff, and that probably some of you on the Board might have some of the same questions. I'm thinking Optum might be a little confused with what our insurance programs are through CalPERS. Maybe just education. But I would like to make the request to be more educated on how those interfaces take place.

Thank you.

CHAIRPERSON MATHUR: Thank you for that suggestion. We'll follow up on that.

Okay. Oh, sorry. There's one more member of the public who wishes to speak on this item, Mr. Collier, if you could also make your way up here.

You can sit here to left. The microphone is --

MR. COLLIER: -- but these ease people are not providing the proper equipment.

CHAIRPERSON MATHUR: So if you could -- would -- if you please -- your microphone is on.

MR. COLLIER: Yeah.

CHAIRPERSON MATHUR: If you could identify yourself and your affiliation for the record.

MR. COLLIER: Yeah.

CHAIRPERSON MATHUR: And you'll have four minutes with which to speak.

MR. COLLIER: Yeah, I realize. Gary Collier, CSR, California State Retirees. Very proud of it.

But I'm having problems with this company. I've asked them and asked them, please give me the larger container for the needles cause some of them are rather large, about that size. This not going to fit two of them in here, hardly three, but that's okay.

They are denying me, and God only knows how many children -- and I'd like to go get maybe investigated, knowing full well about the medicine I take. It's very expensive. It's about 40,000 for one a year. Then it's 10,000 for the cheaper one, at 2,400 for a 90-day supply.

That's a lot of money, and still it keeps me alive. I've had a stroke this year, because I did not get it in a timely manner despite CVS giving them the prior auth. And I provided the prior auth. And yet, they still deny me. As of that date, the last one I provided was March.

CVS did just sent it on, and these people just ah, na, na. They don't want to give me the meds which keep me from breaking bones, and keep me from bleeding, and having a stroke. That's life threatening.

Now, I don't want ever -- I will sue them in a heart beat, Mr. Prince, if you get this drift, you will know I need to also be able to bypass the basic stuff and get the numbers for these people, so I can connect them and say, hey, so-in-so is being a problem. They don't identify themselves, and the denials I keep getting no denial letter, so I can't appeal it.

They just, no, we're not going to give it to you anymore. It's outrageous conduct. And it's life threatening.

I wish you'd take the contract away, but I think that statement, where he's going to be sued, Mr. Prince, if he denies me one more time. They need to slap these people upside the head, but that's illegal.

But doggone it, that's four enough. If you want any questions, you're not going to get my PHI.

(Laughter.)

MR. COLLIER: But if you've got a question anybody, I'd be happy to tell you. I'd love to actually ask Mr. Prince do they know what they doing? Do they get told when they do a denial. I had two authorizations. I don't know how much time -- I can't see, but -- I don't how many authorizations they got, but this is outrageous conduct.

Blue Shield did it for eight months. It's

outrageous. It's criminal behavior, as far as I'm concerned. And I'm going to go talk to the Insurance Commissioner, and say, hey, let's look into this a little deeper than their word, but that's enough said.

Thank you.

CHAIRPERSON MATHUR: Thank you very much, Mr. Collier.

MR. COLLIER: No questions?

CHAIRPERSON MATHUR: I don't think -- I don't see any questions. Thank you.

MR. COLLIER: Cool.

CHAIRPERSON MATHUR: Okay. Well, that brings us to the Agenda Item 9, which is the summary of Committee direction.

Yes.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Madam Chair, there was one from Mr. Lofaso regarding a disruption metric, if you wanted me to put that as a Board directive?

CHAIRPERSON MATHUR: Yes, I think so. And then also to explore on the opioid side --

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: The treatment.

CHAIRPERSON MATHUR: -- the treatment side, as well as when Mr. Slaton was raising around limiting or

requiring prior authorization for a longer script. Maybe we can explore what that exactly means, but I think that was also on the table.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Sounds good.

CHAIRPERSON MATHUR: Okay. Thank you.

Well, that brings us to the end of the agenda, Agenda Item number 10, public comment. I have no requests here.

Is there anyone from the public who wishes to comment at this time?

Would you like to comment, ma'am?

Please come forward, take a seat to my left. The microphone is on. Please identify yourself and your affiliation for the record. And you'll have three minutes with which to speak.

Yes, right there.

MS. COFER-LARSEN: Hi. My name is Kristin Cofer-Larsen. I retired from CalPERS in December of 2013.

I was employed by Local Government Services, who -- Mr. Averett was supposed to be here. I don't think he's arrived yet to have comment.

But the CalPERS is looking at LGS and determining that they were not an employer -- CalPERS employer, where LGS is stating that we were, not only a CalPERS employer,

but I was also working as the Controller for the California Bay-Delta Authority, which was a State agency, that's no longer part of the -- it's been disbanded and part of Resources now.

At that time, it was 2003 I went to work for them. I left at the end of 2005. I retired in 2013. CalPERS knew that LGS was one of my employers. They apparently were already discussing some problems with LGS. I do not know this. It just is all hearsay that way. But I received a notice in June, I believe it was, saying that they were going disallow my three years with LGS. I also got further notice that I will owe -- they will reduce my benefit by 1,020 a month, and I will owe $45,000 back to CalPERS.

I've been retired four years now, and -- so I presented it to them that I did work for California Bay-Delta Authority. My boss -- my last boss at California Bay-Delta Authority is still employed by the State of California.

She is now with the science program that's moved to the Delta Stewardship Council. In all of this, we're having a really hard time getting people to understand that I was assisting a State agency. I got a notice on the 16th of October stating that they would deduct my benefits immediately. LGS was told that they would not do

this while we were in arbitration.

So on the 16th I realized, well, I have to go back to work. So this has dramatically affected my life. I am back to work now full time. I'm waiting to find out what the status is. It's taking an awfully long time. It's a horrible situation to be in.

2003 is how many years ago? And you're coming back. You let me retire at 2013 knowing LGS was one of my employers. So I'm in a really dire financial situation. So I just wanted to express my frustration with the process, and what's happening.

CHAIRPERSON MATHUR: Well, thank you for being with us, and we will -- we will look into this issue.

Thank you very much.

MS. COFER-LARSEN: Thank you.

CHAIRPERSON MATHUR: We do have one other member of the public who wishes to speak. Mr. Averett. If you could please take this same seat. Your microphone is on. If you could identify -- excuse me, identify yourself and your affiliation for the record. You'll have three minutes to speak.

MR. AVERETT: Sure. Thank you. My name is Richard Averett. I'm the executive director for Local Government Services that Kristin just spoke about. We -- the situation that she's describing is unlike L.A. Works.

We're willing to pay our share. We paid our share for 15 and a half years, and continue to pay our share. We -- there's no question that the employees that we provided to local governments were working as public servants, public employees.

We deliberately contracted with PERS to provide a benefit package for them -- a retirement package for them. PERS knew our model. They audited us in 2006, a payroll audit, and reviewed our records, reviewed every employment contract that we had, in which it showed where the employees was assigned.

The PERS audit process said that the PERS audit of -- that was concluded this year said that they were not our employees. They should have been -- they should not have been enrolled, because we didn't exercise a level of control necessary to establish common law employment employee relationship.

I think you all know that that's a judgment call, and we're appealing that judgment call. Where my objection -- and the reason I wanted to talk to you is because this could have been resolved without the legal process, or in addition to the legal process that PERS is pursuing, I'm not here to argue the legal process. I'm here to say that there should be something in the middle that requires PERS to consult with local agencies before

scaring the employees like has been done with all of our employees, threatening them all, and then reassigning or saying they're going to reallocate most of the employees, in other words, changing history for up to 15 years of our organization, that's a discretionary call too to go back that far.

And it's not fair to us or the employees to say, you know what, you were fine for a long time. We took your money. We had no problem with your model. We even helped you implement your model, and then we decide that 15 and a half years later, no, that's not right. We're going to undue all that.

And we just want some process to talk with somebody other than the attorneys to try to resolve this in a way that protects PERS' fiduciary responsibilities and protects what we promise to the employers.

CHAIRPERSON MATHUR: Thank you, Mr. Averett.

Thank you for being with us.

MR. AVERETT: Thank you.

CHAIRPERSON MATHUR: Appreciate it.

Ay other member of the public who wishes to speak at this time?

Seeing none.

The open session is adjourned.

/////

(Thereupon the California Public Employees' Retirement System, Board of Administration, Pension & Health Benefits Committee open session meeting adjourned at 11:13 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 19th day of November, 2017.

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