MEETING

STATE OF CALIFORNIA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

BOARD OF ADMINISTRATION

PENSION & HEALTH BENEFITS COMMITTEE

OPEN SESSION

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A P P E A R A N C E S

COMMITTEE MEMBERS:

Ms. Priya Mathur, Chairperson

Mr. Michael Bilbrey, Vice Chairperson

Mr. John Chiang, represented by Mr. 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

Dr. Kathy Donneson, Chief, Health Plan Administration Division

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

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

STAFF:

Ms. Sabrina Hutchins, Chief, Enterprise Strategy and Performance Division

Dr. Melissa Mantong, CalPERS Pharmacist

Mr. Gary McCollum, Senior Life Actuary

Ms. Antoinette Romero, Committee Secretary

Ms. Anthony Suine, Chief, Benefit Services Division

ALSO PRESENT:

Mr. Ted Behrens, California State Retirees

Ms. Donna Snodgrass, Retired Public Employees Association

Mr. Larry Woodson, California State Retirees

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1 P R O C E E D I N G S

2 CHAIRPERSON MATHUR: Good morning, everyone. I'm
3 going to call the Pension and Health Benefits Committee
4 meeting to order.

5 First order of business is roll. Call

6 COMMITTEE SECRETARY ROMERO: Priya Mathur?

7 CHAIRPERSON MATHUR: Good morning.

8 COMMITTEE SECRETARY ROMERO: Michael Bilbrey?

9 VICE CHAIRPERSON BILBREY: Good morning.

10 COMMITTEE SECRETARY ROMERO: John -- or Matthew
11 Saha for John Chiang?

12 ACTING COMMITTEE MEMBER SAHA: Good morning.

13 COMMITTEE SECRETARY ROMERO: Rob Feckner?

14 COMMITTEE MEMBER FECKNER: Good morning.

15 COMMITTEE SECRETARY ROMERO: Richard Gillihan?

16 COMMITTEE MEMBER GILLIHAN: Here.

17 COMMITTEE SECRETARY ROMERO: Dana Hollinger?

18 COMMITTEE MEMBER HOLLINGER: Here.

19 COMMITTEE SECRETARY ROMERO: Henry Jones?

20 COMMITTEE MEMBER JONES: Here.

21 COMMITTEE SECRETARY ROMERO: Theresa Taylor?

22 COMMITTEE MEMBER TAYLOR: Here.

23 COMMITTEE SECRETARY ROMERO: Alan Lofaso for
24 Betty Yee?

25 ACTING COMMITTEE MEMBER LOFASO: Here.

1 CHAIRPERSON MATHUR: And please also note for the
2 record that Mr. Slaton and Mr. Jelincic are also in
3 attendance.
4 Thank you.
5 Before we move into the items on the agenda, I
6 just want to take a brief moment of personal privilege to
7 thank a Board Member who has been my partner on this
8 Committee for the past several years, Michael Bilbrey.
9 This is his last Pension and Health Benefits Committee
10 meeting. And he has led, I think, this Committee and this
11 Board with great compassion and is really going to be
12 missed.
13 Thank you so much, Michael.
14 Now, to the executive report, Ms.
15 Bailey-Crimmins -- or Ms. Lum.
16 DEPUTY EXECUTIVE OFFICER LUM: Good morning,
17 Madam Chair, members of the Committee Donna Lum, CalPERS
18 team member. Before I begin with my short report, I, too,
19 would like to express our thanks and appreciation to all
20 of the support that we've had by Mr. Bilbrey for all the
21 items that we've brought forward over the last few years.
22 It's been very helpful to have you on the Committee, and
23 again, I wish you the best.
24 And turning to my report. I have three quick
25 items that I'd like to share with you. As you recall

1 previously, unfortunately for the last couple of months,
2 I've been reporting to you updates on our outreach efforts
3 to assist members that have been impacted by either the
4 hurricanes that occurred in Houston, Texas or in Florida,
5 as well as the fires of Sonoma and Southern California.
6 And unfortunately, another fire in Southern
7 California has impacted our members who are receiving
8 paper warrants. As we did previously, our teams worked
9 very quickly to identify. We worked quickly to identify
10 those members who were in the impacted zip code areas,
11 where we knew that mail disruption was occurring. And we
12 assembled a team that consisted of Information Technology
13 Services staff, as well as Customer Services staff to
14 contact these members, and to assist them as needed.
15 And so again, it's kind of an unfortunate
16 situation, but certainly we know that our members really
17 could use the support that we provide during those types
18 of situation, and we're very happy to do the extra
19 outreach and effort.
20 Also, this is a very busy time for the Benefit
21 Services Division, not only are they processing all the
22 year-end retirements, but in addition to that, they are
23 working on the annual process to ensure that over 600,000
24 1099 tax forms are processed to our members who are
25 receiving benefits in January.

1 And so all of that process is on schedule, and we
2 don't anticipate that there will be any disruption in
3 being able to get those out timely.
4 And then lastly, we are kicking off the 2018
5 CalPERS Benefit Education Event, also known as the CBEEs.
6 The first CBEE will be held in January on Friday, January
7 26th and Saturday, January 27th at the Embassy Suites in
8 San Luis Obispo. And then following that, the very next
9 weekend, we will be hosting our largest CBEE of the year,
10 and that is the Sacramento CBEE. And that will held at
11 the Sacramento Convention Center on Friday, February 2nd,
12 and Saturday, February 3rd.
13 Madam Chair, that completes my report.
14 CHAIRPERSON MATHUR: Thank you very much, Donna.
15 And thanks again to you and your team for all their
16 continued efforts in supporting our members.
17 Ms. Bailey-Crimmins.
18 CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Good
19 morning, Madam Chair and members of the Committee. Liana
20 Bailey-Crimmins, CalPERS team member. I, too before I get
21 started on my talking points for my opening remarks, I
22 really want to give Mr. Bilbrey a heartfelt thank you for
23 everything you've done. I know I've been on the Committee
24 for a year now, and we've tackled tough agenda items,
25 you've represented the constituents very well and our

1 members, and I just want to thank you for everything that
2 you do every day on behalf our employers and members.
3 Thank you.
4 So for my opening remarks, I have three items.
5 The first is to provide you insight on the ACA delay and
6 suspension bills that are expected to be voted on December
7 22nd that have an impact on CalPERS.
8 Also, too, I'd like to also share with you some
9 highlights where CalPERS's Health Program was recently
10 recognized by the New York Times and top research journals
11 for our continued leadership and innovation, where we make
12 a positive difference in the health care industry.
13 And then lastly, January 9th, CalPERS will launch
14 the 2018 annual health plan survey. And we look forward
15 to hearing from our members, because their opinion
16 matters.
17 And as a reminder, our member experience is one
18 of the recently adopted health care measures that is
19 reported and overseen by the Board.
20 So for the Affordable Care Act, the CalPERS
21 health team continues to monitor developments in
22 Washington D.C. for legislative, regulatory, and
23 administrative changes that may impact CalPERS.
24 And on Tuesday, December 12th, the House
25 Republicans proposed a delay and/or suspension to several

1 taxes. Currently, the bills are only supported by the
2 Republicans, but they come after bipartisan negotiations
3 with the Democrats. The proposed bills could be merged,
4 but with a must-pass government funding bill. And so the
5 taxes that we're talking about are a delay in the health
6 insurance tax for potentially two years, this year and
7 2018 and 2019.
8 This second is a delay in the excise tax on high
9 cost employer-sponsored health coverage, also known as
10 Cadillac Tax. So what's up for a vote is to extension for
11 an additional year. So instead of it starting in 2020,
12 potentially it could start in 2021.
13 And then lastly, eliminating penalties for
14 employers who do not offer health insurance to their
15 full-time employees as required by the employer mandate
16 through 2018.
17 Since we last met, the CalPERS reference pricing
18 model was highlighted in three publications. The first
19 was New York Times. The article was what states can learn
20 from one another on health care. The second is Health
21 Affairs, which is the top journal for health policy
22 research. And the 1700 studies that are submitted per
23 year only 10 percent are accepted. And so again, CalPERS
24 got accepted for our research this year.
25 And then third, is Duke-Margolis Center for

1 Health Policy. The article was *State Employee Health*
2 *Plans Can Be Leaders and Drivers of Value-Based*
3 *Initiatives*.
4 So some of just the highlights is the New York
5 Times reporter sites that if all states were to improve to
6 the level of top performers, we see gains across the
7 country. And CalPERS was named as one of those top
8 performers. The reporter also cites that CalPERS'
9 reference pricing models was very impressive. And
10 referrals to lower-priced hospitals increased by 20
11 percent, but there was no change to how well patients did
12 or how well -- or how much they paid out of pocket. So
13 that was -- that was a great article.
14 Another was Health Affairs on December 4th.
15 Henry Zhang, who works at the CalPERS Health Policy and
16 Research Division, did some key research, and compared
17 reference pricing to the Centers of Excellence models for
18 hip and knee replacement surgeries. The study concluded
19 that based on the data analytics, the reference-based
20 pricing design reduces price variation while the Centers
21 of Excellence design reduces variation in use. So that
22 was positively received.
23 And then the last one is Duke-Margolis Center for
24 Health Policy, they interviewed David Cowling. He is also
25 in the Health Policy Research Division. They personally

1 thanked CalPERS for the good work we've done on our
2 reference pricing model. The article highlighted specific
3 strategies State employee health plans have successfully
4 undertaken to improve quality and value. And while the
5 article focused on State employee health plans, the author
6 emphasized that large commercial payers and purchasers can
7 also learn from the experience of State employer health
8 plans, and their evidence of what works. And they also
9 say State health plans are great collaborators in
10 multi-payer payment reforms such as CalPERS.
11 And then last January 9th, CalPERS will launch
12 the 2018 annual health plan survey. The questions will
13 focus on the member's experience in utilizing their health
14 plans for the 2017 Calendar year. And members will have
15 until March 5th of 2018 to respond to the survey.
16 CalPERS received all the aggregate results at the
17 end of March, and then we'll report that back to the
18 Board.
19 Madam Chair, this concludes my opening remarks, a
20 and I'm available for questions.
21 CHAIRPERSON MATHUR: Thank you very much. How
22 exciting to be recognized for some of the work that we're
23 doing, and particularly work that we're doing that's
24 trying to advance both the health status of our members,
25 while reducing the cost, which is a really tricky area to

1 tackle. So thanks for -- to you and your team for all of
2 their efforts on that.
3 CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Thank
4 you.
5 CHAIRPERSON MATHUR: Okay. That brings us to the
6 consent items. Agenda -- the action item is the approval
7 of the November meeting minutes.
8 VICE CHAIRPERSON BILBREY: Move approval.
9 COMMITTEE MEMBER TAYLOR: Second.
10 CHAIRPERSON MATHUR: Moved by Mr. Bilbrey,
11 seconded by Ms. Taylor.
12 Any discussion on the motion?
13 Seeing none.
14 All those in favor say aye?
15 (Ayes.)
16 CHAIRPERSON MATHUR: All those opposed?
17 Motion passes.
18 I've had no requests to pull anything from
19 consent, so we'll move on to Agenda Item number 5, the
20 final proposed amended regulation for normal retirement
21 age. Ms. Falzarano.
22 RETIREMENT RESEARCH AND PLANNING DIVISION CHIEF
23 FALZARANO: Good morning.
24 Good morning, Madam Chair and members of the
25 Committee. Jan Falzarano, CalPERS team member. Agenda

1 Item 5 is an action item, and requests the Committee's
2 approval of the final proposed amendments to the
3 California Code of Regulation Section 586.1 defining
4 normal retirement age.
5 At the August 2017 Board meeting, the Committee
6 approved the attached amendments to CCR section 586.1 and
7 established the maximal normal retirement age at age 62,
8 and adds normal retirement age definitions for benefit
9 formulas that have been enacted after 2004, and including
10 those that was added under PEPRA.
11 For clarity, the proposed regulation does not
12 change a member's Benefit formula, and the maximum normal
13 retirement age of 62 is not a mandatory retirement age.
14 The normal retirement age only impacts individuals who
15 chose to work for a CalPERS covered employer after
16 retirement.
17 Members who are younger than the normal
18 retirement age and choose to work for a CalPERS covered
19 employer must have a 60-day break in service prior to
20 returning to work. All members who choose to work for a
21 CalPERS-covered employer, after retirement regardless of
22 their age, are required to have 180-day break in service
23 prior to returning to work under the PEPRA rules.
24 However, there are exemptions to this 180-day
25 rule. Therefore, the 60 break in service applied to those

1 groups that are exempt from the 180 days.
2 So CalPERS already applies normal retirement age
3 definition to the plan benefit formulas thus the proposed
4 amended regulation simply makes these definitions
5 explicit.
6 So CalPERS filed a Notice of Proposed Regulatory
7 Action with the Office of Administrative Law initiating
8 the 45-day public comment period, which commenced on
9 September 15th and closed on October 30th, 2017.
10 We did not receive any public comments or
11 requests for a hearing during the public comment period.
12 The final version of the proposed regulation has not
13 changed from the previous version approved by the
14 Committee back in August. Team members recommend that the
15 Committee approve the proposed amendments to CalPERS
16 normal retirement age regulation CCR Section 586.1.
17 With the Committee's approval, a CalPERS team
18 member will submit the final rulemaking package to the
19 Office of Administrative Law for approve -- for adoption.
20 Upon approval, we anticipate an effective date of
21 April 1, 2018.
22 This completes my presentation. I'm happy to
23 answer any questions.
24 CHAIRPERSON MATHUR: Thank you so much, Ms.
25 Falzarano. We do have one question.

1 Mr. Jelincic.
2 BOARD MEMBER JELINCIC: I thought I heard you say
3 that if someone leaves, they have to be off at least 60
4 days before they could go to a CalPERS employer.
5 That's -- my -- what I did not hear is that applies only
6 if they've retired.
7 RETIREMENT RESEARCH AND PLANNING DIVISION CHIEF
8 FALZARANO: Yes. After they -- prior to returning to
9 work. If they retire prior to the normal retirement age
10 of 62, they would have to have at least a 60-day break in
11 service.
12 BOARD MEMBER JELINCIC: Okay. But if they
13 haven't retired, they can start the new employer the next
14 day.
15 RETIREMENT RESEARCH AND PLANNING DIVISION CHIEF
16 FALZARANO: That is correct.
17 BOARD MEMBER JELINCIC: Okay. And the other
18 question I had was in your write-up on Item 2, you talk
19 about the Treasury finalizing some procedures -- or
20 regulations. I assume we have talked to them and do not
21 expect it to create a problem.
22 RETIREMENT RESEARCH AND PLANNING DIVISION CHIEF
23 FALZARANO: That is correct. You're talking about the
24 Notice of Proposed Rulemaking --
25 BOARD MEMBER JELINCIC: Yeah.

1 RETIREMENT RESEARCH AND PLANNING DIVISION CHIEF
2 FALZARANO: -- specifically for the normal retirement age?
3 Yes, that is correct.
4 BOARD MEMBER JELINCIC: Because you had pointed
5 out that you had, you know, determined the impacts and
6 make necessary amendments, but you're not really expecting
7 any.
8 RETIREMENT RESEARCH AND PLANNING DIVISION CHIEF
9 FALZARANO: No. So far still age 62, yes.
10 BOARD MEMBER JELINCIC: Thank you.
11 CHAIRPERSON MATHUR: Thank you.
12 This is an action item. What's the pleasure of
13 the Committee?
14 COMMITTEE MEMBER GILLIHAN: Move staff
15 recommendation.
16 COMMITTEE MEMBER HOLLINGER: Second.
17 CHAIRPERSON MATHUR: Moved by Mr. Gillihan,
18 seconded by Ms. Hollinger -- sorry.
19 And any further discussion on the motion?
20 Seeing none.
21 All those in favor say aye?
22 (Ayes.)
23 CHAIRPERSON MATHUR: All those opposed?
24 Motion passes.
25 That brings us to our infor -- thank you very

1 much.
2 That brings us to our information items. Agenda
3 Item number 6, Enterprise Performance Reporting, Customer
4 Services and Support Strategic Measures, and key
5 performance indicators.
6 (Thereupon an overhead presentation was
7 presented as follows.)
8 ENTERPRISE STRATEGY & PERFORMANCE DIVISION CHIEF
9 HUTCHINS: Hi.
10 CHAIRPERSON MATHUR: Good morning.
11 ENTERPRISE STRATEGY & PERFORMANCE DIVISION CHIEF
12 HUTCHINS: Good morning, Madam Chair, and members of the
13 Committee. Sabrina Hutchins, CalPERS team member. Today
14 is an information item for several performance measures
15 specifically related to our customer service and support
16 area as part of our enterprise performance reporting
17 system.
18 You may recall that we presented our first
19 quarter report of the EPR system last month. And as we
20 indicated then, this is a new system, and an iterative
21 process, and we will have ad hoc reporting sessions to
22 provide updates and to get your feedback as we continue to
23 move forward. And this agenda item is a perfect example
24 of just that.
25 So CSS is going to be sharing their revisions to

1 several targets and thresholds. And as you are aware, CSS
2 has been a leader in formally developing and reporting on
3 metrics at this level for several years. And now that we
4 do have a consistent platform for the entire enterprise,
5 they now had the opportunity to refine and appropriately
6 align their methodologies to this new model.
7 --o0o--
8 ENTERPRISE STRATEGY & PERFORMANCE DIVISION CHIEF
9 HUTCHINS: So as a reminder of the framework that this
10 system works within, it does align back to our foundation,
11 which is our CalPERS mission, vision, and core values, and
12 in the simplest terms, represents who we and what we want
13 to achieve. This includes our strategic plan goals and
14 objectives, and our outcome measures, which align to our
15 high level operational expectations.
16 --o0o--
17 ENTERPRISE STRATEGY & PERFORMANCE DIVISION CHIEF
18 HUTCHINS: So to provide just a little bit more context,
19 depicted on this slide is a high level visual of our
20 Enterprise Performance Management system, which involves
21 the development, implementation, monitoring, reporting and
22 ad hoc refinements of performance measures that align and
23 support our mission.
24 The intent of this system is to reinforce CalPERS
25 desire to be transparent and accountable in support of our

1 goals, objectives, and operational expectations.
2 The focus of our discussion here today is again
3 to share these revised targets and thresholds as they
4 relate to customer satisfaction and educational outreach
5 to our members and employers, which specifically align to
6 the operational side of the house.
7 The goal for these revisions is again to help
8 better align methodology to the new EPR system, and also
9 set realistic expectations. This system will include an
10 annual review and refresh process to ensure we are
11 measuring meaningful processes, and increasing value to
12 our customers.
13 So with that, I will turn it over to Donna to
14 further discuss these revisions.
15 --o0o--
16 DEPUTY EXECUTIVE OFFICER LUM: Good morning.
17 Donna Lum CalPERS team member.
18 And so as Sabrina mentioned, the Customer
19 Services and Support team has been reporting performance
20 measures to this Committee for many years. And for those
21 of you that have been on this Committee, you may recall
22 when we reported almost a dozen dashboards and very
23 detailed information down to, you know, how many calls
24 were answered within how many period -- you know, period
25 of time of the day, the week, the month, and lots of very

1 detailed information.
2 We since then have received a lot of valuable
3 feedback from this Committee, which has enabled us to
4 really focus on those key performance measures or
5 strategic measures that are really core to the CalPERS
6 mission, as well as ensuring that we are enhancing our
7 customer experience, and specifically those measures that
8 capture the timeliness and accuracy of our benefit
9 payments, as well as customer satisfaction.
10 The newly implemented Enterprise Performance
11 Reporting system is now the reporting system that will
12 provide a comprehensive view of the strategic and
13 operation performance for customer support. And as
14 mentioned, the EPR framework also does provide methodology
15 to refine metrics and targets and thresholds on a periodic
16 basis.
17 Today, we are presenting the revised metrics for
18 customer support. And I do want to note that these
19 metrics are a component of the incentive plans. And
20 although we are not going to be discussing the incentive
21 plans during this Committee, there is an agenda item in
22 the Performance, Compensation, and Talent Management
23 Committee today related to incentive metrics. And if you
24 have questions, the consultant from Grant Thornton will be
25 available to answer questions.

1 So at this time, I'd like to turn the
2 presentation over to Anthony Suine and he will walk you
3 through the revised metrics.
4 BENEFIT SERVICES DIVISION CHIEF SUINE: Thanks,
5 Donna. Good morning, Madam Chair and members of the
6 Committee. Anthony Suine, CalPERS team member.
7 So under the previous 2012 through 2017 strategic
8 plan, we set aggressive operational goals for timeliness
9 of our Benefit payments, as well as customer satisfaction.
10 As Sabrina mentioned, the organization is implementing the
11 enterprise-wide efforts to develop an operating model with
12 now key performance indicators, as they're called, that
13 measure the effectiveness of all our operational efforts.
14 As part of this effort, our previously
15 established operational goals were now incorporated into
16 the new EPR reporting system.
17 We have five KPIs in the new reporting system:
18 Benefit payment timeliness, customer satisfaction, benefit
19 payment accuracy, and then we also have member education
20 satisfaction and employer education satisfaction.
21 So once we identified these metrics, we evaluated
22 the methodology to refine our targets and thresholds to
23 align with the new Enterprise Performance Reporting
24 System.
25 So the enterprise effort has provided us an

1 opportunity to look at the measures we set for our own
2 operations previously. And our analysis indicated that
3 our targets and thresholds could be revised and still
4 reflect the high customer service standards that our team
5 expects to deliver and that our customer demands, while
6 also providing realistic targets for our teams to achieve.
7 Our revised measures for benefit payment
8 timeliness adjusts our target from 98 percent to 95
9 percent, and adjusts our threshold from 90 percent to 87
10 percent.
11 And then our revised measure for benefit
12 payment -- excuse me, for our customer satisfaction
13 adjusts our target from 95 percent to 90 percent, and our
14 threshold from 85 percent to 80 percent.
15 So our rationale for benefit payment timeliness
16 was that our previous reporting cycles have shown us that
17 even when performance falls below targets for our core
18 operations, our customer surveys continue to indicate high
19 satisfaction, signaling that our targets and thresholds
20 surpass the expectations of our customers.
21 In addition, lump sum survivor benefit payments
22 have continually been challenged by our targets and
23 thresholds due to increasing volumes in deaths being
24 reported, and high complex components of that process as
25 well.

1 And again, our customer satisfaction remains high
2 in the lump sum survivor benefits. And our teams are
3 processing these benefits have unrealistic goals to meet
4 while we continue to streamline our processes, find
5 benefit system enhancements, and streamline our processes,
6 and train our newly hired staff that has had a lot of
7 turnover in the last year.
8 So rather than request new resources to keep pace
9 with our current measures, our outlook is focused on
10 monitoring the volumes and trends and continuing our
11 improvements, then reevaluate our targets and thresholds
12 during the regular enterprise performance reporting
13 refresh processes, as Sabrina talked about earlier.
14 These revised goals will help us maintain the
15 morale of our teams, and keep them engaged in serving our
16 customers timely and efficiently.
17 For customer satisfaction, we have performed
18 well, even when our timeliness has been challenged in
19 certain processes. However, striving for a 95 percent
20 satisfaction when industry suggests much lower goals, puts
21 unrealistic expectations on the teams, and also creates
22 morale issues. Achieving 95 percent from a member who is
23 excited to apply for a retirement on line, and receive
24 their much anticipated benefits after a lifetime of
25 service, it is -- you know, it can be done fairly

1 consistently.
2 However, dealing with survivors and
3 Beneficiaries, who are going through difficult situations
4 and our need for verifying documents to ensure benefits
5 are paid according to the law, or from a member refunding
6 who has immediate financial needs, and we are dependent on
7 other parties, has proven more of a challenge to achieve
8 this extremely high target of 95 percent.
9 Furthermore, reporting out on thresholds that
10 fall between 85 and 80 percent, when member feedback is
11 still positive, takes time away from the focus of our core
12 workload. We also know that this data is subject to
13 periodic anomalies based on volumes in certain months, and
14 a handful of disgruntled customers with these complex
15 processes, which can skew results in a short window and
16 cause reporting out with no actionable feedback that has
17 been identified by our customers.
18 We believe the revised targets and thresholds for
19 customer satisfaction will still hold teams accountable
20 for excellent customer service, but also keep employees
21 engaged and keep our focus on the key issues.
22 To align our thresholds with the design of the
23 EPR system, which includes the color-coded methodology
24 with thresholds identified in green, yellow, and red
25 statuses, we developed a methodology that applies a

1 standard proportion of the difference between the
2 established target, and the yellow and red thresholds as
3 identified in attachment A.
4 This method represents a consistent approach to
5 enable the Board to hear about any operational risks as
6 they begin to emerge just as we did before. And using
7 this approach will maximize the value of the status system
8 indicator, correcting the past practice of presenting
9 exception reports for minor aberrations in measures with
10 otherwise stable results.
11 And this concludes my presentation, and I'm happy
12 to take any questions.
13 CHAIRPERSON MATHUR: Thank you very much. We do
14 have a couple questions.
15 Mr. Jones.
16 COMMITTEE MEMBER JONES: Thank you, Madam Chair.
17 Thank you, Mr. Suine.
18 You've explained some of the rationale for
19 reducing some of the targets from what it is to the
20 revised target. And I can understand that when there's
21 one or two reductions in targets with rationale makes
22 sense, but what is the overarching reason for reducing
23 them all? And I'm particularly concerned about the
24 benefit payment timeliness being reduced from 98 to 95
25 percent.

1 BENEFIT SERVICES DIVISION CHIEF SUINE: So, Mr.
2 Jones, the target is cumulative of our five key benefit
3 payments. So as I mentioned, we have survivor benefits in
4 there, and specifically lump sum survivor benefits with --
5 which draws down the overall timeliness reporting. And so
6 when we have these higher goals of say 98 percent, the
7 team morale really struggles.
8 And when you set these unrealistic targets and
9 trying to keep our teams focused on achieving those
10 targets, it really brings up the team morale and keeps
11 them engaged, and allows us to, one, have a realistic goal
12 that we can achieve, because with that number so low, then
13 the 98 percent becomes a challenge to ever reach. And so
14 that was our rationale for moving it to 95 percent.
15 And then the reporting threshold of 87 percent is
16 to keep us from reporting out when there's -- when there's
17 no real actionable feedback or corrective action that we
18 haven't already taken, and again, giving the teams a
19 realistic threshold to achieve.
20 So that was the major reason, while again still
21 striving to achieve that 95 percent and having those
22 handful of constraint cases not affect us from reaching
23 our goals.
24 COMMITTEE MEMBER JONES: So if you were to
25 disaggregate the various types of payments, and you look

at the regular payments, so do you still have a high goal, 100 percent, for example to make those payments?

BENEFIT SERVICES DIVISION CHIEF SUINE: Our goal is always to reach 100 percent in all our payment timeliness.

COMMITTEE MEMBER JONES: So if you're able to disaggregate, what is your rate of payment for the regular retirement?

BENEFIT SERVICES DIVISION CHIEF SUINE: Yeah. So the regular retirements has been right there between 95 and 100 percent. And we have been able to reach 98 percent on several occasions on paying service and disability retirements, and also, our ongoing survivor benefits. So that's where a member dies, and they have an ongoing surviving spouse or beneficiary that's due an ongoing monthly benefit. Those have also struggled in the past, but in recent months, we've been able to accelerate that up to above 90 percent.

COMMITTEE MEMBER JONES: Okay. And so the last question on this is that once the member starts to receive their benefits, then is that 100 percent.

BENEFIT SERVICES DIVISION CHIEF SUINE: Yeah, absolutely. We've never missed a roll.

COMMITTEE MEMBER JONES: Okay. Thank you.

CHAIRPERSON MATHUR: Thank you.

1 Ms. Taylor.
2 COMMITTEE MEMBER TAYLOR: Thank you, Madam Chair.
3 So I just wanted to thank you for this report.
4 It's an excellent report. Having worked in this kind of
5 an environment before, I completely understand why you had
6 to lower the goals a little bit. I want to make sure that
7 our retirees are serviced well, but you can't do that if
8 you're losing employees. And I did write down that you
9 said you had some turnover issues, so that's a problem.
10 But you did say that - and I want to make sure I
11 heard this correctly - that you're not getting new
12 resources. You're just training better, is that what I --
13 or training more towards the goal, is that what I'm
14 hearing?
15 BENEFIT SERVICES DIVISION CHIEF SUINE: That's
16 correct. We're not asking for new resources. And if we
17 were to try to meet the current targets and threshold,
18 that would be a possibility. And so we don't want to do
19 that at this time. We'd rather monitor what I mentioned
20 was the workload volume. So the deaths that have been
21 reported have increased significantly over the last few
22 years. We want to see if we continue that trend.
23 Also, as you mentioned, I did talk about training
24 our new team members and more efficiently managing the
25 workload in those areas. So we -- we are doing that, and

1 we have several new staff in the next -- in the last year
2 or so. And so we're training them and they're coming up
3 to speed in those areas.
4 COMMITTEE MEMBER TAYLOR: Okay. Great.
5 BENEFIT SERVICES DIVISION CHIEF SUINE: And as
6 they become more proficient, we'll be able to better hit
7 the targets and thresholds.
8 COMMITTEE MEMBER TAYLOR: Okay. And just real
9 quick before Donna speaks, so that -- you are training new
10 staff, but that's replacement staff not additional staff?
11 BENEFIT SERVICES DIVISION CHIEF SUINE:
12 Absolutely, yes.
13 COMMITTEE MEMBER TAYLOR: Okay. And I just want
14 to make sure that if we're following -- falling below, and
15 you've monitored that workload, that we are hiring new
16 staff, if need be, that you have the resources you need to
17 service our retirees.
18 BENEFIT SERVICES DIVISION CHIEF SUINE: Thank you
19 for that, yes.
20 CHAIRPERSON MATHUR: Thank you.
21 Did you want to add something, Ms. Lum?
22 DEPUTY EXECUTIVE OFFICER LUM: Yeah. Just a
23 couple of additional points that I'd like to add. So as
24 Mr. Suine indicated earlier, while we are also adjusting
25 these measures, the other thing that we continue to do,

1 and we have seen some success, is reviewing and
2 streamlining our processes. The death benefit metric that
3 Anthony mentioned also is one of our top Lean projects.
4 It is currently underway, and we anticipate that the much
5 success that we achieved using the Lean methodology with
6 our disability retirement payments will also yield
7 efficiencies with our survivor benefits, death benefits as
8 well.
9 And then in addition to that, you all know that
10 technology is a key component of the delivery of our
11 service, and we continue to look at that as well. So it's
12 not just reducing the measures, and being complacent with
13 them, because that's not who we are. We are always trying
14 to achieve the best service that we can, but continually
15 looking internally to how we can become more efficient in
16 lieu of needing additional resources.
17 COMMITTEE MEMBER TAYLOR: Well, and I want to
18 just also emphasize that it sounds to me like the death
19 benefits, the survivor benefits, et cetera, are much more
20 complex than some of these other retirement issues. And
21 I'm not -- like Mr. Jones said, I'm wondering if
22 decoupling that from those metrics might help. I don't
23 know. You guys would have to go through the review
24 process of that just to make sure that you're not --
25 because our system is so complex, I don't want to

1 overburden our employees either. So that would be
2 something I'd think about.
3 DEPUTY EXECUTIVE OFFICER LUM: As we continue to
4 look at refinement of the measures through the EPR system,
5 we can certainly consider looking at if that's a viable
6 option for us.
7 COMMITTEE MEMBER TAYLOR: Okay. Great. Thank
8 you.
9 CHAIRPERSON MATHUR: Thank you.
10 Mr. Gillihan.
11 COMMITTEE MEMBER GILLIHAN: Thank you, Madam
12 Chair. I, like my colleagues, am a little concerned about
13 lowering the bar that we hold ourselves accountable to. I
14 do applaud applying Lean techniques to your business
15 processes review, and trying to find efficiencies there.
16 But I would also recommend that we consider sort of
17 splitting the data sets out, so that our recurring benefit
18 payment, the standard stuff, we can hold ourselves to a
19 higher standard, rather than dragging the average down,
20 because we have a couple problematic benefit payments that
21 drag the average down. So that's my two cents on this.
22 CHAIRPERSON MATHUR: Thank you.
23 Mr. Saha.
24 ACTING COMMITTEE MEMBER SAHA: I just had a
25 couple of quick questions. One, in the report it looked

1 like, I guess, that this was brought to the Board back in
2 December of 2015. So I was curious about if that was
3 fresh our methodology was updated then? Is there an
4 expectation in roughly five years or approximately this
5 would be brought to the Board again?
6 DEPUTY EXECUTIVE OFFICER LUM: So in 2015, we
7 worked with the Committee to establish a new set of
8 targets and thresholds, which we didn't previously have.
9 We only had one performance metric. And then, as
10 mentioned, through the EPR system, there will be periodic
11 reviews of each of the KPIs. This is one set of many
12 across the enterprise that will be brought forward on a
13 periodic basis.
14 So as we go through the experiences and we do the
15 reporting through that system, there is a possibility that
16 they could be refined. Hopefully, we have set these at a
17 state in which they will be greater long term for us as
18 well.
19 ACTING COMMITTEE MEMBER SAHA: Okay. And really
20 quickly, could you elaborate a little bit more on the
21 survivor benefit, and what makes that a complicated
22 problem with your technology?
23 BENEFIT SERVICES DIVISION CHIEF SUINE: Sure. So
24 we have two different type of survivor benefit payments.
25 One, I described earlier, where the member dies and they

1 have an ongoing beneficiary survivor, typically a spouse,
2 that continues that ongoing benefit because of the option
3 they chose at retirement. So those are our most critical.
4 And when our timeliness struggles, we put all our
5 resources towards that, because we don't want that benefit
6 stream to stop, and especially the health benefit side of
7 that. So that's our focus. We struggled lately. We've
8 been up to 90 percent over the last several quarters.
9 The other type is what we call lump sum benefits.
10 So this is when you -- when a member passes away, there is
11 no ongoing survivor, but a beneficiary may be entitled to
12 a lump sum death benefit to 3, -- $5,000 And then maybe
13 some other return of contributions, depending on the
14 option they chose at retirement.
15 So the complexities come in in the various type
16 of benefits across all our different employers. They all
17 have -- the public agencies can all have various types of
18 contracted benefits, whether it's a preretirement case, so
19 whether they die when they're active member versus a
20 retired member adds complexity. There's a lot of
21 documentation we need from the beneficiaries to prove that
22 we can make that payment. We need death certificates.
23 They may not have a designation on file, so we ask for
24 wills and testaments.
25 And so there's just -- what we ask of the

1 beneficiaries in order to make sure we're paying those
2 benefits can be complex, a lot of paperwork. Plus, it's a
3 manual process. It's hard to automate all those different
4 triggers and the needs from our customers. So that
5 requires a lot more from our team members.
6 ACTING COMMITTEE MEMBER SAHA: Thank you, Madam
7 Chair.
8 CHAIRPERSON MATHUR: Thank you.
9 Mr. Jelincic.
10 BOARD MEMBER JELINCIC: Donna, you mentioned when
11 we were getting detailed reports on the phones how long it
12 took, how many calls, et cetera. But I think it should be
13 also recognized that that was at a point where that was a
14 major problem. And once the problem came under control,
15 that went away.
16 I would hope that if we get another major crisis
17 like that, we will see those kind of detailed reports, or
18 at least my successor Board will. So it was a bit of an
19 anomaly.
20 When I read this, a couple of things struck me.
21 We've learned some lessons from INVO. If you can't meet
22 the bar, lower the bar. And I -- and the morale issue, I
23 really kind of sympathize. I remember going through the
24 furlough days. And when they did the one furlough day,
25 people kind of dug in and says I can do this. And then

1 they went two furlough days. Oh, man, okay. And then
2 they went three furlough days, and they said screw it.
3 You're not giving me the resources to do the job.
4 So I understand its impact on morale, but morale
5 shouldn't drive the bonuses -- or the goals. I mean, if
6 we -- if we want that, we could set all the goals at 50
7 percent, and morale would be great. That's not what
8 you're proposing, but I mean we need to balance that.
9 You raised the issue of performance incentives,
10 because the bonuses are tied to those goals. You've said
11 that's going to come up in Comp. I know from talking to
12 Marcie that their suggestion is going to be to hold staff
13 to the original benefits -- or the original targets. And
14 I think that's the appropriate thing to do.
15 I would like to point out though that it's not
16 just not asking for more resources. Another committee I
17 sit on, Finance and Admin, we're actually cutting the
18 budget for the resources. And so I'm wondering how you
19 reconcile the two saying we need lower benefits because we
20 don't have the resource, but we're cutting resources out
21 of the budget.
22 DEPUTY EXECUTIVE OFFICER LUM: So in response to
23 the budget. Over the last couple of years, there have
24 been only a small number of requests that have come
25 forward from customer service for additional resources,

1 and primarily the largest one that we had was about a
2 year -- two years and that was related to the Customer
3 Contact Center, where we were eliminating temporary
4 positions, and creating new and permanent positions.
5 The -- we're always very cognizant of the budget,
6 and where we are in our funded status, and what we need
7 resource wise in order to deliver the services that our
8 members have come to expect of us.
9 We are not coming forward with additional
10 requests for resources in this budget year for these
11 customer service areas that are being discussed. And so
12 changes in the budget overall for the enterprise do not
13 have a immediate direct impact on the customer service
14 teams.
15 What we have seen, and what we have experienced
16 through technology through the projects that we've had
17 underway with streamlining, is our ability to have
18 capacity to redirect resources from other workstreams into
19 these more critical areas. And we will continue to do
20 that.
21 What I also wanted to emphasize is this reporting
22 framework, the EPR, does not change the reporting methods
23 that we've had in place where if we have a specific target
24 that is underperforming in something like survivor
25 benefits, we will continue to report that out in detail

1 for you.
2 So although there is a roll up and an aggregation
3 of the data that takes place from the EPR perspective, we
4 are continuously committed to identifying those individual
5 metrics that fall below and report out to them on an
6 exception basis.
7 BOARD MEMBER JELINCIC: Okay. And then one of
8 the things I heard is that our standards are higher than
9 industry standards, and so we ought to reduce it to
10 industry standards. And I will argue that we ought to be
11 a leader, and make the industry standard come to us.
12 But most of the changes, quite frankly, don't
13 create a lot of heartburn, except one, and that's in the
14 strategic measurement for customer satisfaction. When --
15 we're on target if only a fifth of our members are
16 complaining about satis -- you know, are unsatisfied. And
17 I think that's a level that at least gives me heartburn.
18 You know, having a fifth of our membership
19 unhappy is not on target. So I would suggest that you go
20 back and at least look at raising that, and maybe even
21 restoring it to the 85, because even then, you know, 15
22 percent of the members are unhappy. And, you know, if
23 we're going to be a world class organization, 15 percent
24 of your membership being unhappy is not good.
25 Thank you.

1 CHAIRPERSON MATHUR: Thank you.
2 Mr. Slaton.
3 BOARD MEMBER SLATON: Thank you, Madam Chair. I
4 know that, as you know, I've always been focusing on
5 strategic measures and KPIs. And, you know, one of the
6 real challenges on customer satisfaction is it tends to be
7 transactional. And as you approach the high nineties, I
8 can see where the frustration comes in, particularly as
9 you described on the more complex transactions.
10 And I would suggest, and I'd like your comments
11 on this, and it's a suggestion to the Committee, that more
12 and more organizations are not just looking at customer
13 satisfaction, they're looking at customer experience,
14 which is a longer view about the relationship. And I
15 would suggest, this is not to replace customer
16 satisfaction, but I would suggest that we should really be
17 looking at customer experience over the time period,
18 because our customers, active and retirees, and employers
19 are with us over a long term.
20 So rather than only focus on the transactional,
21 it's really about the relationship. And I would challenge
22 us to create the metrics and the process to look at
23 customer experience as an additional way to look at how
24 we're doing.
25 BENEFIT SERVICES DIVISION CHIEF SUINE: So, Mr.

1 Slaton, I -- we do do that, both on the transactional
2 process -- so just to clarify a little. While we do ask
3 for their satisfaction on the process, we do ask them
4 several questions about their experience with the entire
5 process, and the different touchpoints along the way.
6 And then our annual member satisfaction survey
7 also tries to capture some of those more comprehensive
8 satisfaction with their experience with CalPERS. So I
9 just wanted to --
10 BOARD MEMBER SLATON: Okay. It just seems like
11 our focus -- or the focus of the Committee and this Board
12 tends to be more transactional rather than the long
13 experience. So maybe it's just a choice of language
14 that's used, so that we could maybe put a little more
15 emphasis on how we're doing with the relationship over the
16 long period of time, and all of the touchpoints, not
17 necessarily just the specific once.
18 Thank you.
19 CHAIRPERSON MATHUR: Thank you.
20 Mr. Jones.
21 COMMITTEE MEMBER JONES: Yeah. Thank you, Madam
22 Chair.
23 Mr. Jelincic's comment triggered another question
24 in my mind when we mentioned that we would be -- he was
25 advised that you may be using one target for customer

1 satisfaction and a different target for compensation. And
2 I believe there are inherently problems in using -- how do
3 you even do that? So I'm just concerned about even trying
4 to have two sets of data, one for compensation, one for
5 satisfaction, because the data is what it is.
6 So I don't know. Maybe that's a broader
7 discussion for the Compensation Committee, but I thought
8 that's what I heard J.J. say, so...
9 DEPUTY EXECUTIVE OFFICER LUM: So I can -- I can
10 address part of that. And again being conflicted, because
11 it is part of the plan as well, it certainly is a good
12 discussion for Performance and Comp.
13 So the metrics and the measure -- the KPIs that
14 we are setting are for the actual performance of each of
15 the individual items for the team as a whole, for each of
16 the work streams that we have.
17 When it gets to the compensation plans, there is
18 a set of targets that may appear to be different, but
19 these feed into them, and then those targets are actually
20 set a little bit higher than the targets that we have on
21 some of these measures.
22 And so if there are questions about it, Madam
23 Chair, I would encourage the Committee members to ask the
24 consultants in the Performance and Comp Committee.
25 CHAIRPERSON MATHUR: Thank you. I will pass that

1 along to the Chair of the Performance and Comp Committee.
2 (Laughter.)
3 CHAIRPERSON MATHUR: You know, one thing that you
4 discussed with sort of the resource question. And I heard
5 a couple of questions about resources. At some point with
6 customer satisfaction, you can continue to add significant
7 additional resources, but the marginal return of each
8 additional resource diminishes as you get closer to 100,
9 sort of asymptotic as I understand it. And so we do have
10 to be, as prudent stewards of this system, we do have to
11 be conscientious about what is -- you know, whether we're
12 getting value for the additional resources that we
13 request.
14 And I appreciate that the executive team is
15 trying to do just that. And I think it's a fruitful
16 discussion to have is to -- for each additional percentage
17 improvement in customer service, how much do we have to
18 spend for that, and is it -- is it really the best use of
19 the system's funds?
20 So I just make that one point, but I think we've
21 had a very robust discussion here this morning, and thank
22 you very much for your report. I see no further requests
23 to speak on this item.
24 BENEFIT SERVICES DIVISION CHIEF SUINE: Thank
25 you.

1 CHAIRPERSON MATHUR: Okay. That brings us to
2 Agenda Item number 7, Prescription Drugs Utilization and
3 Cost Trends.
4 (Thereupon an overhead presentation was
5 presented as follows.)
6 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
7 DONNESON: Good morning, Madam Chair and members of the
8 Pensions and Health Benefits Committee. Before I start, I
9 want to thank Mr. Bilbrey for serving for us as our Vice
10 Chair of this Committee, and to tell him what a pleasure
11 it's been working with him.
12 Thank you.
13 This is Agenda Item number 7, Prescription Drugs
14 Utilization and Cost Trend. This is our annual report.
15 The person who will make the presentation is with me, Dr.
16 Melissa Mantong, our CalPERS Pharmacist. So I'll turn it
17 over to Melissa
18 DR. MANTONG: Thank you. Good morning, Madam
19 Chair and members of the Committee. Melissa Mantong,
20 CalPERS pharmacist. This is an informational item.
21 Before we begin, I would like to call your attention to
22 two items. The presentation deck contains selected key
23 slides from the full deck. The slide numbers are the same
24 in both documents for ease of use. This is why the slide
25 number for the presentation deck is not sequential.

1 Secondly, the generic dispensing trend graphs on
2 page 2 and 3 of the written report are missing the
3 footnote. The missing footnote states, "Standard
4 definition of generic by the Health Care Division..." --
5 excuse me, "...by the Health Care Decision Support System
6 was used".
7 Now, it's my pleasure to share with you
8 highlights of the report.
9 --o0o--
10 DR. MANTONG: We will begin with prescription
11 drugs covered under the pharmacy benefits. New this year,
12 basic and Medicare plans are reported separately.
13 Medicare plan in red, basic plan in blue. The combined
14 total is above the column. The plan total is inside the
15 corresponding colored area.
16 In parentheses is the annual percentage change.
17 Consistent with what you're hearing in the news media,
18 prescription drug costs continue to increase. For 2016,
19 the total prescription cost was $2,153 million dollars.
20 Of the total, Medicare accounted for $857 million, and
21 basic account for $1,286 million.
22 --o0o--
23 DR. MANTONG: Let's take a closer look at basic
24 2016 prescription utilization and costs by drug type. In
25 previous years, we reported member cost share, which

1 included copayments, deductible, and co-insurance.
2 Deductibles and co-insurance does not apply to most of
3 CalPERS plans. Therefore member copay is reported, and we
4 feel this provides a more accurate reflection of the
5 member's out-of-pocket costs.
6 The 2016 average member copay per prescription
7 for basic was $8.95, or 7.55 percent of the drug cost.
8 For comparison, the average member copay per prescription
9 for OptumRx book of business for State and government
10 employers was $12.58, or 11.5 percent, of the drug cost.
11 --o0o--
12 DR. MANTONG: In regards to specialty drugs,
13 there is no industry standard definition exists.
14 Therefore, the data shown used CVS Caremark specialty drug
15 lists across all plans. Specialty drugs are generally
16 classified as drugs with serious adverse effects, and are
17 high cost drugs used to treat complex diseases. Both
18 utilization, as illustrated by the number of prescriptions
19 in the first row, and costs, as illustrated by the allowed
20 amount in the third row, continue to increase, in fact,
21 nearly doubled in 5 years.
22 In 2016, the total specialty drug allowed amount
23 accounted for 31.76 percent of the total prescription drug
24 spend. While it is almost one-third of the total
25 prescription description drug spend, it accounted for 1

1 percent of the total prescription numbers. The average
2 member copay remained at less than 1 percent.
3 --o0o--
4 DR. MANTONG: This and the next slide are the
5 same metrics for Medicare, with similar utilization and
6 cost trends as basic plan. The 2016 average member copay
7 per prescription for Medicare was $9.52, or 7.26 percent
8 of the drug costs.
9 Again for comparison, the average member copay
10 per prescription for OptumRx book of business for Medicare
11 was $27.13, or 26.1 percent of the drug cost.
12 --o0o--
13 DR. MANTONG: Also, like basic, specialty drug
14 utilization doubled. However, the cost nearly tripled
15 from $82 million in 2012 to $240 million in 2016. In
16 2016, the total specialty drug allowed amount accounted
17 for 28.1 percent of the total prescription drug spend.
18 And this total -- I'm sorry. This 28.1 percent specialty
19 drug spend accounted for 0.8 percent of the total number
20 of prescriptions. The member copay remained at relatively
21 constant at less than 1 percent.
22 --o0o--
23 DR. MANTONG: Now, let's switch gears to look at
24 prescription drugs covered under the pharm -- medical
25 pharmacy benefit. Last year, we started reporting on

1 medical pharmacy costs. These are drugs covered under the
2 medical benefits, and typically is administered provided,
3 such as infusion therapy. Medical pharmacy costs for both
4 basic and Medicare nearly doubled in 2 years with
5 chemotherapy, shown in blue, accounted for a large portion
6 of the spend.
7 As you may recall from earlier, specialty drugs
8 covered under the pharmacy benefit nearly doubled in 5
9 years. Medical pharmacy costs increased it at a much more
10 rapid rate. Nationally, it is estimated that medical
11 pharmacy accounts for 50 percent of the specialty drug
12 spend.
13 --o0o--
14 DR. MANTONG: Finally, as we continue to explore
15 opportunities in medical pharmacy, new this year is place
16 of service. The most common place of service is office
17 shown in blue, home shown in red, and outpatient hospital
18 shown in green, with outpatient hospital being one of the
19 most expensive place of service.
20 And that concludes my presentation. And I'm
21 happy to answer any questions you may have.
22 CHAIRPERSON MATHUR: Well thank you for this
23 report. What I'm interested in is what sort of strategic
24 takeaways do you take from this data? What -- where would
25 we be focusing our efforts, what kind of legislative

1 efforts should we be undertaking from a -- and then a --
2 what -- I know we're also working on various benefit
3 design or other strategies to manage these costs. I don't
4 know who's the right one of you to take that question.
5 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
6 DONNESON: That's a tall order to answer that set of
7 questions.
8 As you can see over the years, including looking
9 at some of the reference pricing, ideas that we've used in
10 hips and knees and site of service for ambulatory surgery
11 centers, we believe that there is going to be a lot of
12 value in looking at a reference price associated with
13 pharmaceuticals.
14 In fact, that research has already -- that has
15 already been accomplished. We are preceded by the Reta
16 Trust, who worked with the company to develop a reference
17 pricing program. And the results of that program have
18 been published in the New England Journal of Medicine.
19 We believe that that holds a great deal of
20 promise for us as part of our path forward in terms of
21 dealing with variations in pricing for pharmacy. We are
22 also looking at what is happening to the high cost of
23 generics, that is we have always tiered our generics at
24 tier 1. Now, as a result of market -- marketability for
25 manufacturers to -- you know, to increase price of

1 generics, some of the generics that have been around, you
2 know, for over a century, they are taking advantage of
3 that ability. And we are seeing an inflationary effect on
4 high -- on higher cost generics.
5 The way the market is responding in terms of
6 dealing not only with just higher priced generics, but
7 also the specialty drugs is to add tiers. We have looked
8 at more than three tiers. Our current design has
9 generic -- a generic tier, a preferred brand, and a
10 nonpreferred brand. But actually the current state of the
11 market now is to have multiple tiers, generic, higher cost
12 generic, preferred brand, nonpreferred brand, specialty,
13 and I suspect there's even other tiers.
14 That makes ability -- our ability to manage an
15 outpatient pharmacy program very difficult in terms of
16 increasing complexity. So one of the things we're looking
17 at, and we have talked -- we introduced the tiering idea
18 probably back in the early part of 2017. But that becomes
19 very complicated for us, and it becomes very complicated
20 for our members. And so we would have to really study
21 that to determine if that were a good approach for us.
22 What we find more promising is that there are now
23 teams working on taking quality and cost and using
24 evidence-based formularies to look at specialty drugs and
25 perhaps look at some type of reference pricing approach

1 using quality and cost to tackle the specialty drugs.
2 So those are the things that other purchasers are
3 looking at. It's what we're looking at, and we -- there's
4 evidence that some of these approaches are going to be
5 good for us, and maybe get us out of sort of that
6 quagmire, where we have to deal with the complexities of
7 multiple tiers.
8 Other directions that we're going is to look at
9 the medical pharmacy side. We only began that work last
10 year. The medical pharmacy is a black box to us, because
11 it's managed by hospitals and doctors, and it's not as
12 clean in terms of our ability to parse data to find -- to
13 get down to some of the nuances of medical pharmacy that
14 we want to get to.
15 We did report to you several months ago that
16 there is a coding system for pharmacy in the provider's
17 office, using what are called the J codes. So we started
18 to look at that. And in doing so, what we found is that
19 it's really complicated to look at the outpatient
20 hospital, because there's a whole -- several sets of codes
21 that get mixed up, and we'd have to tease that out.
22 It's easier to look at the cost of drugs that are
23 being administered in the physician's office. We know
24 that site of care, as Dr. Mantong has just presented to
25 you, we have identified that you could have the very same

1 drug being administered. And the cost of that
2 provider-administered drug differs based on site of
3 service.
4 So that's one of our new frontiers is really to
5 not just look at cost of the same drug and where it's
6 administered, but actually to look at what's going on in
7 the outpatient hospital, and that's a longer range
8 project.
9 In terms of policy, we need your help and the
10 help of our Legislative Affairs Division to come to us
11 with changes to policy and ask for our advice in terms of
12 any legislation at the State or federal level.
13 So I know that's a -- that's a long response, but
14 as you can see from this data it's important that we take
15 a multi-pronged approach to dealing with the increasing
16 cost of pharmaceuticals.
17 CHAIRPERSON MATHUR: Absolutely. One thing that
18 I believe you're also looking into that Mr. Slaton raised,
19 as part of the opioid discussion last month, was the
20 quantity of prescriptions that -- was this what you were
21 going to raise? I'm sorry, Ms. Bailey-Crimmins. I'll let
22 you -- I'll let you comment on that.
23 CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Yes,
24 Madam Chair, exactly. Two-fold. One I want to put a plug
25 in for January offsite. We will have a pharmacy panel.

1 Pharmacy continues to be a large driver of health care
2 affordability and cost. And so we will have some Panel
3 experts to talk about innovations. Ms. Donneson is going
4 to be one of those to talk about what we're doing.
5 And as Mr. Slaton had talked about is the
6 quantity of member -- doesn't necessarily need to get a
7 30-day quantity if really they only needed it for 3 to 5
8 days. So what innovations, who's doing it out there
9 correctly, and things that we can model as we move forward
10 and look at other design changes we need in relation to
11 pharmacy.
12 And then as just a reminder, federal -- for the
13 fed rep priorities pharmaceutical cost is one of our
14 priorities. And so we, on a monthly basis, work with the
15 federal reps to see what's going on there -- out there
16 from a regulatory or legislative perspective that we can
17 get behind to make sure our voice is very clear that
18 pharmaceutical cost is something that we're keeping an eye
19 on.
20 CHAIRPERSON MATHUR: Terrific. Thank you.
21 We have a number of Committee members who wish to
22 speak.
23 Mr. Lofaso
24 ACTING COMMITTEE MEMBER LOFASO: Thank you, Madam
25 Chair.

1 I think three questions. Maybe they'll be short,
2 because your last answer was pretty comprehensive. But
3 how do our data compare to national data in general? Are
4 we -- are our trends slower, on target? I know there are
5 definitional apples and oranges questions -- excuse me,
6 issues embedded in that question.
7 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
8 DONNESON: I think Melissa is preparing her response. We
9 actually -- I think in terms of our strategies, we've been
10 very forward thinking. And some of the numbers that she
11 might give in terms of the utilization are better than
12 what perhaps a national average is. Also, the cost
13 component I think she'll provide some information. So are
14 you ready, Melissa?
15 ACTING COMMITTEE MEMBER LOFASO: I think you just
16 turned your microphone off.
17 DR. MANTONG: Thank you. I'll take us back to
18 the first slide. So this shows the percentage of annual
19 changes. Recently, I came across an article. Rutgers
20 reported that the total spending on prescription drug rose
21 by 1.3 percent in 2016. This reference did not give
22 information as to what type of plan that is. So for -- so
23 that give you a perspective, our annual percentage change
24 for basic plan was 2.14, and for Medicare the annual
25 percentage change was 12.07. Again, this is just one

1 number that I recently came across.
2 Across nationally, the health care costs increase
3 have slowed it down this last year -- year or so, with
4 health care spending increase of 4.3 percent last year,
5 just to give perspective.
6 ACTING COMMITTEE MEMBER LOFASO: Appreciate that
7 very much. I think I saw similar numbers. And I'm not
8 sure all those calculations capture all we capture. But
9 anyway, it seems like a good useful benchmark.
10 Two more questions. When we talk about generics,
11 I'm just wondering do we include name brand drugs long out
12 of patent with potential competitors when we talk about
13 generics. And we're still struggling from the Martin
14 Shkreli example from 2 years, which was actually not a
15 generic, even though he theoretically could have had a
16 competitor.
17 DR. MANTONG: So for our reporting, we use the
18 standard definition of generics in our health care
19 decision support system, because we found that is the most
20 standardized way of doing, because each health plan
21 theoretically can tag a drug as generic as it wishes. So
22 perhaps because there might be very good pricing for a
23 brand product that is equal or less than the generic
24 drugs, and that became the rationale for tagging that
25 brand drug as generic. But for our study, it is the

1 standard definition in the database.
2 ACTING COMMITTEE MEMBER LOFASO: Okay.
3 Appreciate that.
4 Last question. You all ended on comments about
5 policy. And there's a big push on transparency, and we're
6 a little bit more of a closed system. And I always got
7 the sense we had a little bit of a let up on transparency.
8 But what does it mean for our system with regard to the
9 policy focus on drug pricing transparency.
10 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
11 DONNESON: We do have the benefit of having a health care
12 decision support with a lot of data and requirements for
13 our PBM, and Kaiser, and Blue Shield who manage our
14 members and their programs to provide very detailed
15 information. So we can do these deep dives into our data.
16 And I think we do serve as a leader in terms of the
17 analyses that we do, because we do have that ability.
18 In terms of market transparency, it continues to
19 be a black box in terms of how drugs are priced and
20 bringing them to market, in terms of contractual
21 relationships. Under our current OptumRx contract, we
22 insisted on full transparency all the way through to
23 manufacturer contracts, and we have taken advantage of
24 that transparency in looking at retailer contracts with
25 the pharmacy benefit management company.

1 I think that shows our leadership, but I think it
2 also shows that there are other purchasers that are
3 struggling with the same thing we are. And I think also
4 even in our public programs, that is probably continuing
5 to be a struggle. So I think transparency as a policy it
6 would be a direction that we would want to continue to
7 make headway, you know, for all of us that are struggling
8 with the same issues around cost and utilization.
9 ACTING COMMITTEE MEMBER LOFASO: Thank you.
10 CHAIRPERSON MATHUR: Thank you.
11 Ms. Taylor.
12 COMMITTEE MEMBER TAYLOR: So I'm probably going
13 to do a lot of repeat questions here, so -- but I think --
14 I appreciate the report. It's rather disheartening to see
15 the cost of drugs continue to go up that drives our
16 member's benefit prices as well.
17 So I think I just read an article where it was a
18 free generic drug that just got bought by another company
19 and now it's $109,000 for a year's worth of treatment. I
20 don't remember what drug that was. And I guess my
21 question -- as you were talking before, you were talking
22 about legislative remedies. And I think that rather -- I
23 don't know. In my opinion, I think maybe we should seek
24 out partners and seek legislative remedies, because in
25 that article it basically said, you know, we can't

1 seem -- we can't leave this to the market and the uproar
2 of the American people to correct that kind of issue, that
3 we do need legislation.
4 And I'm wondering if, rather than sitting back
5 and waiting for legislation, if we want to craft
6 legislation going forward to get that under control.
7 Because I think treating our life-saving drugs or any kind
8 of drugs that are helpful to our members as a commodity
9 definitely isn't within our mission or values. And I
10 think that it would behoove us to, like you said earlier,
11 maybe sit with the Board and look at who we can partner
12 with, STRS, somebody, to craft some legislation and see if
13 we can get it through, either State or federally. That's
14 my suggestion.
15 CHAIRPERSON MATHUR: I think it warrants a more
16 robust discussion of what's practical and possible in
17 today's environment, but I do -- I do think we -- you
18 know, the is an issue that is not facing us alone or our
19 members alone. And there's probably some appetite out
20 there. Maybe there are already efforts under way, I'm
21 sure.
22 CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Well, and
23 what I'm hearing from you, Ms. Taylor, is being more
24 proactive, not just waiting to sign onto a bill, but is
25 there something that we can be more proactive and show

1 some leadership. So we would be happy to look into that
2 and bring that back to the Committee of any
3 recommendations
4 CHAIRPERSON MATHUR: Thank you.
5 Mr. Jelincic.
6 BOARD MEMBER JELINCIC: Figures 1 and 2 in the
7 agenda item certainly gave a hit to Kaiser's reputation.
8 But I had a question about slides 4 and 5. The
9 cost per prescription for Medicare is higher, but the cost
10 per day for Medicare is lower. And that -- what's the
11 anomaly that's causing that?
12 DR. MANTONG: So I'll try to answer your first
13 question regarding generic dispensing graph. The missing
14 footnote stated that we use the standard definition in the
15 health care system. And because health plans individually
16 may adjust the definition of generic, that may be the
17 reason why you didn't see the results you would expect in
18 a generic dispensing graph.
19 Secondly, regarding the cost per prescription
20 difference for basic and Medicare plan, one contributing
21 factor could be that the Medicare plans tend to have
22 prescriptions that have longer day supplies. Therefore,
23 it would cost more for that drug.
24 BOARD MEMBER JELINCIC: Okay. That makes sense.
25 And on the medical pharmacy benefit, I know we're

1 just basically beginning to try and get a handle on, have
2 we made any effort to try and track outcomes from the
3 pharmacy -- the medical pharmacy benefit.
4 DR. MANTONG: No, we have not looked at outcome,
5 because we are really trying to understand our data and
6 pull the data out first. And as Dr. Donneson suggested,
7 it is really a black box right now for prescription drug
8 covered under the medical benefits. So we're still
9 working on pulling useful information out.
10 BOARD MEMBER JELINCIC: Okay. Thank you.
11 CHAIRPERSON MATHUR: Thank you.
12 Well, that concludes all of the questions I have
13 -- the Committee has at this time for this item. Thank
14 you very much for this report. A very important report.
15 That brings us to Agenda Item number 8, which is
16 the CalPERS PPO Plans: Optimizing Health Care Benefits
17 and Outcomes.
18 (Thereupon an overhead presentation was
19 presented as follows.)
20 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
21 DONNESON: Good morning, Madam Chair, and members of the
22 Committee. This is Agenda Item number 8. It is the
23 CalPERS Basic Plans: Optimizing Health Care Benefits and
24 Outcomes.
25 --o0o--

1 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
2 DONNESON: For our agenda today, we're going to walk
3 through the background of the 18-month journey We've been
4 on in terms of talking about a value-based insurance
5 design product and using the select PPO health plan as the
6 vehicle by which we might consider a value based insurance
7 design, or VBID approach.
8 We will talk about the PPO plan modeling that we
9 have done to date. Most of our efforts have been put on
10 modeling a VBID Select plan design. But in that process,
11 we also have started looking at the PERS Choice and
12 PERSCare plan designs as well, so that we have three
13 plans, they work together in terms of the benefit designs,
14 the migration, the cost. So we've looked now across our
15 three plans, but it's just a start. We're continuing to
16 examine how those three plans interact, and how we might
17 attain the goals of the VBID at the same time as some
18 additional benefits on looking at the Choice and Care
19 design.
20 We will also look at some estimate -- at some
21 estimated savings in terms of modeling the three plan
22 designs. We do have estimated savings for the VBID, which
23 we have produced in the past, but now we're looking at how
24 again those three designs work together and potential
25 savings associated with the modernization of our PPOs.

1 Next slide.

2 --o0o--

3 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
4 DONNESON: I want to spend a little bit of time on this
5 slide to up -- to remind the Committee on the journey that
6 we did take. This is the fifth time we've addressed the
7 Committee to talk about a VBID design, and its potential
8 use for CalPERS.

9 In July, we introduced the VBID -- that's July of
10 2016, we introduced the idea of a VBID plan design when
11 Dr. Mart Mark Fendrick came from Michigan and talked about
12 the merits of these types of designs.

13 In January, Mr. Robert Krzys came out and talked
14 about how Connecticut used a Value-Based Insurance Design.
15 And in that description of their design, they actually had
16 two types of -- they had a PPO product, but they require
17 their membership that if they wanted to have the value at
18 a lower premium for a Value-Based Insurance Design, they
19 actually had to leave the PPO plan and join that other
20 plan.

21 And so we looked at whether that was a model that
22 might work for us, where you have two plans, and based on
23 what they do in terms of wellness and health programs,
24 they would actually either stay in the PPO or be placed in
25 the other plan.

1 We found that to be an intriguing approach, but
2 there would be some system challenges for us. In July, we
3 brought out Josh Fangmeier to talk about Minnesota's
4 approach Value-Based Insurance Design. Mr. Fangmeier
5 talked about how they tiered their physicians into four
6 tiers. And based on the tier you selected, that is how
7 your premium would be determined.
8 That, too, we thought had some challenges. But
9 in looking at the those two models, we felt there were
10 pros and cons of each. So in July, we also presented our
11 idea of how to develop Value-Based Insurance Design, which
12 would be based on using health and wellness incentives to
13 reduce the deductible components of the PERS Select plan.
14 We continued to look those designs, and in
15 September came back and said we have come up with not
16 three but five health and wellness products that we want
17 to include in a VBID design, and we have identified $100
18 per incentive that could reduce a deductible in the
19 Value-Based Insurance Design. And then we also looked at
20 our -- our Choice and Care plans as well.
21 And so today, we said that we could come back and
22 continue explore -- to explore not only a Value-Based
23 Insurance Design approach that we thinks work, it's
24 efficient -- works, it's efficient, it works within the
25 systems that we have that support our benefit designs.

1 And so we're here to continue to update you on
2 the progress of the VBID, as well as progress for making
3 on a modernization of PERSCare and PERS Choice.
4 --o0o--
5 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
6 DONNESON: So this just is an illustration of our journey.
7 We did the sample, as I discussed. We came up with a VBID
8 plan for the PPO. We have looked at Care and Choice, in
9 terms of aligning the three plans as a single ecosystem,
10 in terms of how they work in relation to each other.
11 For the VBID, the greatest attribute, in terms of
12 managing the health and wellness of the Select population
13 would be the mandatory attribution of our members to a
14 primary care physician who would then direct the care of
15 that population. And because this PPO Select is in all 58
16 counties, members in a select VBID plan would have the
17 opportunity to have Care directed like HMOs, even though
18 and HMO is not available in 18 of the 58 counties that we
19 have today. So this gives you an HMO type of design, but
20 it is a PPO product.
21 We then looked at the wellness incentives that
22 would reduce the deductible. And I'll get into the design
23 in the next slide. But we also, in looking at the three
24 plans together, we looked at the migration that happens
25 between our plans, Select to Choice to Care.

1 And, Gary McCollum, or CalPERS actuary, will help
2 answer questions related to both the design and the
3 migration between those three plans.
4 --o0o--
5 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
6 DONNESON: Gary.
7 SENIOR LIFE ACTUARY McCOLLUM: Thank you, Kathy.
8 Gary McCollum, CalPERS team member. Good
9 morning, Madam Chair and members of the Committee.
10 CHAIRPERSON MATHUR: Good morning.
11 SENIOR LIFE ACTUARY McCOLLUM: So in this process
12 in developing a proposed VBID product, it prompted a
13 review of the Choice and the Care benefit designs, which
14 have not changed since somewhere in the mid-2000s.
15 So we would really want the Board to consider the
16 interaction of the three plans in a total perspective. As
17 Kathy mentioned, think of it as an ecosystem, because the
18 three plans do interact with each other. Member
19 perception of the PPO program will drive migration between
20 the three plans.
21 Currently, Select is the lowest premium, Choice
22 premium is a little higher than Select, and then Care is
23 the most expensive. Now, under the proposal that we're
24 putting forth for optimizing the design of the plans, this
25 premium relationship will remain the same, but with the

1 introduction of the VBID, we're attempting to guide
2 members to the plan with not just the lower cost, but also
3 the higher value care.
4 So as Kathy mentioned, the Select VBID design
5 acts Similar to an HMO design, but it's offered through a
6 PPO plan. And this would be a benefit that would then
7 become available to our members in the areas of the State
8 where HMO coverage is not an option currently.
9 So it's going to go back to Kathy now to talk
10 about the proposed plan design changes, and then I'll talk
11 about the financial impacts.
12 --o0o--
13 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
14 DONNESON: So -- and I wanted to walk you through the
15 designs that we are putting forward as the Value-Based
16 Insurance Design to -- for Select. I also want to direct
17 your attention that there is Attachment 1, page 1 that
18 lays the three plan designs out next to each other.
19 So this first slide I'm going to walk you through
20 VBID and the attributes of the VBID plan. And then I will
21 walk you through the attributes of the changes that we
22 intend to make where we would like to ask you to make, in
23 terms of PERS Choice and PERSCare, so that we've aligned
24 our three products.
25 If you look at this proposal, we propose that the

1 deductible would raise from 500 for a single individual
2 and 1000 for a family, to 1500 and 3000. Now, that seems
3 like a considerable change. However, if we add $500 of
4 incentives to reduce that deductible, and then when we
5 combine that with a premium decrease, you're looking at
6 about a 9 percent premium decrease, and about $500 for a
7 single decrease on the deductible and $1,500 decrease on
8 the families. So that is a -- that's a change.
9 However, we're also recommending a drop of the
10 copay if the member vol -- mandatorily attributes to the
11 physician to drop the copay for the office visit from $20
12 to $10, and to also reduce copays for certain value-add
13 services in terms of being directed by the primary care
14 physician.
15 Now, in terms of those attributes of health and
16 wellness that drive the incentives, we would be looking at
17 biometric screening, nonsmoking certification, a second
18 opinion -- a second opinion program should surgery be
19 warranted, a condition care program, in which that is
20 designed for members with chronic conditions such as type
21 1 or type 2 diabetes.
22 I also want to point out that mental health or
23 behavioral health primary care would be $10, the same as
24 it would be for another type of primary care visit, which
25 we think is really important.

So these are the different incentive programs. And you don't just certify once. Every year -- it's similar to Connecticut, you certify every year. And through that certification, you have that lower deductible.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Moving on to the PERS Choice and PERSCare. We are recommending some change to certain copays related to high value, low value care. Specialist visits, our PPO PERS Choice and PERSCare members have the option of going straight to a specialist. We are not recommending any mandatory attribution. That component would continue to remain, that you -- they still -- a Choice or Care member still can select their specialist. If the specialist directs them to surgery, they don't have to have a second opinion. So we have retained some of the elements of those -- the flexibility and freedom of choice in the Care and Choice plans.

I would like you to note, however, that for several years, over 10 years, the deductibles of 500 and 1000 have been the same for the three plans Select, Care and Choice. Those deductibles have not changed. Yet, the Care plan has a 90/10 benefit, and the Select and the Choice plans have an 80/20 benefit.

And so there has been -- as we've looked at

1 migration over especially the last three years, and the
2 price of the Care product compared to the price of the
3 Select product, we do know that we've lost a population of
4 healthy members into the Care plan, which has a tendency
5 to be a -- it's a ro -- it's a better set of cost share in
6 terms of 90/10, and our healthy members are going and
7 using the same services as those of our sickest members.
8 So the idea behind this is to capture those
9 healthy lives, bring them back to the Select plan, and
10 have them have the benefits of maintaining their health.
11 They tend to be younger, and they tend to be healthier.
12 We want to have them back and work on programs designed to
13 keep them healthy, and then look at our Care population
14 and look at programs that we can do for those that tend to
15 be older that tend to have more chronic conditions.
16 So this is a -- this is again why we are looking
17 at this as kind of an ecosystem so that we can look at
18 benefit design that guides behaviors to maintain health,
19 but also to look at, on the Care side, population health
20 programs that may render better care to those members.
21 --o0o--
22 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
23 DONNESON: Moving on, I don't want to -- I want to turn
24 this back to Gary, so you can look at some of the costs
25 associated with our plans and have him walk you through

1 some of the cost savings.
2 SENIOR LIFE ACTUARY McCOLLUM: Okay. So we've
3 illustrated using current 2018 premiums the impact on the
4 Select plan between what it currently is and what it would
5 be under the proposed VBID. The first column are numbers
6 before risk adjusting. As you can see, the current Select
7 is about $474. And with a 9 percent estimated reduction
8 in premium, the new VBID would be about $431. That's
9 about $43 a month reduction.
10 If you go to the next column, that's the impact
11 after risk adjustment. The current Select program is at
12 $661. A 9 percent reduction would reduce it to about 601,
13 which would be $60 dollar reduction. Now, don't be fooled
14 by thinking that the $60 reduction is actually a better
15 deal, so to speak, than the $43 reduction, because it's
16 $60 off of a higher starting point, as opposed to 43 off a
17 lower starting point.
18 If we look at the impact that we've proposed to
19 the Care and Choice plans, the Choice plan would be
20 reduced by approximately 2 percent under the proposed
21 increase to the deductible, and the Care plan's premium
22 would be reduced by approximately 4 percent by increasing
23 that deductible.
24 And then the impact of risk adjustment, of
25 course, if we were to eliminate risk adjustment, the Care

1 plan premium would go up significantly.
2 So next slide.
3 --o0o--
4 SENIOR LIFE ACTUARY McCOLLUM: This is an overall
5 look at the cost reductions under the proposal. The first
6 line is just the impact of the plan designs. As you can
7 see, the Care plan would be reduced by about $12 million,
8 the Choice plan by about 34 million, and the new Select
9 VBID plan would go down by about 11 million for a total of
10 $57 million.
11 And the reason the Choice plan reduction there is
12 so large compared to the other two is because the Choice
13 plan is so much larger than the other two plans in terms
14 of members. It has 130, 140 thousand members, I believe,
15 as opposed to 30 or 40 thousand members in the other two
16 plans.
17 The second line, the migration impact, you can
18 see the migration impact would actually increase the cost
19 to Care, and decrease the cost to Choice, and increase the
20 cost to the new VBID, but an overall reduction of about a
21 half a million dollars. And that's assuming that
22 migration is the same as it's been for the last four our
23 five years with the impact of risk adjustment influencing
24 individual's choices of plan movement.
25 And then the wellness incentives due to the VBID.

1 As you can see, it only would impact the new Select plan,
2 and it would add about two and a half million dollars to
3 the cost, but that's, of course, because we're encouraging
4 them to take advantage of these wellness incentives to
5 generate a healthier population.
6 And then finally, the network impact. You can
7 see it would actually increase costs in Care and Choice by
8 small amounts, but it would decrease costs by almost three
9 million in the PERS Select plan, because it is a more
10 efficient network. And when you add those all together,
11 you get about $57 million estimated reduction in costs.
12 CHAIRPERSON MATHUR: Gary, can I just note that
13 there's a typo I think on the migration impact line, that
14 the estimated total savings, it should be 0.5 instead of
15 0.05, is that right?
16 SENIOR LIFE ACTUARY McCOLLUM: Oh, you're right.
17 Thank you. Yes. 0.5.
18 CHAIRPERSON MATHUR: Thank you. You said it
19 right, but it was --
20 SENIOR LIFE ACTUARY McCOLLUM: 0.5 million yes,
21 $500,000.
22 Now, one last point to make on this slide is that
23 it does not include any potential cost savings that might
24 result from lower claims costs as a result of members
25 participating in these wellness activities, and as I said,

1 becoming healthier and reducing costs in the future.
2 --o0o--
3 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
4 DONNESON: I want to remind the Committee that as we
5 started this journey, it was a value-based approach to
6 managing health, wellness, and affordability, and also a
7 mechanism by which we want our members to be guided to
8 higher value care.
9 For example, when you have back pain, for
10 example, you can go straight to a specialist, you can be
11 diagnosed with a bulging disc, and you can go straight to
12 surgery. You will find in the literature that is not
13 considered high value care. And more and more, the
14 evidence shows that it is not high value care.
15 So in these -- looking at these three designs, we
16 are also proposing to increase the deductible in the
17 Choice population from 500 to 750, and we're also looking
18 at the Care with that 90/10 differential to increase that
19 from 500 to 1000 for a single-person deductible.
20 So again, the Value-Based Insurance Design is --
21 has been put forward here as a high-value approach to care
22 in the maintenance of a member's health. And for those
23 who wish to select this design, even if they have multiple
24 chronic conditions, it is an option for them, in which
25 they will mandatorily attribute to a primary care

1 physician and have that care managed.
2 For the Choice population, they still have the 80
3 -- the advantage of the 80/10 cost share. They still
4 retain the Choice of specialist of how to -- they -- in
5 fact, that's why most members are in Care and Choice is
6 because they want to keep their own specialist, and they
7 want to deal with all doctors who may not be within
8 that -- a particular plan design.
9 So there's choice in Choice, and there's choice
10 in Care, but Care is a 90/10 plan design. And that is a
11 richer benefit for whom the deductible is not matching the
12 design appropriate to that largesse within the 90/10
13 benefit.
14 So choice is retained, we've balanced our plans,
15 we've offered a VBID, and that is going to take us to what
16 are the next steps.
17 --o0o--
18 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
19 DONNESON: We continue to model. We're not done. We're
20 presenting this update so that we can seek additional
21 guidance. We do need to evaluate the impact of risk
22 adjustment, which we will come back with that analysis in
23 February.
24 We continue to look at changes in migration that
25 have occurred really over the last three years, in which

1 we're losing Choice members to Care, and we've lost Select
2 members to Care, which has supported its growth.
3 We will continue to engage with our stakeholders
4 to seek feedback. We'd also like feedback from employers,
5 and we will seek board approval in March, but should you
6 not feel that you're ready in March, we actually have till
7 June when we adopt all the rates, and that's when we
8 finalize our plan designs.
9 So as part of this process, we will incorporate
10 between now and June rate -- the 2019 rates associated
11 with either the current plans or the future plan designs.
12 That concludes our presentation and we're happy
13 to take particular questions.
14 CHAIRPERSON MATHUR: Thank you. Well, before I
15 turn to questions, I just want to say thank you to the
16 team for continuing to pursue really innovative,
17 thoughtful approaches to both improving our members health
18 outcomes and driving them towards evidence-based care and
19 high value care, and reducing the cost of care for our
20 members as well.
21 And this is -- that's the magic formula that
22 we're all trying to hit, I think, as purchasers. And I
23 really respect and value the contributions of your team on
24 this. Okay. So let me move to Ms. Hollinger who has a
25 question.

1 COMMITTEE MEMBER HOLLINGER: Yeah. Thank you.
2 I just want to say that -- reiterate Ms. Mathur
3 that the work you're doing in lowering costs, increasing
4 value, my compliments to the staff.
5 I have a question when we're talking about
6 migration. Since the majority -- since we have a maturing
7 plan where the majority of our members are aging versus
8 the young people coming in, do we still get the same
9 impact? You know, does it carry the weight in terms of
10 reducing the cost for our members who are at the top of
11 the health care pay scale?
12 SENIOR LIFE ACTUARY McCOLLUM: The member
13 migration will impact this overall design by -- if they
14 migrate to the VBID plan --
15 COMMITTEE MEMBER HOLLINGER: Uh-huh.
16 SENIOR LIFE ACTUARY McCOLLUM: -- we're
17 anticipating, we're confident that it will help improve
18 their outcomes, whether they're currently healthy and they
19 say healthy or whether they're --
20 COMMITTEE MEMBER HOLLINGER: So you're not just
21 counting on a certain segment, you're just -- on our
22 overall population.
23 SENIOR LIFE ACTUARY McCOLLUM: Correct
24 COMMITTEE MEMBER HOLLINGER: Okay. Got it.
25 Okay.

1 SENIOR LIFE ACTUARY McCOLLUM: Yes. This is --
2 this is designed to be -- to be applicable to the full
3 population from soup to nuts.
4 COMMITTEE MEMBER HOLLINGER: Got it.
5 CHAIRPERSON MATHUR: In the basic plans.
6 COMMITTEE MEMBER HOLLINGER: Right.
7 SENIOR LIFE ACTUARY McCOLLUM: The VBID plan,
8 yes.
9 COMMITTEE MEMBER HOLLINGER: Okay. Okay. Thank
10 you for clarifying that for me.
11 CHAIRPERSON MATHUR: Mr. Lofaso.
12 ACTING COMMITTEE MEMBER LOFASO: Thank you, Madam
13 Chair. Also ditto what the Chair said, there is a lot
14 going on underneath the hood, as they say.
15 Two questions back to member migration. So I
16 heard a couple things you said but I was tempted to ask
17 whether or not it was a zero sum game. And then, of
18 course, I reread the chart. The chart says that member
19 migration has a net cost of half a million dollars, but I
20 think your answer Mr. McCollum, just indicated that the
21 cost savings are in the VBID incentive side of the
22 equation. But I guess why does member migration in and of
23 itself have a -- seem to have a slight cost?
24 SENIOR LIFE ACTUARY McCOLLUM: Under -- you're
25 talking about in the chart?

1 ACTING COMMITTEE MEMBER LOFASO: Yeah.
2 SENIOR LIFE ACTUARY McCOLLUM: Yeah. Okay. In
3 the new PERS Select, it shows the increase of about
4 $600,000. That would be in anticipation of less healthy
5 members moving into the -- choosing the VBID. And they're
6 going to increase the cost to begin with, because they're
7 less healthy.
8 Now, the idea is that once they go into that
9 plan, they would then hopefully employ the incentives that
10 are a available, the wellness activities and so on, and we
11 could either improve or at least maintain their health.
12 Now, on the Care side, it shows an increase in
13 migra -- a cost due to migration. That would be under the
14 assumption that the healthier members of Care would be the
15 ones most likely to move, which would leave the Care plan
16 less healthy, so that the costs would go up on the --
17 under the Care plan.
18 ACTING COMMITTEE MEMBER LOFASO: Costs would go
19 up on the Care plan. Okay. Appreciate that.
20 As I looked around all this, I thought I saw
21 something in the agenda materials about actuarial values,
22 and I was working my brain, because I was thinking about
23 the deductibles, and the cost sharing. And I think I did
24 see that there was a further action step on actuarial
25 values.

1 But I just couldn't quite figure out how to,
2 thinking that way, A, it seems to me the VBID incentives
3 don't write -- figure into actuarial values because it's
4 claim not paid ultimately; but B, that -- with if
5 cost -- with the 90/10 versus the 80/20 in comparison to
6 deductibles, where do you think we're going on actuarial
7 values with these plans?
8 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
9 DONNESON: In terms of actuarial values, I don't think we
10 actually wrote any analysis of actuarial value, but what
11 we did do in the exhibit attached to this agenda item was
12 to compare the Covered California Silver Plan, and that
13 might be what's triggering an actuarial value. We did not
14 do any analysis, but the Silver Plan -- we compared the
15 Silver Plan for Covered California to the three plans that
16 we're proposing here.
17 ACTING COMMITTEE MEMBER LOFASO: Appreciate that.
18 Thank you.
19 SENIOR LIFE ACTUARY McCOLLUM: Could I just clear
20 something up?
21 CHAIRPERSON MATHUR: Please.
22 SENIOR LIFE ACTUARY McCOLLUM: An actuarial
23 value, a simple way to think of it is it's the percentage
24 that the plan pays, as opposed to the percentage that the
25 member pays. Our current PPO plans, currently designed,

1 are what the Covered California considers Gold, somewhere
2 in the 80 percent range of plan coverage.
3 The Silver Plan that she mentioned drops you into
4 the 70 percent range. And we have not analyzed where the
5 current VBID proposal would end up, whether it would be a
6 Gold Plan or a Silver Plan.
7 ACTING COMMITTEE MEMBER LOFASO: Thank you.
8 CHAIRPERSON MATHUR: Okay. Thank you.
9 Mr. Gillihan.
10 COMMITTEE MEMBER GILLIHAN: Thank you, Madam
11 Chair. As somebody whose been rather critical of our
12 ever-increasing health care costs, I do want to thank you
13 for this plan. It looks like we're moving in the right
14 direction. I'd still like us to be perhaps a little more
15 aggressive in some of these design choices, but I do want
16 to thank you, because this is headed in the direction that
17 we've been asking the staff to consider for a few years
18 now, so thank you.
19 CHAIRPERSON MATHUR: Thank you. Mr. Jones.
20 COMMITTEE MEMBER JONES: Yeah. Thank you, Madam
21 Chair. Yeah, thank you for the report. As you move
22 forward, I would be interested in having a profile of a
23 member, what's the impact on an individual? That's the
24 important thing. Because we could see a lot of this is
25 based on assumptions. If this happens, that happens. If

1 this happens -- so I would like to know what those
2 assumptions are, and what's the actual impact on our
3 members as you go forward with this?
4 Because it would be different, I would imagine,
5 based on the plan, and whether it's 90/10 or 80/20?
6 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
7 DONNESON: We intend to go back now and look at
8 migration -- why people are migrating to look at, as you
9 said, on new member experience and get greater detail on
10 what's underneath our membership for the -- that are
11 within these plans, and what -- kind of what is their
12 profile in terms of why they have moved, why they would
13 come back, and bring that back to you.
14 CHAIRPERSON MATHUR: Thank you.
15 Mr. Jelincic.
16 BOARD MEMBER JELINCIC: Yeah, on the issue of
17 migration over the last three years, I think a big part of
18 that has been our risk adjustment. If we narrow the gap
19 between Select and Care, and Care offers higher values,
20 but the premiums are narrower, people are going to move
21 there. So I think that's been a big part of the
22 migration. And if you think I'm wrong, explain why I'm
23 wrong.
24 SENIOR LIFE ACTUARY McCOLLUM: No, I can't
25 disagree with anything you just said.

1 BOARD MEMBER JELINCIC: Okay.
2 SENIOR LIFE ACTUARY McCOLLUM: And that's why I
3 pointed out that the current migration assumptions that
4 have been built into this -- these estimates are based on
5 the last five years of migration patterns.
6 BOARD MEMBER JELINCIC: And then on Attachment 3,
7 page 9 of 11, wellness incentives in the new Select two
8 and a half million dollars that's the $500 savings -- or
9 reduction in deductible.
10 SENIOR LIFE ACTUARY McCOLLUM: That's correct.
11 BOARD MEMBER JELINCIC: Okay. Years ago, I was
12 an insurance analyst. And one of the things I learned as
13 an analyst is that if you provide less insurance, it costs
14 less. And that's really what I'm seeing here. I'm seeing
15 this as a movement towards a higher deductible plan. And
16 I'm not particularly inclined to go that way, but I'm not
17 going to be around to vote on it, so you may not have to
18 worry about what I think.
19 But what I don't see here is how do we actual --
20 how does this proposal actually increase the use of high
21 value service, and how does it actually reduce the use of
22 low value service?
23 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
24 DONNESON: The reason we have presented this design in the
25 manner we have and really focused on the primary care

1 provider is that if you look at the -- how our HMO members
2 are directed in terms of their care, they do attribute to
3 a primary care physician by virtue of being in the HMO.
4 And that physician guides their care. And that physician
5 has some incentives in terms of guiding that care in terms
6 of integrated health, in terms of knowing where they are,
7 in terms of their wellness activities.
8 So we believe that primary care driven behavior
9 for patients is good, and we believe that that has enabled
10 our patients to have better care, and to keep our costs
11 down. So the debate about high value/low value care will
12 continue in terms of what is high value care. But we
13 believe, as a minimum, primary care directed patient care,
14 on the basis of evidence, is what we need to be moving
15 forward, whether it's in an HMO or a PPO.
16 Again, if you look at the freedom of choice
17 within our PPOs, and what the evidence shows on behaviors,
18 such as reference pricing for hips and knees, and
19 ambulatory surgery centers, our members are motivated to
20 seek high quality care. And they're being directed by, at
21 least in the HMOs, by the primary care physicians.
22 So if you take an example of what is high-value
23 care around say low back pain, which is one of our
24 initiatives under Smart Care California, there's a lot of
25 evidence now that surgery should be the last resort. And

1 even physical therapy might be an intermediate approach to
2 good provider-guided behaviors for a member who has low
3 back pain. That is to walk, that is to lose weight, that
4 is to do exercises.
5 So if you -- that is an example of high value
6 care. And it's the direction that we want, not just
7 treatments for low pack pain to go, but a whole
8 constellation of care that should be high value. For
9 example, MRIs, x-rays, are they necessary to have in terms
10 of low back pain?
11 So it's a constellation of efforts that look at
12 what -- on the basis of evidence. What is good care, and
13 what is the cost of that good care? And high-value care
14 tends to be lower than low-value care.
15 BOARD MEMBER JELINCIC: Almost by definition.
16 (Laughter.)
17 BOARD MEMBER JELINCIC: So what we are saying
18 will drive people to higher valued care and away from
19 lower valued care is that we've reduced the copay for a
20 doctor visit from 20 to 10, and the doctor controls
21 whether you get to see a specialist, or get surgery, or
22 that. So that's where we think it's driving.
23 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
24 DONNESON: Driving I don't know is the word I would use.
25 I really believe in primary care physician care.

1 BOARD MEMBER JELINCIC: I've belonged to Kaiser
2 forever, so yeah.
3 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
4 DONNESON: Okay. So, yes, under this plan and under the
5 changes that are happening in terms of how care is
6 delivered in integrated health models, these do coordinate
7 very nicely with each other, so...
8 BOARD MEMBER JELINCIC: Okay. And on -- it was
9 on slide 9 of 11. Now, I've got to find it, because it
10 was in an exhibit. Oh -- I'm sorry. I had already asked
11 that question.
12 The -- okay. I've asked my questions. Thank
13 you.
14 CHAIRPERSON MATHUR: Thank you, Mr. Jelincic.
15 Ms. Taylor.
16 COMMITTEE MEMBER TAYLOR: Yeah, I wasn't going to
17 ask any question, because it was pretty self-explanatory,
18 but then you were talking about the low back pain. So
19 currently what you're saying is HMOs make sure that if
20 there's -- if it's not necessary to do an MRI, or have
21 surgery, or have physical therapy, they -- they don't do
22 that, but that -- but the PERSCare -- I'm sorry, whichever
23 one it was -- is not doing that. So that's where you're
24 trying to drive those patients.
25 HEALTH PLAN ADMINISTRATION DIVISION CHIEF

1 DONNESON: Let me clarfy. Currently, there's a lot of
2 choice in Care -- in the PPOs for our members to seek care
3 that is not in a managed care environment. My only point
4 was we have -- we have a number of members in the HMO
5 population, and that care is managed. And we work with
6 our HMOs in terms of how they're managing that care.
7 COMMITTEE MEMBER TAYLOR: And so then to
8 extrapolate what you're saying is that PERSCare, this new
9 VBID program would work kind of like an HMO to make that
10 happen?
11 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
12 DONNESON: That's correct.
13 COMMITTEE MEMBER TAYLOR: I just wanted to clarfy
14 that, because I think it sounded a little confusing, and I
15 just wanted to make sure that that was --
16 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
17 DONNESON: Okay. So again, it's the idea that under a
18 VBID with a primary care physician, care would be directed
19 in a very similar manner to how the HMOs direct care, and
20 it would be available in counties that are -- that don't
21 have an HMO to -- that's the idea.
22 COMMITTEE MEMBER TAYLOR: Right. So -- and then
23 hopefully bring some of those costs down.
24 I think the only other question I had, I think it
25 was Mr. Jones that brought up whether or not we should be

1 looking at, as this goes into effect, are we going to lose
2 people out of the PERS system -- the PERSCare system into
3 other -- if they can. I don't know if they can move
4 elsewhere, and are you going to be looking at -- because
5 of this, and are you going to be looking at that? Are you
6 going to be doing like a survey if they -- you know, if a
7 population of -- an amount of people leave or a
8 substantive amount of people leave because we're
9 instituting this, it would be nice to know why, et cetera.
10 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
11 DONNESON: I think you're -- if I'm understanding your
12 question, are we looking at the migration out of the PPO
13 plan --
14 COMMITTEE MEMBER TAYLOR: Right.
15 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
16 DONNESON: -- into the HMO product?
17 COMMITTEE MEMBER TAYLOR: Like, if we institute
18 the VBID, right, are you expecting a migration because of
19 this?
20 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
21 DONNESON: Only across -- the only migration we're looking
22 at now is across the three plans, but certainly we would
23 look at any expected migration to the Health Maintenance
24 Organizations where they're available. But we've tended
25 to not see, I don't think -- and I'll ask Gary to answer

1 the question -- a lot of migration out of the PPOs to the
2 HMOs.
3 SENIOR LIFE ACTUARY McCOLLUM: No, the migration
4 between HMOs and PPOs is fairly small.
5 COMMITTEE MEMBER TAYLOR: And you don't think the
6 cost will -- the increased costs will drive that, and
7 maybe the inability or unwillingness for them to change
8 their behavior would -- I guess it would -- they would go
9 to one of the other PPOs.
10 SENIOR LIFE ACTUARY McCOLLUM: Right. If they
11 choose -- if they don't want to attribute to a physician,
12 if they don't want to go through those wellness
13 incentives, they might choose Choice.
14 COMMITTEE MEMBER TAYLOR: Right. They'd choose
15 the Choice plan instead. Okay.
16 SENIOR LIFE ACTUARY McCOLLUM: Because that's --
17 that's remaining as a traditional PPO plan.
18 COMMITTEE MEMBER TAYLOR: Okay. So they could
19 migrate out of that. And that might be nice to know --
20 CHAIRPERSON MATHUR: That's what slide 9 --
21 COMMITTEE MEMBER TAYLOR: -- see how many people
22 are, one, willing to --
23 CHAIRPERSON MATHUR: That's what slide 9 is
24 highlighting, correct, is the migration between those
25 three plans, between Sil -- the VBIDs --

1 SENIOR LIFE ACTUARY McCOLLUM: Right. Yes, under
2 current migration patterns.
3 CHAIRPERSON MATHUR: Yeah.
4 COMMITTEE MEMBER TAYLOR: Yeah, and not -- the
5 program isn't instituted yet, so yeah.
6 CHAIRPERSON MATHUR: Right, yeah.
7 COMMITTEE MEMBER TAYLOR: And then my last
8 question was the $200 copay for the hospitalization. I'm
9 just a little concerned about that, because if you don't
10 get hospitalized, you have to pay it. So that went from,
11 what, $50 to $200, I think that -- that could be something
12 that could be an issue with folks. It's just my concern,
13 maybe not.
14 But we don't expect to go to the emergency room,
15 when we go. So it's just a thought on that.
16 Thank you.
17 CHAIRPERSON MATHUR: I see no further requests
18 from the Committee, but I actually have a few questions.
19 One is you've talked a lot about what attributing to a
20 primary care physician does and how that helps this
21 VBID -- this proposed VBID plan to mimic, in some ways,
22 and HMO plan. But you haven't talked as much -- or maybe
23 I haven't fully understood why we are reducing the premium
24 and increasing the deductible? How -- what does that due
25 to drive to better value, higher value choices?

1 SENIOR LIFE ACTUARY McCOLLUM: Well, we need to
2 correct a misstatement there.
3 CHAIRPERSON MATHUR: Okay.
4 SENIOR LIFE ACTUARY McCOLLUM: We're not reducing
5 the premium and increasing the deductible. The proposal
6 is to increase the deductible. That creates a reduced
7 premium, since it's a reduction in plan costs.
8 CHAIRPERSON MATHUR: Right, it's a balance
9 between the two, right?
10 SENIOR LIFE ACTUARY McCOLLUM: Right.
11 CHAIRPERSON MATHUR: So -- but why -- why would
12 we -- even -- so even after the $500 reduction or
13 incentives, that there is still an increased deductible
14 under the proposed Select plan. And, in fact, an
15 increased deductible for PERS Choice and PERSCare under
16 the proposal in Attachment 1. What is the justifi -- what
17 is the argument or what is the rationale behind increasing
18 the deductible?
19 SENIOR LIFE ACTUARY McCOLLUM: The increase in
20 the deductible for the VBID program is part of creating a
21 lower cost higher value plan. The increases proposed to
22 the Choice and Care are being done in an attempt to align
23 the three plans together, so that the migration -- as I
24 said, member perception drives a lot of their -- what they
25 choose.

1 And we're trying to avoid making the Care plan,
2 with its 90/10 benefit, and if it only has a $500
3 deductible, it could easily be perceived as the best value
4 out there.
5 And everybody flocks -- not everybody, but a lot
6 of people flock to the Care plan, and that's not the goal
7 of our proposal.
8 CHAIRPERSON MATHUR: Yes. But I guess what I'm
9 trying to get at is how is it that a higher deductible
10 leads to a lower cost plan? What is -- why does that make
11 it a lower -- you mean, it's a lower premium plan?
12 SENIOR LIFE ACTUARY McCOLLUM: Correct.
13 CHAIRPERSON MATHUR: So, but -- and so you think
14 it's the premium that's going to drive members to select
15 the PERS Select plan, that they -- that the -- that
16 having -- so that -- it is a -- the 9.1 percent reduction
17 and the propose -- or estimated reduction in the premium
18 is driven completely by the change in the deductible, not
19 the other behaviors, the attribution to the PCP, or is it
20 some combination of all of those things?
21 SENIOR LIFE ACTUARY McCOLLUM: Well, the 9
22 percent reduction is driven by the deductible change, and
23 also the changes in the copay that are there. So it's the
24 cost changes that drive that premium. It's not the member
25 attribution.

1 CHAIRPERSON MATHUR: Okay. And did you --
2 SENIOR LIFE ACTUARY McCOLLUM: Member attribution
3 is hopefully going to drive their future.
4 CHAIRPERSON MATHUR: Future cost savings.
5 SENIOR LIFE ACTUARY McCOLLUM: Cost savings,
6 correct.
7 CHAIRPERSON MATHUR: So -- and did you look at
8 what keep -- if you kept the deductible at 500, let's just
9 say, or maybe 750, did you look at different levels of
10 deductible and what that would -- what the resulting
11 premium would be -- what the premium differential would
12 be?
13 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
14 DONNESON: We haven't looked at that yet, but we are at a
15 point in time where we thought we could come forward and
16 show you how the three plans work together, and then go
17 back to the drawing board and continue to do additional
18 analyses, both around the plan design, and around what we
19 expect migration might be, what we -- I mean, there's
20 still more work to do.
21 We haven't looked at what it means to drop the
22 deductible for -- from $20 dollars to $10. And we haven't
23 looked at how that relates to mandatory attribution. We
24 believe that there will be savings associated with changes
25 in deductibles. We also want to look at what might be the

1 EV use from an expected population to see if the 200 is
2 too aggressive. So there's -- there's still quite a bit
3 of work to do, which is why we're --
4 CHAIRPERSON MATHUR: Yeah.
5 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
6 DONNESON: -- we're just giving you an update now, and
7 seeking your questions, and coming back in February to
8 continue the dialogue, and, you know, also build in some
9 impacts to the 2019 rates. We need you to take a look at
10 that as well. We don't get to -- we don't do our designs
11 in the vacuum without looking at what the savings are
12 associated with premiums.
13 CHAIRPERSON MATHUR: Of course.
14 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
15 DONNESON: Thinking also about contracting agency
16 employers and retirees and whose benefits may not be as
17 generous.
18 CHAIRPERSON MATHUR: Well, I think it would --
19 oh, sorry, Ms. Bailey-Crimmins, did you want to add
20 something?
21 CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: I just
22 wanted to also point out one of the things -- regardless,
23 if we move forward with VBID or not, it's been more than
24 10 years that we've actually looked at the deductibles of
25 the PPO. So we have to look at are we going to risk

1 adjust, what is that deductible, are we staying current
2 with the inflation of health care?
3 You know, are we working against ourselves. So
4 there's lot of analysis. I just wanted to make sure
5 individuals understood that even if we decided not to do
6 VBID, there still is an inflation factor here. And as we
7 go through the rate process, we'll have to look at what
8 those deductibles will need to be in order to pay for the
9 services in that -- in those plans.
10 CHAIRPERSON MATHUR: I think it would also be
11 worthwhile though, understanding -- you know, one of the
12 things we've talked about before is that at a certain
13 price, it might keep people from getting necessary care.
14 So what -- is there a deterrent factor?
15 And I don't want to presume whether there is or
16 is not, but I think it would be worthwhile exploring that
17 also, because we don't want to, on the one hand, be trying
18 to incentivize people to get high-value care, and on the
19 other hand keeping people from actually seeking the care
20 that they need, when they need it.
21 So just -- I know there's a lot more work to be
22 done, and there's probably -- endless amounts of work to
23 be done, but I would just add that maybe we can look at
24 that as well.
25 One thing -- another question I had, and I think

1 maybe you mentioned this, Ms. Donneson, is how much
2 evidence is there, or what kind -- what do studies of
3 similar types of structures show about how long it takes
4 lower claims to manifest when you attribute to a primary
5 care physician, or, you know, try to drive to a higher
6 value care.
7 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
8 DONNESON: Well, we can certainly go back to some of our
9 counterpart's dates that have been practicing with VBIDs
10 longer, certainly for several years now, and ask them that
11 question, ask them if they did see lower claims costs,
12 especially with the Connecticut model. Did you see lower
13 claims costs associated with the health and wellness
14 approach to plan design?
15 And then from Minnesota with the tiered
16 physicians, your premium is based on what tier of a
17 physician you go to. We can also go back and ask them
18 what their results are showing in terms of that type of
19 approach to a VBID.
20 CHAIRPERSON MATHUR: Because ultimately, we do
21 want to see better health outcomes and lower long-term
22 costs due to improved health status. And so to the extent
23 that we can get a better sense -- and I know it's going to
24 be hard to fully predict what that's going to look like in
25 our own population. But to the extent that we can get a

1 better sense of what that might look and over what time
2 period that might manifest, I think that would be useful.
3 Finally, I did want to underline what has been
4 said a couple of times, that this is a way of getting
5 closer to an HMO structure, particularly in those rural
6 areas where only a PPO is available. And we've heard from
7 our members for quite a number of years about the desire
8 to have a lower cost plan, a more HMO style plan in some
9 of those rural areas, where we've been unable to get, you
10 know, the physician groups or the hospitals to agree to
11 that type of a structure
12 So I think that that's also really exciting
13 aspect of this conversation is to -- the ability to really
14 offer something like that to our members in those areas
15 where it's not been available.
16 So we have one more request from the Committee.
17 Mr. Jones.
18 COMMITTEE MEMBER JONES: Yeah. Thank you, Madam
19 Chair. Understanding that this is a work-in-progress and
20 you mentioned that you had met with the retirees and
21 stakeholders, and you plan to continue to do so, which is
22 good, I applaud that, but could you give us a sense of
23 what issues or concerns they've raised to date regarding
24 these options that you're putting forth?
25 HEALTH PLAN ADMINISTRATION DIVISION CHIEF

1 DONNESON: Well, I think the -- one of the first issues is
2 that it's change, and that change in terms of where we are
3 today versus some of the goals of this Committee around
4 affordability and where we want to go. I think the
5 greatest concern that I've heard so far is from our State
6 retiree representatives that there are combo enrollment
7 members who are in the basic plan that affects -- that are
8 affected by this versus those in the Medicare plan.
9 I would say that we have discussed these VBIDs
10 now for a long time, several months actually to almost 18
11 months when it was first introduced, I think, in January
12 of 2016.
13 So I think -- but I think it did. If you missed
14 either not being at the offsite or you missed one of our
15 prior presentations, then perhaps it does seem like it's
16 come as a surprise.
17 We want to continue talking to our stakeholder,
18 but State and local, you know, contracting agencies. We
19 want to talk to the employers and see what their concerns
20 might be in terms of premium affordability. We're trying
21 to look at balance, both affordability, care delivery, and
22 continuing to manage costs as part of our overall goals
23 associated with CalPERS' desire to have value. Not just
24 cost and quality, but value.
25 So we have had that dialogue. Those are the two

1 things that came up. It came as surprise. It does affect
2 a -- potentially effects the combo enrollment members.
3 COMMITTEE MEMBER JONES: And on the combo
4 enrollment, didn't we approve a combo plan last year?
5 Which one was that?
6 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
7 DONNESON: It was the -- it was the Anthem Medicare plan
8 that matches the Anthem HMO plan, so --
9 COMMITTEE MEMBER JONES: And so that's the only
10 plan that provides the combo?
11 HEALTH PLAN ADMINISTRATION DIVISION CHIEF
12 DONNESON: It did provide some relief to the combo plans.
13 We have about 400 members that did migrate to the Anthem
14 HMO product. Some came from another carrier like Kaiser
15 has -- or United, but some did not. Some -- so I think
16 that your goal to make a Medicare plan align to an HMO
17 plan has worked the way we described it back in June.
18 COMMITTEE MEMBER JONES: Thank you.
19 CHAIRPERSON MATHUR: Thank you.
20 We do -- that exhausts the Committee's questions
21 as I see it now, and -- but we do have three members of
22 the public who wish to speak, so I'd like to call forward
23 now. Mr. Larry Woodson, Ms. Donna Snodgrass, and Mr. Tim
24 Behrens. If you could take these two seats here, identify
25 yourself and your affiliation for the record, and you'll

1 have 3 minutes in which to speak.
2 MR. BEHRENS: Good morning, Madam Chair, members
3 of the Committee. My name is Tim Behrens. I'm the
4 President of the California State Retirees. I appreciate
5 you giving me this opportunity to comment this morning.
6 The California State Retirees has strong objections to
7 many of the provisions in the proposed Value-Based
8 Insurance Design strategy that's been presented to you
9 today.
10 The agenda item title, "Optimizing Health Care
11 Benefit and Outcomes" will not optimize health outcomes,
12 but does create significant financial burden for all
13 members on Anthem PPO basic plans. In the statement that
14 it supports CalPERS strategic goal to transform health
15 care purchasing and delivery to achieve affordability is
16 contradicted by the huge increases in deductions for all
17 combination plan members, as well as pre-Medicare members.
18 The staff presentation at the stakeholders'
19 briefing last Thursday did not focus much on these
20 dramatic increases in deductibles across all three Anthem
21 PPO basic plans.
22 The focus was on incentives to allow credits to
23 reduce deductibles. We do not have any issues with
24 rewarding good health care practices. However, this does
25 not -- this does much more than that. The proposal would

1 increase deductibles for PERS Choice by 50 percent, fro
2 $1000 to $1500 for a family.
3 It would double deductibles for members in
4 PERSCare from 1000 to 2000 creating significant financial
5 hardship for many, and would triple deductibles for a
6 family on preselect to 3000 with an option to reduce that
7 by mere $100 increments resulting in a large out-of-pocket
8 expense before any insurance coverage would kick in.
9 This is not affordability for members at all. It
10 is worth noting that staff focuses entirely on the
11 pre-select plan to implement health and wellness
12 incentives, but offers no incentives to members in the
13 PERS Choice and PERSCare plans. It just raises their
14 already high deductibles by 50 percent and 100 percent.
15 We understand that staff has negotiated this with
16 Anthem with the intent to modestly reduce premiums. But
17 the reduction is being made on the backs of the members.
18 Combo families will be hit the hardest, because
19 they will not benefit from premium reductions, since combo
20 Medicare monthly premiums have always been fully covered
21 by the CalPERS contribution.
22 It is likely this plan will have the opposite of
23 the intended effect, and discourage members who may have
24 financial difficulties from seeking much needed medical
25 treatment, because their coverage won't kick in till

1 they've dished out $3,000 out of their retirement.
2 We urge the Board to direct staff to revise this
3 plan, especially for combination families on Anthem plans.
4 Larry Woodson will now give you some more details
5 regarding your proposal.
6 CHAIRPERSON MATHUR: Mr. Woodson.
7 MR. WOODSON: Good morning, Larry Woodson,
8 California State Retirees. Madam Chair, Board members,
9 than you for the opportunity to comment. I concur with
10 Mr. Behrens comments regarding this proposal, and will add
11 to them.
12 And by the way, some of my comments are right
13 along the lines of Madam Chair's comments and questions
14 and concerns.
15 So thank you.
16 First, I submit that this is much more than a
17 VBID proposal. Certain aspects are positive, but it is a
18 significant redistribution of cost from CalPERS to the
19 members to the tune of tens of millions of dollars.
20 To offer no cost reduction incentives to members
21 in two of the three PPO plans, while raising their already
22 high deductibles by 50 to 100 percent. It's not accept to
23 us, as is the tripling of deductibles to Select members,
24 hoping that that will motivate them to participate in
25 health incentive rebates.

1 Even full successful participation for Select
2 members and the incentives would still result in a much
3 higher cost for them realistically.
4 There is an implication in the information that
5 there is these higher deductibles are justified, because
6 they bring plan more in line with the National APA
7 deductibles.
8 And the high deductibles of the ACA have received
9 universal criticism from both supporters and opponents of
10 the ACA. There are many accounts of high deductibles
11 preventing people from seeking needed medical treatment,
12 often can result in higher costs as well as poor medical
13 outcome directly contradicting some of the assumptions of
14 this proposal.
15 There are 68,000 combination plan members, and we
16 know that not all of those have Anthem PPO plans, but
17 thousands do. And many of them have Anthem plans because
18 that's the only game in town in 18 counties, where Kaiser
19 and UnitedHealth are absent.
20 So they will have no choice to migrate to HMO
21 plans, and will be saddled with large deductibles.
22 Combination families will be the most financially
23 impacted, but are not the only impacted members under this
24 proposal. All Medicare-age retirees will have --
25 pre-Medicare age retirees will to pay these high

1 deductibles, as well as all active employees on Anthem
2 plans.
3 I'd like to point out that it wasn't long ago
4 when the PPO plans had 100 percent medical coverage, and
5 now they only cover 80 or 90 percent.
6 Lastly, we see again and again that medical and
7 drug costs are rising, and we're told why premiums and
8 deductibles must rise, but we also see the insurers year
9 after year, or in the top 20 percent of 500 -- Fortune 500
10 for revenues and profits. And again, in 2017, Anthem is
11 33rd. We don't feel that they need more of our money. We
12 hope that the Board and staff will reconsider these
13 deductible increases while retaining some of the more
14 positive aspects and provisions that reward good health
15 practices.
16 Thank you.
17 CHAIRPERSON MATHUR: Thank you, Mr. Woodson.
18 Ms. Snodgrass
19 MS. SNODGRASS: Good morning. Donna Snodgrass,
20 Director of Health Benefits for the Retired Public
21 Employees Association.
22 I did have just a statement. But as the
23 conversation went on, I was taking notes, so I'm going to
24 be jumping around a little bit.
25 What I was originally going to say is that I'm --

1 I'm going to call this one a swing and a miss, but there's
2 two more strikes, so we still -- we can still go forward.
3 Unless my math is considerably wrong for this
4 proposal, the only way it saves any member anything is to
5 never use it, or almost never.
6 How does a combined family even understand the
7 intricacies of something like this? Even with all the
8 increases in deductibles and copays, plus the restrictions
9 that appear to be in the usage, or discouragement in the
10 usage the premium reductions are minimal.
11 So who saves 57 million? It doesn't look like
12 the member gets anything. Certainly not the end user.
13 This looks more what's been touted as a high-low
14 insurance plan only under a different name. And by that,
15 I mean high cost and low benefit.
16 And it feels like the PERS members are being
17 herded into this. Well, at least it felt like it this
18 morning, but it was confirmed I think when Mr. Lofaso
19 answered -- asked a question.
20 The narrative that was presented states that this
21 will align with the industry. Well, I've always heard and
22 considered CalPERS as a leader in the industry, the second
23 largest health insurance purchaser in the United States.
24 So why are we aligning with an industry that we
25 know is broken? Why aren't we leading the industry in

1 something new?
2 It seems that someone may be overthinking this
3 whole thing. Can we please just take a step back and
4 rethink it? RPEA stands ready to work with CalPERS staff
5 to find a better way to serve our members, and even the
6 active members, since we allow those in our organization.
7 We've already begun a series of meetings inside
8 RPEA to discuss any and all possibilities.
9 Mr. Jones, your question about individual what it
10 would cost, I'm one of those retirees who are still on a
11 basic plan. And being the selfish person I am, I did
12 crunch the numbers for me. If I were to choose this plan,
13 it would be a net increase of $1500 a year. I do not
14 qualify for two of the incentives. I could do the
15 biometric screening. I'm a non-smoker. The flu shot
16 immunizations, I can't take some of those because I'M
17 allergic to the medium that they're grown in.
18 So I would disqualify for some -- for
19 immunizations. And I stopped taking the flu shots after
20 having two reactions to those 2 years in a row.
21 I have no chronic conditions except maybe being a
22 complainer. So that would -- I don't qualify for that.
23 So I get $300 in the incentives.
24 Maternity wouldn't do my any good, obviously, but
25 I'm willing to pay for someone younger for that, because

1 they're also quote subsidizing us oldies who are getting
2 more medical care, So that's a wash in my mind.
3 CHAIRPERSON MATHUR: Thank you, Ms. Snodgrass.
4 I'm sorry your time has expired.
5 Well, thank you very much for your engagement on
6 this. I think we're going to have continued
7 conversations. I encourage you to engage in this. I
8 think there might be some opportunities for further
9 refinement.
10 So I hope we can get some place that's
11 constructive. Thanks very much.
12 Okay. So that brings us pretty much to the end
13 of the agenda. The number 9 is Summary of Committee
14 Direction.
15 CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Thank
16 you, Madam Chair. I have two. One is to look at
17 opportunities to have increased proactive -- a proactive
18 role when it comes pharmaceutical legislation, and
19 potentially to work with our Legislative Affairs office to
20 bring some recommendations back to you.
21 And then, the second is really related to VBID.
22 There was two pieces, one related to profiling. As Mr.
23 Jones pointed out, profiling a member based on the
24 different plans. Understanding the true impact, and --
25 profiling in a nice way.

1 (Laughter.)
2 CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: But
3 really truly coming up with an impact so we can help make
4 the right decision. And then I also heard from you, Ms.
5 Mathur, making sure our analysis looks at the deterrents.
6 If we're actually moving away from the value because we're
7 deterring, you know, the right care.
8 CHAIRPERSON MATHUR: Yes. So also the long-term
9 implications of driving members to better higher value
10 care, and ultimately hopefully better health outcomes.
11 CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS:
12 Definitely. So those are the two that I have.
13 CHAIRPERSON MATHUR: Thank you. That corresponds
14 with what I have.
15 So with that, that brings us to the end of the
16 agenda. I see no further requests from the public, but is
17 there anyone from the public who wishes to speak at this
18 time?
19 Seeing none, the public open session is
20 adjourned. Thank you very much.
21 (Thereupon the California Public Employees'
22 Retirement System, Board of Administration,
23 Pension & Health Benefits Committee open
24 session meeting adjourned at 10:18 a.m.)
25

1 C E R T I F I C A T E O F R E P O R T E R
2 I, JAMES F. PETERS, a Certified Shorthand
3 Reporter of the State of California, do hereby certify:
4 That I am a disinterested person herein; that the
5 foregoing California Public Employees' Retirement System,
6 Board of Administration, Pension & Health Benefits
7 Committee open session meeting was reported in shorthand
8 by me, James F. Peters, a Certified Shorthand Reporter of
9 the State of California;
10 That the said proceedings was taken before me, in
11 shorthand writing, and was thereafter transcribed, under
12 my direction, by computer-assisted transcription.
13 I further certify that I am not of counsel or
14 attorney for any of the parties to said meeting nor in any
15 way interested in the outcome of said meeting.
16 IN WITNESS WHEREOF, I have hereunto set my hand
17 this 20th day of December, 2017.
18
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