MEETING

STATE OF CALIFORNIA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

BOARD OF ADMINISTRATION

PENSION & HEALTH BENEFITS COMMITTEE

OPEN SESSION

ROBERT F. CARLSON AUDITORIUM

LINCOLN PLAZA NORTH

400 P STREET

SACRAMENTO, CALIFORNIA

TUESDAY, FEBRUARY 13, 2018

8:32 A.M.

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

A P P E A R A N C E S

COMMITTEE MEMBERS:

Ms. Rob Feckner, Chairperson

Ms. Theresa Taylor, Vice Chairperson

Mr. John Chiang, represented by Mr. Steve Juarez

Mr. Richard Gillihan

Mr. Henry Jones

Ms. Priya Mathur

Mr. David Miller

Mr. Bill Slaton

Ms. Betty Yee, represented by Mr. Alan Lofaso

BOARD MEMBERS:

Ms. Margaret Brown

Ms. Dana Hollinger

Mr. Ramon Rubalcava

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

Mr. Rob Jarzombek, Chief, Health Account Management Division

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

STAFF:

Ms. Renee Ostrander, Chief, Employer Account Management Division

Ms. Jennifer Jimenez, Committee Secretary

ALSO PRESENT:

Mr. James Anderson, Retired Public Employees Association

Mr. Tim Behrens, Retired Public Employees Association

Dr. Laura Clapper, Anthem Blue Cross

Mr. Al Darby, Retired Public Employees Association

Ms. Stephanie Hueg, California State Retirees

Ms. Donna Snodgrass, Retired Public Employees Association

I N D E X

P R O C E E D I N G S

CHAIRPERSON MATHUR: Good morning, everyone. We're going to bring the Pension and Health Benefits Committee to order. First order of business is roll call.

COMMITTEE SECRETARY JIMENEZ: Priya Mathur?

CHAIRPERSON MATHUR: I'm here

COMMITTEE SECRETARY JIMENEZ: Steve Juarez for John Chiang?

ACTING COMMITTEE MEMBER JUAREZ: Here.

COMMITTEE SECRETARY JIMENEZ: Rob Feckner?

COMMITTEE MEMBER FECKNER: Good morning.

COMMITTEE SECRETARY JIMENEZ: Richard Gillihan?

COMMITTEE MEMBER GILLIHAN: Here.

COMMITTEE SECRETARY JIMENEZ: Henry Jones?

COMMITTEE MEMBER JONES: Here.

COMMITTEE SECRETARY JIMENEZ: David Miller?

COMMITTEE MEMBER MILLER: Here.

COMMITTEE SECRETARY JIMENEZ: Bill Slaton?

COMMITTEE MEMBER SLATON: Here.

COMMITTEE SECRETARY JIMENEZ: Theresa Taylor?

COMMITTEE MEMBER TAYLOR: Morning.

COMMITTEE SECRETARY JIMENEZ: Alan Lofaso for Betty Yee?

ACTING COMMITTEE MEMBER LOFASO: Here.

CHAIRPERSON MATHUR: And please note also for the

record that we have Ms. Hollinger, Ms. Brown and Mr. Rubalcava also with us in attendance this morning.

Before I move on to the next agenda item, which is the election of the Pension and Health Benefits Committee Chair and Vice Chair, I just want to take a brief moment of personal privilege to say that I'm stepping down as Chair of this Committee after I think more than a decade of serving this Committee. And it has been such an honor to work with all of you, to work with this Committee to try to drive better health outcomes, and reduce the cost of health care for our members.

And we've had such an amazing team working at the helm for both -- on the health side and the benefits side. And I just can't express to all of you what a pleasure and a joy it has been to serve as Chair of this Committee.

Choking up a little.

Okay. So with that, I will now entertain nominations for Chair of the Pension and Health Benefits Committee.

Ms. Taylor.

COMMITTEE MEMBER TAYLOR: Yes. Thank you, Madam Chair. I'd like to nominate Rob Feckner for Chair of the Pension and Health Benefits Committee.

CHAIRPERSON MATHUR: The name of Rob Feckner has been entered as -- for Chair of Pension and Health

Benefits Committee.

Any other nominations?

Are there any other nominations?

Are there any other nominations?

Hearing none.

I'll entertain a motion to elect Rob Feckner as Chair of the Committee by acclamation.

COMMITTEE MEMBER TAYLOR: So moved.

CHAIRPERSON MATHUR: Moved by Ms. Taylor.

COMMITTEE MEMBER GILLIHAN: Second.

CHAIRPERSON MATHUR: Seconded by Mr. Gillihan.

All in favor please say aye?

(Ayes.)

CHAIRPERSON MATHUR: All opposed?

Motion passes.

Congratulations Mr. Feckner.

CHAIRPERSON FECKNER: Congratulations, Mr. Feckner.

(Applause.)

CHAIRPERSON FECKNER: Thank you, Madam Chair. That brings us to the next agenda item is the Vice Chair of the Pension and Health Committee. I'll now open nominations for Vice Chair of Pension and Health.

Ms. Mathur.

COMMITTEE MEMBER MATHUR: Thank you. Well, it is

my pleasure to nominate Ms. Taylor for Vice Char of Pension and Health Benefits Committee.

CHAIRPERSON FECKNER: Thank you.

Ms. Taylor has been nominated.

Any further nominations for the Office of Vice Chair?

Any further nominations for the Office of Vice Chair.

Third and final time, any third -- any nomination for Vice Chair?

Seeing none.

The nominations for Vice Chair are now closed. I will propose that we elect --

COMMITTEE MEMBER MATHUR: Move by acclamation.

CHAIRPERSON FECKNER: There we go.

We have a motion.

And a second?

ACTING COMMITTEE MEMBER JUAREZ: Second.

CHAIRPERSON FECKNER: It's been moved and seconded that we elect Ms. Taylor by acclamation to the position of Vice Chair.

All in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries.

Congratulations.

(Applause.)

CHAIRPERSON FECKNER: So now we're going to take a quick five minute break to allow the staff to move everything around up here. So we'll be right back with you.

(Pause in the proceedings.)

CHAIRPERSON FECKNER: Very good. Thank you. Welcome, everybody. Nice to see everyone this morning.

The next order of business, Item 3, will be Executive Reports, Ms. Bailey-Crimmins and Ms. Lum, please.

DEPUTY EXECUTIVE OFFICER LUM: Good morning, Mr. Chair --

CHAIRPERSON FECKNER: Good morning.

DEPUTY EXECUTIVE OFFICER LUM: -- members of the committee. Donna Lum, CalPERS team leader.

Before I get started with my executive report, I'd like to extend congratulations to Mr. Feckner for your election to the Chair of this Committee, as well as Ms. Taylor as the Vice Chair. In addition, I'd like to welcome Mr. Miller to the Committee, and also our new Board members and representatives for observing the Committee as well.

I have a couple of updates that I'd like to share

with you. And first, kicking off the -- our CalPERS Benefit Education Events. We successfully kicked off the 2018 year with two events, one which was held in San Luis Obispo on January 26th and 27th. And the other in Sacramento on February 2nd and 3rd.

As you are aware, the CalPERS Benefit Education Events, also known as the CBEEs, are one of our most important member outreach tools. During these events, we're able to communicate face to face with our members, answer their questions directly across the state.

And we also offer classes that are geared towards a member's lifecycle from mid-career to those that are nearing retirement. We have a lot of exhibitors that are there to assist with questions and to provide information to help our members get ready for retirement. In San Luis Obispo, we had over 950 attendees for the two-day event, which far exceeds the highest attendance that we've had in that area, which was previously 520.

So we almost doubled the attendance there, which again demonstrates that when we do go to our outer cities in our remote areas, that we do get quite a bit of attendance. And this is considered to be one of our remote CBEEs for the sheer fact that the nearest regional office is two hours away in Fresno. So again, we're very pleased to be able to serve that membership.

We followed up with San Luis Obispo with our largest CBEE each year, which is here in Sacramento. And through extensive planning and preparation, we were able to assist over 3600 attendees during the two-day period. The team was very delighted to be able to share the CBEE experience and to visit with a couple of our Board members that attended. And we'd wish to thank Ms. Brown, Mr. Miller, and Mr. Feckner for attending the CBEE. Hopefully, for Ms. Brown and Mr. Miller, this was your first CBEE and that it was a positive experience.

I'm always continuously impressed with the team's commitment to customer service and to our members. We did have to overcome a few minor challenges as we were preparing for the large events. But the team and their dedication was able to overcome those challenges and ensure that our members were going to have an excellent experience.

We do have four events remaining for 2018 with the next event scheduled to be in Visalia on March 2nd, and March 3rd.

Next, I want to share with you a couple of the things that we've been doing in the areas of customer service that really are in alignment with our strategic plan of reducing complexity, reducing paper, streamlining our processes, enhancing our member and employer online

services, as well as enhancing our member and employer services.

So we recently revised, what we call, our my|CalPERS employer guides to eliminate the non-added value-added information, as well as to reduce jargon and to make the document much more readable. As an outcome of the work effort, we were successfully able to reduce the page count by 47 percent, which then will result in over -- in approximately a $20,000 savings in printing each year, so an ongoing savings that we expect to achieve.

In addition to that, we've also been reviewing our content for our classes for our employers. And we were recently able to streamline the content and make it much more accessible to our business partners and our employers. And so, for example, our retirement enrollment for public agencies and schools course is now two hours versus three hours.

So again, an example of how we are looking across the branch and across customer service to streamline our processes.

We also added an enhancement in January to our member self-service. So this is the online service that we provide to our members. And in December, we implemented the ability for our members with a community

property claim on their retirement account to be able to reti -- apply for retirement online.

Previously, this was -- this option was not available. So as you'll hear in the next part of my, report, we are continuing to see quite an uptick in the trend of retirement applications being submitted online, and providing this additional option for those with community property will continue to promote our member self-service.

And then lastly, as we rounded out last year, I just wanted to share with you some statistics as related to our service retirement. We processed over 37,000 service retirement applications in 2017, which was an increase of 3,060 retirement applications over the 2016 calendar year -- or fiscal year. The volume of self-service applications has steadily increased in 2017 peaking at 38 percent of the total applications that we received in September and December were applications that were submitted online.

In addition to that, on the January monthly roll, we successfully processed over 6,500 members onto -- or retirees onto the roll. And of that total, 4,044 were for retirement dates of December 30th and December 31st. So you can see the high volume of the retirements in the short duration of the time frame that we have to get them

onto the roll to ensure that they receive their benefit payment without disruption is an extremely high volume. And I'm very pleased with the work and the effort that the team has made to be able to do that work very timely.

Overall, this was an increase of almost 600 from the 2017 to -- roll as we had placed 5,900. So, Mr. Chair, that completes my report, and I'm happy to answer any questions

CHAIRPERSON FECKNER: Thank you.

Mr. Juarez.

ACTING COMMITTEE MEMBER JUAREZ: Yeah. I just want to take a moment to compliment the staff. I did attend the Sacramento event, and it was very well done. The presenters were great. A little crowded, but that's a good thing, I think. And I just want to again commend you, Donna, and the staff. Just did an excellent job the way they covered the landscape of the many, I think, very -- just very difficult issues that members face as they get ready for retirement, and I thought just did an excellent job, so --

DEPUTY EXECUTIVE OFFICER LUM: Well, thank you.

ACTING COMMITTEE MEMBER JUAREZ: -- my kudos.

DEPUTY EXECUTIVE OFFICER LUM: And thank you for attending.

CHAIRPERSON FECKNER: Thank you.

Seeing no other -- pardon me, Mr. Miller.

COMMITTEE MEMBER MILLER: Yeah. I would just also echo those sentiments. Very well coordinated, systematic approaches to the event. And just the -- the kind of, I guess I would call it, representation of that customer service culture that you're trying to develop was really evident in watching the interactions of the staff with the members. And I just couldn't be more impressed.

Thank you for that opportunity.

CHAIRPERSON FECKNER: And I, too -- as you mentioned, I was there. And I was impressed with the fact that the common room, the vendors room, was so much wide open this year that people actually didn't have to bump into each other to get around, and they actually were having a good -- ability to have good conversation with folks.

And then as I left the room, I see there's 25 people standing line for the next class, because that's how full they were. So that was a good thing to see as well, so great job, especially since you had an entire volley ball tournament going on down stairs at the same time. That was impressive.

DEPUTY EXECUTIVE OFFICER LUM: Well, one of the challenges that we do have with the Sacramento Convention Center is we are outgrowing the capacity of even their

largest rooms.

And so as we are planning going forward, that's something that we have to look at in terms of the duration of the time that we have here in Sacramento for the event, and then the possibility of trying to expand within the convention center as well.

But it has been a challenge. And as I mentioned, we did have a few difficult challenges as we were planning for it. But as you experienced, the work effort really was done well, and I do think that you all and our members had a very good experience.

CHAIRPERSON FECKNER: Great. Thank you.

Ms. Bailey-Crimmins.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Good morning, Mr. Chair and members of the Committee. Liana Bailey-Crimmins, CalPERS team member. I second Donna's sentiments, and I would like to congratulate Mr. Feckner and Ms. Taylor for their new positions as Chair and Vice Chair. And I look forward to working with you and the rest of the Committee members on having a successful 2018.

For my opening remarks, I have three updates. The first is the Dependent Eligibility and Verification Project. For this month, CalPERS will be working with employers to validate dependent information on file for two groups, one are the active State members, and the

other is the active CSU members.

The second update that I will provide is that the Government recently did pass the funding bill we talked about in December, and there were specifically health-related taxes that I'd like to provide you an update on, which specifically the CalPERS team monitors.

And then lastly, as we've seen, the national influenza epidemic. OptumRx has been very proactive, even though there has been a shortage of an anti-flu drug called oseltamivir. And so I'd like to talk to you a little bit about what our members will experience when they show up to get Tamiflu.

So for the Dependent Eligibility Verification Project, we have done this project before. Again, it's for the State and CSU members only. The employers will be responsible for collecting the information and verifying dependents' eligibility.

Members will receive a series of notification letters. It is through a three-year cycle. So once that three-year cycle stops, then it will repeat every three years thereafter. The first notification letter will be 90 days from the validation date. And then a reminder letter, if we have not received information 60 days in. And then as we get closer to the 30-day mark, there will be a last cancellation reminder letter at that point.

But something of this size we know requires communication. It is vital to the success to reduce confusion and streamline the process. And so therefore, we have worked closely with CalHR and the CSU to develop procedures to assist employees and employers, including basically frequently asked questions to help kind of navigate that process.

Also, CalPERS published in the PERSpective both the fall of 2017 and spring 2018 process procedures to help our -- inform our members. And then looking ahead, as we get closer to the end of 2018, there will be the Dependent Eligibility Verification Project will expand for State and CSU retirees.

As a reminder, CalPERS is the health benefits officer for the retirees. And so we will be responsible for verifying dependent information and collecting those -- that -- those documents. And so as we get closer to that date, we'll be bringing back more information for you.

And so for the ACA taxes, there were three health-related taxes that were in the funding bill. Good news on all fronts. The good news is the bill extended the existing suspension of the ACA excise tax also known as Cadillac Tax. It pushed it out from 2020 to 2022. So that's an additional two years.

Also, for the medical device tax, that got pushed out to 2020. And then for 2019 only, the bill suspended the health insurance provider fee. And industry experts say that basically it counts for two to three percent of your HMO premiums. So this is great news. Since we're going right into the 2019 rate development process, we'll make sure that those plans are not including that tax.

And then lastly, the bill did include a six-year extension on the Children's Health Insurance Program, also known as CHIP. It provided an additional four years of CHIP funding for a total of 10 years. The loss of CHIP funding would have impacted 1.3 million California children.

And the funding for CHIP and other federal health programs is important to CalPERS. It was great to see bipartisan agreement on a health bill.

Also, we see that it would have impacted commercial market as well. And we obviously want to make should that our most vulnerable population of children are being taken care of. So good news on all fronts there.

Not so good news, the national influenza epidemic, there has been a supply shortage of the generic anti-flu medicine, as I was mentioning, oseltamivir. And what this means is that only the brand version of Tamiflu is available. So typically, when you pay for a name

brand, you pay a higher co-pay.

Our pharmacy benefit manager, OptumRx took a proactive approach to address the severity of this issue, and Tamiflu will now be available at -- without the brand name price. So that's a great thing to address this. They'll continue to stay in effect until the shortage abates and/or the flu season ends, which they're expecting to be approximately the end of May.

It is important, because in addition to the influenza-related mortality, recently published research indicates that this year's flu vaccine is estimated to be only 10 percent effective against the predominant influenza strain. And as such, this means there's a likelihood of an increased utilization of drugs, such as Tamiflu. So this is a very important note.

And PHBC's agenda is fairly comprehensive today, but two highlights. Just letting you know PPO and value-based insurance design improvements have been made. We have worked with the stakeholders and did quite of bit of outreach. So what you will see today is improvements based on that input. It is an information item beaut we'll be coming back tow in March for a decision.

And then as requested at the November PHBC, the health program is going to provide an OptumRx improvement update. And you will see that the data provides

significant improvement, but we also want to make sure that that does not mean that there are not additional areas of improvement. Whenever there is a concern of our member escalated to CalPERS, we treat it with the utmost importance, and we look for opportunities to make systemic issue -- systemic improvements that improve all of -- the system for all of our members.

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

CHAIRPERSON FECKNER: Very good.

Thank you. Seeing none.

We'll move on to Agenda Item 4, the consent calendar. Item 4a and 4b is the approval of the minutes, and then Option 4 form.

What's the pleasure of the Committee?

COMMITTEE MEMBER MATHUR: I would move approval.

VICE CHAIRPERSON TAYLOR: Second.

CHAIRPERSON FECKNER: It's been moved by Mathur, seconded by Taylor.

Any discussion on the motion?

Seeing none.

All in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries.

CHAIRPERSON FECKNER: Item 5, consent items. I have no requests to remove anything from the information consent items.

So we'll move on to Item 6, Proposed Regulation for Definition of Full-Time Employment.

Ms. Ostrander.

EMPLOYER ACCOUNT MANAGEMENT DIVISION CHIEF OSTRANDER: Good morning.

CHAIRPERSON FECKNER: Good morning.

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

Before you today is Agenda Item 6, the proposed regulations which define full-time employment for purposes of determining CalPERS membership eligibility, reporting over-time positions, and determining compensation earnable and pensionable compensation.

The Board originally adopted a resolution in 1932 to defining full-time employment. It's then been amended a couple of times with the most recent being in 1980.

With that resolution, the Board adopted a minimum and maximum full-time work week, and states that the individual contracting employer determine full-time employment for its employees.

The proposed regulation before you provides multiple benefits. It further solidifies the Board's

current position as a regulation, a step in strengthening the position already established, continues the practice of the individual employer defining what is full time, and it removes the maximum cap to provide flexibility for our employers.

We've seen some changes over time in employer's practices. For example, our firefighters that work a 56- or a 72-hour work week. The removal of the cap allows the employers flexibility in developing what constitutes full time for their agencies.

To address any potential perceived conflicts between the current Board policy that is transitioning to this regulation and the statute, we've included a sentence in section A of the regulation.

The section states, "This regulation does not apply to the extent it conflicts with a provision in the Public Employees' Retirement Law". It goes on to cite the example of Government Code section 20636.1, Section (b)(1), which is related to payroll reporting of classified members at school districts. The schools will not be asked to change any of their current practices of reporting.

If the Board approves the proposed regulation and the initiation of the regulatory process, staff will request the publication of the notice of proposed

regulatory action in the California Regulatory Notice Register.

As part of the notice of proposed regulatory action, a minimum 45-day comment period is required. At this time, we do not have a public hearing scheduled for these regulations. If we receive a request to schedule this from the public prior to 15 days before the close of the comment period, we will schedule a public hearing coordinated with a future Pension and Health Benefits Committee meeting.

This completes my presentation. I'd be happy to answer questions that you have.

CHAIRPERSON FECKNER: Thank you. First of all, I want to thank you for the clarification on the school piece. That was -- I've been hearing a lot of questions since your stakeholders' meeting, so I'm glad you cleared that up for everyone.

What's the pleasure of the Committee?

COMMITTEE MEMBER JONES: Move approval.

COMMITTEE MEMBER MATHUR: Second.

CHAIRPERSON FECKNER: Moved by Jones, seconded by Mathur. Any discussion on the motion?

Seeing none.

All in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries.

Thank you.

EMPLOYER ACCOUNT MANAGEMENT DIVISION CHIEF OSTRANDER: Thank you.

CHAIRPERSON FECKNER: Now, moving on to the information items. Item 7, Public Agency Recruitment and Retention for Health Benefits Program.

Mr. Jarzombek.

(Thereupon an overhead presentation was presented as follows.)

CHAIRPERSON FECKNER: Other side probably. There you go.

He's on.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: All right. Good morning, Committee Chair and congratulations on your appointment. And Vice Chair congratulations on your appointment as well.

Good morning, members of the Committee. Rob Jarzombek, CalPERS team member. I'm presenting this information item as an annual update on the health program's public agency retention and recruitment efforts.

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HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: Today, I'll focus on three areas: Our 99

percent retention rate in 2017, new information about untapped market of potential contracting agencies, and our marketing team, which may be small, but it is mighty when it comes to competing in the very competitive health insurance marketplace.

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HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: A few years ago, there was an effort to expand public agency and schools marketing. This was part of the 21 initiatives. In response to the request made last year, we have an update on our marketing efforts. With the health marketing team again under the Chief Health Director's leadership, we are identifying new areas and opportunities to recruit public agencies and schools and retain existing ones.

As many of you may know, the CalPERS Health Benefits Program has over 1.4 million total covered lives, or TCLs.

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HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: These TCLs are comprised of employees, annuitants and their families. The majority are from the State and 41 percent are from public agency and school employers.

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HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: The health program continues to grow as you can see from this 10-year chart. Over the last decade, we have gained over 177,000 TCLs, which equates to almost 18,000 a year.

What's important to note is that this growth occurred during a period of significant change in the health marketplace. We experienced a recession in 2008, the ACA was signed into law in 2010, the California Health Care Exchange began in 2014, and we saw the advent of high deductible plans that have gained interest amongst employers.

Even through these dynamics, we've still added TCLs, demonstrating that both employers and employees appreciate the high quality health benefits and value that CalPERS offers.

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HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: In 2017, we again achieved a 99 percent retention rate of our contracting agencies staying with us. Agencies stay with us for a variety of reasons, many of which are the same reasons that make us competitive in the marketplace. For instance, we do not charge any broker fees. We maintain a very low administrative fee, which is currently just 0.33 percent. And by statute,

this fee cannot be more than two percent, and we've never come close to that. Brokers on the other hand, can charge from one to three percent or even more.

We don't require 100 percent participation. We have the largest risk pool in California, which makes us a leader. And we announce our benefit rates and changes in June, so both employers and employees can plan for the following year.

While there are significant advantages, the health marketplace is still very competitive. Our small but mighty marketing team regularly meets with employers, labor groups and management across the State, as well as attends many conferences. We compete for business against private sector brokers that have very deep pockets, which at times can make it very challenging four our team.

Additionally, brokers use a wide array of tactics to discourage agencies from contracting with us or lure current ones away. These tactics include regularly sponsoring receptions and giveaways at conferences, interrupting our presentations at employer locations, and misleading decision makers and employee groups by providing incorrect information about the CalPERS Health Benefits Program.

I'd like to share a quick example of what happened last year that illustrates the competitiveness in

the marketplace.

During a health enrollment event for a new contracting agency, the previous broker set up a table and brought in a team to sell their health benefits to our members. We repeatedly asked the broker to leave, advising them they could not sell their health insurance at our health enrollment event. After a lot of back and forth, they eventually did leave, but they certainly didn't go quietly.

Now, despite our competitor's best efforts, last year, we brought on ten new public agencies, and nine new employee groups from current contracting at cease, which account for over 6,000 new TCLs. We did, however, lose some agencies, and those are outlined in the agenda item.

For 2018, we have already brought on 5 new public agencies, including the City of Inglewood, which is returning to us after over 10 years. According to the city, they plan to save $4.5 million in their first year with us.

In the end, despite what brokers may do, our team is open, honest, and professional when it comes to our interactions with employers. We've received thanks and kudos for assisting them, and explaining the complexities of health insurance to both current and potential customers.

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HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: Recently, we partnered with the State Social Security Administrator, and we now know there are approximately 5,642 employers available to participate in the CalPERS Health Benefits Program. This untapped market is a huge opportunity for CalPERS. Having this data and contact information will help us better target our outreach efforts.

We also know there's a subset of these employers that already have a CalPERS retirement contract with us. These agencies already know how to do business with us and know the value that CalPERS brings to their agencies and their employees. We plan to create a special marketing campaign to focus on them.

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HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: For next steps, we are developing an outreach campaign to establish ongoing regular communication to raise awareness of the CalPERS Health Benefits Program. These activities include partnering with the State Social Security Administrator to market to the over 5,000 agencies I just spoke of; increasing our level of attendance at conferences, so we may increase our exposure to new agencies; continuing to conduct health workshops at

regional offices and the Ed Forum, so that we may meet face to face with employers and answer their questions; and developing new and targeted marketing materials with the assistance of Public Affairs.

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HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: Overall, The CalPERS Health Program is strong. We continue to achieve a 99 percent retention rate. Our small and dedicated team of marketers achieves results year after year, and we have an excellent potential for growth through an untapped market of public agencies. This concludes my presentation, and I'm happy to answer any questions.

CHAIRPERSON FECKNER: Thank you.

Mr. Juarez.

ACTING COMMITTEE MEMBER JUAREZ: Yeah, I have a couple of things. One is you mentioned Compton coming back into the program after 10 years. And then in the write-up there was an example of San Luis Obispo County. And they were very explicit as to why they left the program. And I'm wondering if -- and the reasons why and whether or not we could address those issues that they raised, and whether we're going to attempt to do so in the future in order to draw them back in at some point?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Mr.

Juarez, just to let you know, one of the things they cited, which we discussed, was the regional volatility. The other northern region had a 40 percent increase. And so what we're doing is over the next 12 months looking at the total cost of care across all counties, and seeing if there's any changes either in the regions or the regional factors that would help employers that have these ups and downs, which is very difficult for them to budget, and it's also difficult on their members to be able to budget for within their household.

So we are looking at that. And you will be -- we will be bringing a recommendation back to this Committee in December.

ACTING COMMITTEE MEMBER JUAREZ: Okay. Thank you for that. The other issue was, as I was reading the item, it said -- you noticed that there -- the total covered lives is greater going out than coming in for the last year. And I don't know whether that is historical, whether that's an aberration, and so I'd like to get just a sense of how that stacks up about what we've seen in the past and whether we -- what we see in the future, I guess?

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: That is a difference than what we've seen in the past. This is one of the first years in recent time where we have had a fewer -- more lives going out.

However, with the new agencies we brought on in 2018, it is still a net increase to the program.

ACTING COMMITTEE MEMBER JUAREZ: Okay. Thank you.

CHAIRPERSON FECKNER: Ms. Taylor.

VICE CHAIRPERSON TAYLOR: Thank you, and thank you for the report. I was just kind of wondering, and I think Mr. Juarez asked part of the question I was going to ask, as we are seeing some of our agencies leave, and it seems to be apparent they're leaving because of regional issues, and it's -- and you're saying it's an outlier. As we consider our regional rates and stuff, is -- is this going to -- hopefully, are we working to help mitigate this issue of the regional issues? That's where my concern is.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Spot on, Ms. Taylor. It was 13 years ago where we established the -- where the lines are drawn. And so we believe, and one example I've given is just Stockton historically. Stockton over the last 13 years, we know - San Joaquin County - has more hospitals, more provider networks than they did 13 years ago. And we owe it to our employers and our members to at least, every five years, look at the total cost of care and bring that back and see if there should be changes.

In addition to regions, within a region, the HMO carries are able to establish the -- they use their actuary formula for the regional factors. And so we will be looking at opportunities to -- now that we have multiple carriers, how do we provide more direction to them on how they do the calculation? And then based on that -- you know, the big thing for as an employer is just the volatility that's creating the issue.

I mean, everyone expects potentially a little bit of an uptick every year. But when you have it go up or go down, it's very difficult for the employers. And so we really need to look at the data, and then based on the data provide you a good recommendation, so that we can see how we can help these employers in the regions.

VICE CHAIRPERSON TAYLOR: Are you seeing -- I don't know if we know -- for example, is San Luis Obispo going to a high deductible low cost plan? Is that what they're -- you know, because then that's sort of out of our realm, other than our PPOs. But is that -- are they mitigating costs in that way, or are they -- on are they getting a better deal?

I would imagine it wouldn't be much different, but -- if they were to seek the same type of insurance. But if they're looking for something we don't offer, there's where we would sort of --

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So employers do look at and we have seen where employers believe a high deductible is the best option for their members. Statistically, that isn't necessarily the case. Actually, as we're starting to see where employers are leaving, many are coming, back because what happens is then your employees are making a decision on what they can afford.

So do I pay the deductible or do I get the care? And we want people to get the care, because then they're healthier --

COMMITTEE MEMBER TAYLOR: Right.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS:

-- they're more productive employees when they show up for work. And it's just an overall better healthier system. So I think part of it is also educating employers that CalPERS offers choice -- competitive choice. And based on that and based on what's in the region, we bring things to the table that others may not. And what I find is many times the brokers will low -- low ball, get them in, and then they are in a situation where now it swings way up. And because of our regulations, they have to stay out of CalPERS for five years in order to come back.

VICE CHAIRPERSON TAYLOR: Right.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: And so if they make the wrong deal, and then they're in the situation like we heard of City of Inglewood, where now they're coming back, we just want to make sure we're giving the employers as much education as possible. Ultimately, it's their decision, but our job is to make sure that they're making a data driven decision for their employees.

VICE CHAIRPERSON TAYLOR: And part of our education process is also advising them on some of these outlier plans, the high cost low deductible, because it does drive higher costs in the long run. So when we're educating the employers, we're also, I hope, doing that, because I know that that seemed to be an issue last year, where we lost some of the employers and they were saying they wanted choice of that kind of a plan. And we don't offer that, except for our PPO, but -- so that's where my concern lies is that it ultimately drives everybody costs up to do that kind of plan. But in the long run, it's -- it's more helpful to do our HMOs or our PPOs that we offer. So I'm glad you guys are doing education. I appreciate the report. And it's good to see that some are coming back in.

Thank you.

CHAIRPERSON FECKNER: Thank you.

Before I go to the next person, in your professional opinion, how many, if any -- and you may not know, but it's nice to say it's a regional issue or it's a cost factor, but how many of them do you think is the underlying issue to escape paying for retiree health care?

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: So on the attachment 2, there is some of that concern. We have one, two, three, four, five that have been cited out of the -- all those that we lost that that was one of their concerns. So, yes, that is still an issue.

CHAIRPERSON FECKNER: Sadly, but thank you.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: And, Mr. Feckner, also part of it is education. I believe they have to cover the retirees if they're a part of CalPERS, but there are options. And again, this comes down to sitting down and having the conversation that they can cover retirees and then -- but they have flexibility within that.

And so I think it's just getting out there to make sure that they have accurate information on what they can include in their resolution with CalPERS and still be a part of the system.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: Correct.

CHAIRPERSON FECKNER: Thank you.

Mr. Miller.

COMMITTEE MEMBER MILLER: Yeah. In terms of those 5,000 plus prospects, could you talk a little bit about, you know, your expectation of a likelihood of being able to successfully engage them. And I don't know how much of, you know, a profile of them you've -- your team has been able to put together, but what are the kind of key characteristics or factors that you would say are the things that lead you to think that you can really penetrate that potential market? What would characterize those prospects?

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: Well, I think that -- so we haven't begun that yet. We're just starting our partnership with the State Social Security Administrator. It's under way right now actually.

I think some of the key factors that I shared on like how we are better, the significant advantages we have, the low administrative rate, 100 percent participation is a big deal, where some brokers require every employee to have their health coverage, even if they have coverage with their spouse through other means. Our admin fee is extremely low. We are the largest risk pool. So those are the -- those -- it kind of sells itself.

What we need to do is try to really get out there and get to those right decision makers and those employee groups who do make those decisions and do want better health care and a better value. So that's what we're -- that's what we're targeting.

Especially with those who already do business with CalPERS on the retirement side, we think those would be -- they're at least -- they're more aware of us and know how to do business with us, and know the value that CalPERS brings to both their employees and their agency. So that's where we'd like to start.

But there is a lot of different pockets that we can look in. And we're looking at them now to how -- to figure out how we can best do it and then also do it in a way where our team can still provide that excellent customer service, and outreach and education. So we're not bombarded and then we're leaving people where we can't actually respond to the demand.

COMMITTEE MEMBER MILLER: So on the flip side of that, where do you see the challenge? What are the primary objections or obstacles, and how are you going to target what you go after first? Would it be, you know, things like rural areas where there's been big changes in that marketplace and availability of providers? Would it be their financial structure the way it is now with their

health care? How do you -- how do you see that?

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: We're really just starting to look into all of that to figure out what will give us the most bang for the buck, if you will. And so I think that we'll probably start with some level of current contracting agencies on the retirement side. And then there's also the potential to grow with other employee groups within an agency.

The problem there is we don't know how many other employee groups every employer has. And so -- but by doing that, there's also potential for growth there. So we are just still figuring all that out on what to do first and when. But we definitely wanted to take advantage of this new opportunity.

COMMITTEE MEMBER MILLER: Thank you, sir.

CHAIRPERSON FECKNER: Thank you.

Ms. Mathur.

COMMITTEE MEMBER MATHUR: Thank you.

I just wanted to make sure I -- well, I have a couple of comments, but first a question. On attachment 1, for 2017, I thought I heard you say that we had 9,000 new total covered lives come in, but this chart shows that that's how many we lost. Is -- did I misunderstand?

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: I may have misspoke.

COMMITTEE MEMBER MATHUR: Okay.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: For 2017 we lost 9,000.

COMMITTEE MEMBER MATHUR: Okay.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: And then we gained almost 6,000 -- 5,900. But then so far for 2018, we've gained 9,000.

COMMITTEE MEMBER MATHUR: Okay.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: So despite that fluctuation last year --

COMMITTEE MEMBER MATHUR: Yes.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: -- we still are at a net increase.

COMMITTEE MEMBER MATHUR: We're still at a net increase between the two years.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: Correct.

COMMITTEE MEMBER MATHUR: Thank you. That's a helpful clarification.

So obviously, you focus both on recruitment of new agencies and on retention of our existing agencies. And do you have a sense of what the split is between the resources that are dedicated to those efforts?

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: So we spend about 20 to 25 percent of our time

on retention. And so that's going out to different employers and talking with their employee groups or their management teams when they're thinking about going someplace else. Their -- their -- or a broker has approached them and say, hey, we can give you a better deal. Here's why.

So we do spend -- it's a regular part of our workload. And then the rest of it is outreach for the new contracting agencies, and then bringing them actually on board.

COMMITTEE MEMBER MATHUR: And what do we do proactively before say a broker has approached an agency that's within our pool? Do we have sort of a proactive relationship management effort going on.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: We do. We do have a small team through I should note.

COMMITTEE MEMBER MATHUR: Yes. No, I recognize that. That's why --

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: Each year, we do have health workshops at each of our regional offices. So that's a regular thing that happens like in the July/August timeframe, where we meet with them and talk through all of the changes that are coming for the following year. So that's our most

regular, I guess, outreach effort for retention to ensure everybody knows of the changes.

We also do get special requests for us to come visit the employer agencies. So we will gladly do that to come talk with them, whether it's on the recruitment side or retention to make sure everybody is aware of what they can do. And if they want to change some of the benefits or change their resolution, we can work with them, so they can do that as well.

COMMITTEE MEMBER MATHUR: I guess what I'm getting at is it seems like -- I know you have a very small team. And it seems like there could be a sort of -- pretty significant return on investment for each additional marginal resource that we have in this group. That the benefit to the pool as a whole and to the -- to our existing members, as well as to the new members we might bring in is significant, and that perhaps it's -- and I know you were thinking about this, but I think it's worth considering what size -- what would be the optimal size of a team to really have a robust retention effort, where employers aren't even, for the most part, you know, enticed by other brokers. You know, that they feel so confident in the service that we're providing that they're not -- that we don't have a significant risk of departures, and that you can have a really effective

recruitment effort.

And I guess I would like to know what that would take and what we think the value-add would be for those additional resources, because I do think that this is an area where we could -- we could invest a fairly small amount, and have significant gains. That's my suspicion.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: And that's something we'll definitely take back and look into and report back.

COMMITTEE MEMBER MATHUR: Terrific. Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you, Mr. Chair.

I have two questions. The first one is you refer to groups in here and is that like classifications?

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: That's like bargaining groups. So like Group 1, 2, 3, 4, or the different employee groups who may have been hired after a certain date, or miscellaneous versus safety. It's a variety of different ways.

COMMITTEE MEMBER JONES: And so some of them I noticed go up as high as 37 different groups in one agency.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF

JARZOMBEK: That's -- that 37 was for all of those ten, I believe. So there's -- amongst the 10, there were 37 groups with them that came on board.

COMMITTEE MEMBER JONES: Oh, okay. Okay.

Okay. My second question was triggered by this statement about successor agency to redevelopment agencies of the City and County of San Francisco. And what triggered my -- it triggered the question on JPAs, joint powers agreements. And we've had significant issues with the pension side for employees in those agencies. And so my question is do we have joint powers agreements that are providing health benefits to their members, and if so, have we reached out to be sure that the sponsoring agency is providing coverage in terms of liability for those costs?

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: Excellent question. I'm not exactly sure. I'm confident we do have JPAs that contract with us.

COMMITTEE MEMBER JONES: Okay.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: As far as how we reached out to make sure their funding source is owned?

COMMITTEE MEMBER JONES: Being covered by the sponsoring agency.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF

JARZOMBEK: I'm not sure. Health does work a little bit different than retirement, where it's more pay as you go versus you have this big liability. So there is less of a risk to the employees and to the employer. However, it's still something that we need to be mindful of.

COMMITTEE MEMBER JONES: Okay. Yes, I think it's important, because it's -- we had a lot of discussion about how to deal with that on the pension side. So I think we need to look at it on the health side.

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

Yes, exactly what Rob was talking about is that since it's a pay-as-you-go, so if there's any issues with the JPA and there's a nonpayment, then it's just they cut the benefits going forward. So there isn't a continued loss like you'd have with an actuarial liability that would accrue if we don't receive the funds that we need for that year.

COMMITTEE MEMBER JONES: Yeah, right. And I understand that, but the final impact is the employee loses their health coverage.

EMPLOYER ACCOUNT MANAGEMENT DIVISION CHIEF OSTRANDER: Correct.

COMMITTEE MEMBER JONES: And the sponsoring agency needs to be held accountable for providing that, if

they are the sponsoring agency for that JPA. Okay. Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Slaton.

COMMITTEE MEMBER SLATON: Thank you, Mr. Chair.

Just to build on what Mr. Jones was saying. Not only loss of health care for actives, but the real problem is on the retiree side. And so that's, I think, where that liability can come into play.

So bear with me a moment, I'm knew to the Committee, so I've got a couple of questions on this issue. One is you talked a lot about broker behavior. And the implication of your comment is that that whole segment are bad actors. And I just want to make sure that we understand there are people who are ethical and appropriate, and do the job well, and compete in an appropriate manner. I assume you would agree with that.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: Yes, absolutely.

COMMITTEE MEMBER SLATON: Okay. Good, because you didn't talk about the good actors. You only talked about the bad actors.

In attachment 2, page one of one, on the agencies that have left, some mentioned more -- a high cost, but they also mentioned OPEB liability concerns. So I'm not

sure I quite understand why moving from CalPERS to somebody else can -- could positively impact OPEB, unless they're just going to get lower costs going forward.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: So what this means is that with -- so with the CalPERS Health Program, we -- there is a retiree requirement. And so we do have to -- employers do need to cover retirees at some point to -- at least at some level. And so without that -- when they go to a different broker, there is no retiree requirement. And so then all the retirees are basically --

COMMITTEE MEMBER SLATON: So it reduces the OPEB liability --

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: Correct, because they're --

COMMITTEE MEMBER SLATON: -- if they suddenly decide we're not going to cover --

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: Correct, so they're --

COMMITTEE MEMBER SLATON: -- retirees or we're going to cover them with a less expensive alternative.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: Correct, or they're only going to recover their actives.

COMMITTEE MEMBER SLATON: Uh-huh. Okay. All

right.

At the scale we're at in terms of the number of covered lives we have, I understand that we always want to grow and add agencies. I'm not sure I quite understand what the net benefit is to the people who are already covered, because the scale we're already at.

So if we add another 10 agencies, another 9,000 covered lives, does it actually move the needle in any respect, other than, you know, we added 9,000?

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: We get to say we're larger, right. So that's an excellent question and that really comes into our ability to negotiate with our plans and to bring new benefit designs to our members. And so it's seen that way. It's maybe not as tangible as we'd like it to be, but that's where we can really -- that's where we're really trying to make sure we're still a leader, and to be able to negotiate better rates for our members and employers, as well as have the benefits that they -- that we think they need.

COMMITTEE MEMBER SLATON: But if you add -- you have how many covered lives? We have 1. --

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: 1.4.

COMMITTEE MEMBER SLATON: 1.4 today. So if you

add 10,000 next year, does that really impact our ability to negotiate with the carriers?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Yes.

COMMITTEE MEMBER SLATON: It does. Okay. All right. You're the expert.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: The carriers would love those lives. And also, it's -- one of the things coming into health is understanding when we talk about members, members on the pension side, is the employee. For us, when we talk about members, it's the total covered lives. So you take that 1.4 million, and an average family has, what, two and a half people in their family. That's really not that many employees. And so there's just a big opportunity here where many employers do just pension business with us, and do not do health. And I just think it's -- it's definitely an opportunity.

And at some point, you're right, there is a scale. But I think the more of those lives it does equate to -- when I'm sitting across the table from the plans, they're really interested in getting more.

COMMITTEE MEMBER SLATON: Okay. So the 5,700, whatever it is, agencies in the database that are possible, how many of those are in the pension system?

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: So we don't know that figure exactly. So the

way they're counted is different. So for the -- so, for instance, for COE's, the county offices of education, they have their contract with us, but then -- and they have one contract for pension with us for all their districts. Whereas, the schools would have -- each school district would have their own health retirement contract with us.

COMMITTEE MEMBER SLATON: I see.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: So we tried to make that comparison to get that, but it's an apples and oranges, so it's never going to add up.

COMMITTEE MEMBER SLATON: Right. But I assume that you would -- if again total covered lives is the objective to grow the system, that you would start with the largest and work down, rather than start with smallest and work up.

So my question is when you get to large employers -- so my coverage is through SMUD. And SMUD is note in the health care. I'm sure you'd love to have them in. So for SMUD and for other large employers who have some scale, and obviously can negotiate and have several thousand lives that they're covering besides the issue of retiree health -- so SMUD provides full retiree health -- what other reasons for these large employers are they resisting coming into CalPERS?

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: I think some of them may already -- their employees like what they have. It's a good program. They feel they're in a good position too where they're able to negotiate good rates as well. I'm not sure all the specifics. I think everyone is different and that's what we're noticing when we go out there. Every bargaining unit is different. Every employer is different. And so that is part of the challenge that we face when we go out there. It's not a one-size-fits-all for all of these employers. And even within an employer, all the different groups that may be in there.

So I'm not sure how better to answer that question.

COMMITTEE MEMBER SLATON: Is part of it just having control? Kind of, you know, the concept of local control, so as opposed to being part of a large pool, I now have the ability to custom design the plan to negotiate? Maybe I want this feature and CalPERS has these three features. Is that a big part of it, the ability to kind of design what you want?

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: It could be possibly.

COMMITTEE MEMBER SLATON: It could be.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF

JARZOMBEK: But however -- that is also a workload. And so that is something that they need to have their own people. They're paying somebody to do that.

COMMITTEE MEMBER SLATON: Sure.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: And so we have a fabulous team here that's doing that, and does it at a very competitive rate.

So, again, it's really individual to each agency.

COMMITTEE MEMBER SLATON: I see. Well, they're right down the street, so --

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: They are.

COMMITTEE MEMBER SLATON: Okay. Thank you very much.

CHAIRPERSON FECKNER: Thank you.

Mr. Gillihan.

COMMITTEE MEMBER GILLIHAN: Thank you, Mr. Chair.

I have a couple of questions. I'm referring to the same table that Mr. Slaton was referring to regarding the losses. And one of the -- there's sort of groupings of reasons why. And one says high cost and OPEB liability concerns. In that grouping, are those employers telling us they want a different plan design such as a low cost high deductible plan?

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF

JARZOMBEK: It's either. It's either that or it is the regions that we've been discussing, yes.

COMMITTEE MEMBER GILLIHAN: Okay. And where it -- it simply says seeking more flexible benefit package allowing lower premiums, is that in reference to a high -- a low cost high deductible plan?

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: Correct.

COMMITTEE MEMBER GILLIHAN: So our -- and I believe in prior years we've been hearing this as well from our employers. So the reality is if we don't offer it, they're going to go get it somewhere else.

With regard to scale, I don't think it's particularly provided us the leverage we had hoped to drive costs down or contain the escalating costs year over year. And I wonder pursuing more scale what that does to the quality of services delivered to our members. We have a stack of letters from a lot of unhappy folks with respect to our pharmacy benefit manager. And I wonder how adding thousands and thousands of more people into the mix helps that problem in any way.

And then I just had one last question. I heard Ms. Taylor say -- I think I heard Ms. Taylor say from dais, and I saw staff nodding in agreement, that a statement of fact that high cost -- or low cost high

deductible plans ultimately lead to higher costs? And I just wondered, do we have any data to support that? Is there objective studies that say that, and if so, have they been submitted to the Board for review?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: There is studies out there of high deductible plans not promoting healthy actions on behalf of members of the system. And so we would be happy to bring that back at a later time.

COMMITTEE MEMBER GILLIHAN: That's a different issue than drives up cost.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So drives up cost to the system?

COMMITTEE MEMBER GILLIHAN: That's what I thought I heard. And I -- I believe Ms. Taylor made a statement to the effect that low cost high deductible plans ultimately lead to higher costs. And as she was making that statement, I saw staff nodding in agreement. So I was just asking if that is, in fact, true, and if we have data to support that?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So the data is that if people are not getting treated early on and doing preventative, because they believe their deductible is too expensive, then ultimately it costs the system more especially since the system of CalPERS handles it from cradle to grave. You either pay now or you pay

later. And so later usually equates to a lot higher dollars amount. So we would be happy to bring back some of that information to you.

COMMITTEE MEMBER GILLIHAN: I would like to see that. In addition, it's my understanding the most high -- low cost high deductible plans that preventative care is not included in deductibles.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Not always.

COMMITTEE MEMBER GILLIHAN: But nothing would prevent us from structuring a plan where preventative care is not part of the out-of-pocket expense?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: We are bringing to you on a later agenda item, the PPO where we are increasing the deductible and promoting a value-based insurance design, where we are incentivizing value-based items. And so we believe that that is, to some degree, exactly what you're talking about.

COMMITTEE MEMBER GILLIHAN: All right. Thank you.

CHAIRPERSON FECKNER: Thank you.

Ms. Mathur.

COMMITTEE MEMBER MATHUR: Thank you.

I recognize that there is -- I think this is a fruitful area to explore, whether scale really adds value.

I think for us, our members are not concentrated in one place. In some -- in some regions or some zip codes, having more concentration would actually mean better leverage in that area, either for the plan that is -- that we contract with or for us with that -- with the plan and the providers.

Because if we only have 10 members living in a -- you know, seeking care from a particular provider group or a hospital, that's not going to -- that's not going to really move -- we're not going to be able to have much leverage. But if we were to get a new employer located in that jurisdiction and bring in 300 members, that might -- that might be a more significant share of that medical group's patient load, et cetera.

So anyway, I think it's not as simple as saying we have 1.4 million members. We have 1.4 million members distributed across the state.

Thank you.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Yeah. That is a great point, Ms. Mathur, because -- when we look at the regions some health plans have a small number of bodies. And when they have a high number of claims, based on the low number of total covered lives, that does drive premiums sometimes up. And so having more total covered lives in that specific area would reduce cost.

CHAIRPERSON FECKNER: Thank you.

Mr. Lofaso

ACTING COMMITTEE MEMBER LOFASO: Thank you, Mr. Chair.

Actually, I was going to raise the same issue that Ms. Mathur did, but I'll just take it one step further. Have we thought of targeting some of our outreach to look at those areas where we might get a significant synergy where if added new lives in a particularly -- a geographic edge of our program, we'd improve our ability to retain the people who are already there and make the coverage area and the service more robust in that particular area. I wonder if that's been a retention focus or an outreach focus.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: That hasn't been as of yet, but we definitely can add that. And it does work well with the regions discussion we're having as well.

ACTING COMMITTEE MEMBER LOFASO: Appreciate that. Thank you.

CHAIRPERSON FECKNER: Mr. Miller.

COMMITTEE MEMBER MILLER: Yeah. Is it fair to say that the prospects who are most interested in these high deductible plans would likely be the ones who are concerned about costs for their actives, but don't have a

concern for the retirees, because they don't plan to cover them, and that would certainly make them the natural objectors to a plan that requires coverage for retirees, and ergo high deductible plans would be attractive to them, but not to those who have to actually take care of their retirees.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: That's an excellent point.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Yeah. Mr. Miller, so when we bring back the high deductible to the system and to the members, I'll make sure we -- and make sure that we do the data against the retirees versus actives. And so that we could see if that's maybe what's driving some of the decision-making on the employer side.

COMMITTEE MEMBER MILLER: Thank you.

CHAIRPERSON FECKNER: Thank you.

Ms. Taylor.

VICE CHAIRPERSON TAYLOR: Yes. Thank you. I just wanted to reiterate Mr. Gillihan's point of, yeah, it would be good to have that information about the high deductible low cost plans in terms of the cost drivers, because ultimately it does do cost shifting to the employees. Our plan, notwithstanding right now, as we continue to construct the plan, is a little bit different. But generally speaking, high cost low deductible plans are

cost shift on to employees. And it -- and I have read many reports that have stated that employees or members of those plans wait to get service until they're so sick that the service costs a fortune.

So I think it's something that would be advantageous to have, as well as Mr. Miller's information on, well, if that's the case, then they obviously don't want to pay for post-retirement benefits. And that makes sense.

So it is important that we do that. And I know that I open that up. But then my other statement is that I think it's also important to remember we have a regional issue. We have rural counties where health care is very high cost. And as Ms. Mathur said, if we get more members in these regional areas, that gives us the benefit of being able to push these small hospitals for better costs, and the small doctors' offices et cetera. I got a lot of complaints from my members that they have to travel forever just to get care. So if we have another 300 or 1,000 people in that area that we've recruited, then we have much more leverage to tell these hospitals that are closer to these members that they -- you know, they need to bring their costs down.

So thank you

CHAIRPERSON FECKNER: Thank you.

Seeing no other requests, thank you very much.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: Thank you.

CHAIRPERSON FECKNER: That brings us to Agenda Item 8, CalPERS PPO Plans: Optimizing Health Care Benefits and Outcomes.

Ms. Donneson.

(Thereupon an overhead presentation was presented as follows.)

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Good morning. Mr. Chair, congratulations, and Ms. Vice Chair, congratulations.

Kathy Donneson, CalPERS team.

This is Agenda Item number 8. It's a continuing update to you on the work we've been doing on value based insurance designs for our PERS Select, and also to update you on additional work that we've been doing in looking at PERSCare and PERS Choice.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: So for the agenda today, I'm going to talk about -- I'm going to bring -- I'm going to remind you of some of the history of how our PPO plans were developed. We will then look at some population health statistics, which I was asked to bring back, and I think you'll find

some of those findings pretty interesting. I would then like to speak to PERSCare and PERS Choice specifically in terms of its design. And then discuss the CalPERS -- the design of Cal of PERS Select as a value-based insurance design, and then discuss next steps.

Joining me today is Dr. Laura Clapper. She's the Provider Enablement Medical Director for Anthem Blue Cross. Thank you Laura for joining us.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: This is the current plan design in -- for the PERS Choice PERsCare and PERS Select plan. As you can see from this plan, PERS Choice has an 80/20 type of plan design, PERSCare a 90/10 plan design, and PERS Select an 80/20 plan.

Thinking back through the development of these self-funded plans, PERSCare was the first plan introduced in 1989 as a self-funded plan. In 1993, PERS Choice was then introduced as an alternative to the PERSCare plan, and in 2008, PERS Select was introduced as a narrow network plan, both for providers and hospitals. And you will note that there was even a subdesign within PERS Select that if a member went to a tier 2 hospital, they paid more cost share in terms of using that hospital.

Of interest actually, and I want to thank the

Committee for asking us to do this. If you look at this chart, it provides for you some -- our top six disease management programs we've been running for almost two decades. So we've been working on reducing prevalence of chronic conditions and improving the health of our members for a very long time.

But you can see that in this design, there was a significant migration of the PERS -- of members to the PERSCare product, and the average age has been reduced, and the prevalence of these chronic conditions has been reduced. And this is a result of simply the migration of 9,000 members from PERS Select and PERS Choice to PERSCare. So as the membership increased, the age dropped and the prevalence actually dropped as the denominator got larger.

But I do want to add in looking at this table, and these six conditions, we are going in the right direction. So between 2013 and 2017 you have seen prevalence decrease.

I will note that depression still needs some work, and this is good for us to know, because we'll go back and continue to work on that specifically as a chronic condition.

I do want to talk just about PERS Choice and PERSCare as a plan design.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: And we went back between December and today, and re-examined the plan design. And so in many instances, we reduced the deductible in Care and Choice, and we also retained the co-pay as a $35 co-pay for the urgent care and specialty care.

So we -- for the deductible, when we look at the chart later on in this presentation, you'll see that we did hold the PERS Choice deductible, the same as it is today. And the PERSCare, when we get to that chart, we actually increased it, because that's the value of a 90/10 versus an 8020 plan.

Now, let's move on to the value-based insurance design, which is the -- I will focus on for the remainder of this presentation.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: We've been working on a value-based insurance design for nearly two years. And we've had expert speakers come out and talk to us. And over the last year, we've really looked at a design that's specific to CalPERS. I won't repeat all the presentations we made at off-sites and prior presentations to this Committee, but this does show the length of time that we have been

working on a value based insurance design for PERS Select.

Now why did we take this journey for a value-based insurance design? We did it primarily because in our PPO population, there is a lot of choice for our members. They can choose one of three plans. They can choose to go straight to a specialist, they can choose to go to a richer benefit design, should they wish to pay the premium.

So the idea behind the Value-Based Insurance Design was really to promote physician engagement and member engagement. And we've built in some incentives to get our members to do some of the evidence-based engagement that makes sense that -- and Dr. Laura will talk about the importance of that from the provider's perspective in a little bit.

So what we did is we took our -- we took our deductible. If you look at this chart you can see that in the VBID, the PERS Select, we reduced the individual deductible to $1,000 from what I previously presented as a single deductible. And then we identified five incentivized activities for our members to do to engage in their health and wellness to take some -- to -- to engage with their physicians in things that we believe are preventative, health, and wellness activities.

And if you take those five, which we have

designed to be very easy to achieve for any member in this plan, it takes the deductible right back down to the current $500.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: We believe in the value rather than just the cost implications of this plan. And I think Dr. Laura is going to be very helpful in explaining from the provider perspective why what we have designed is important in terms of physician engagement.

But I do want to point out one -- one other aspect of this program, and that is for expectant mothers and babies prior to delivery. If a mother engages in the Healthy Mom Baby Program, then those deductibles -- that 20 percent co-insurance is waived. So we really believe that the health and wellness of our mothers is important, particularly in the rural areas. And that is one of the advantages of engaging in the PERS Select program.

We also think that if members engage and babies and mothers are healthy, then it will also help us address the C-section rate.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Before turing to Dr. Laura, I just want to restate why we believe Value-Based Insurance Design is

important as a direction. One, it's an innovation. It is -- there are a few states that are progressively moving towards this. And CalPERS is among that mix of really thought leaders in terms of Value-Based Insurance Design.

So this is -- these are the points that we wish to make in terms of the journey and where we are. It offers personal doctor-supported care. That is the member has a personal physician that's going to direct their care, guide them to different sites of care, and really engage with them in terms of sort of advanced primary care. Do they really need a specialist? Do they really need a surgery? That's why that's important, those first two.

It also -- this approach aligns with the Healthier U and Let's Get Health California initiatives, which really focus upon health, wellness, prevention, and chronic disease management, and maintaining health and wellness.

And then using our three plans, you still have choice of the plan. And even within the PERS Select VBID plan, there's still choice. There's choice to engage or not to engage. And finally, it does eliminate that 70/30 tiered hospital approach that's part of the current design.

So now, I'd like to turn this over to Dr. Laura

Clapper, who's going to talk about this VBID plan from the provider's perspective.

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DR. CLAPPER: Thank you for including me. I'm really honored be here, particularly in such a -- with the -- with all of you who have been thought leaders in really in terms of thinking about how to improve health outcomes and affordability.

I think that a Value-Based Insurance Design is a really great step towards how do we engage both providers and members in improving care. I think to speak to this about, you know, why -- why should we have something that really encourages members to select a physician and -- or enroll, we use -- we kind of use those terms interchangeably. And what's the importance of that primary care physician relationship?

I think that if we all would think back to when we were kids, you all thought about what doctor you would go to. You know, you either went to your family doctor or pediatrician. And I think with all the different changes in complexity in health care, we've many times moved away from that. And I think that when we look at the literature, having that relationship is really important. People have taken different strides about it, really working on patient-centered medical homes. And there's

literature primarily in that area about improving quality.

In Anthem's ACO program, Enhanced Personal Health Care, we have data that shows that if a member stays with a PCP for greater than one year. So obviously, that you don't have to select a member in that. You actually can, but you don't need to. It's by all choice.

But if we see in the claims that someone is persistently seeing a PCP over one year, that their costs are actually 2.5 percent less. And we think that that's from the care coordination, the navigation, someone is making sure you're not getting duplication of services, there's shared decision making going on, because I know you.

And so I think that's the kind of relationship and personal care we really want to have for CalPERS members and trying to include in this benefit design.

I think that the other thing, and I think to Kathy's point, is physicians that we've been pushing and I -- in my title is says provider enablement. I work on working with our California medical groups and how to improve the care through our ACO program. And they're looking at their data. We have people working with them, how to do outreach, how to do all these things.

And I continually am told, well, what -- well, what is our employers doing to encourage members to engage

with us, right? We're calling them, and a lot of times they don't want to do it. So I really salute you in terms of thinking about how to engage the providers and the members together to improve health outcomes, affordability, to the triple aim.

And I know you're all familiar. Kathy has talked about how much, you know, we've talked at with CalPERS about the triple aim. And this design really encourages both the two people that need -- are most important working together, the primary care doctor and the member, to improve their health outcome.

And I think that this slide is -- does a great job of talking about really providing that Medical Home, the help with navigation, the -- encourages the ongoing relationship, so you can still go to us -- directly to a specialist, but the idea is to really encourage having a PCP involved, so you have the care closer to home, and having it be coordinated.

You know, Anthem takes really seriously our role as being the PPO provider in the rural counties for CalPERS. And we're continually thinking about how do we provide the same quality of care throughout the state?

And so I think there's more that we can do to support primary care doctors when they're involved in the care to help provide the specialist's care plan, but

closer to home. And I think by getting the primary care doctor involved in the member going to see the primary care doctor, there's going to create more opportunities for us to think about how to involve or that combination of consultation with the specialist, but getting some of that care closer to home.

The opportunity for disease prevention, I think it's not just in terms of immunization and things like that, but all the HEDIS measures. So better diabetes care, the primary care. Kathy's point around depression, that primary care plays an important role in depression identification and treatment.

And, you know, Anthem has done a lot of work in terms of our telehealth. And we have the telehealth psychology. So you could see your primary doctor and then have telehealth psychology if you lived in a rural area.

And then bridging the -- bridging between the patients and the health care, having co- -- having engagement, but both of them having aligned engagement.

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DR. CLAPPER: Just move on to the next slide.

So I've talked a little bit about this, the member and the engagement to the five behaviors, because it's always scary to make changes. And I know that there's some concerns about increasing the deductible, but

I think the important point is that people can earn it back so it stays the same.

So you're doing -- and you're doing it in a very innovative way. So I think -- and continuing your role as thought leaders. So the five areas where people -- members -- everyone is eligible, and all the deductibles credit for each year. So the biometric screenings, and it can be in person or the packet can be mailed to your house. So trying to take into account accessibility, the preventive flu shot, the non-smoking certification that can be done online -- that would be done online, the surgical second opinion. And if you don't need surgery, then you would get the credit. And then participating in condition care or disease management.

So if you've not identified, you don't have a condition, you would still earn it. But if we're trying to call you, and you say I'm not interested, then that's -- you wouldn't earn it, right? So either you engage or you don't have a condition, and then you would earn the credit.

So there's been a lot of thought about what are the right things, making sure that it's evidence based, that these are the things. That it's not just pure wellness, that it's the combination of chronic conditions and surgical, because we want to support the shared

decision making around surgical opinion.

So I think -- and really being a good consumer of health care. So I think that that -- this does a good job of aligning all those -- all those different aspects of total health care costs, as well as holistic perspective on the member.

And with that, I'll turn the last -- for closing to Kathy.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Thank you, Dr. Clapper.

We will be coming back with the final presentation on our Value-Based Insurance Design asking you to make a decision on the package of benefits that we have been presenting over almost a year. We would then, as part of next steps, a full engagement not just with our members, but with the providers as well. And I did raise this design with physicians that attended our last Smart Care California meeting. And they're very excited about it.

Oftentimes, there -- the administrative burden in terms of care -- care management, it just seems like it continues and even -- and gets more complicated. This is one in which they have a design -- a plan design that they can work hand-in-hand with the patient. We're

particularly interested in the idea that it gives you a -- it's not an HMO managed care, but it is an advanced managed care through a PPO product design that will work either in the urban or rural counties.

So with that, I think I'll close and take questions. And also, Dr. Laura will take questions as well.

Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Juarez.

ACTING COMMITTEE MEMBER JUAREZ: Yeah. Thank you for the presentation. It was very good. I wanted to ask the question, do you need to meet all five of the offerings in order to qualify for the reduced deductible?

DR. CLAPPER: No. My understanding is you would earn like partial credit.

ACTING COMMITTEE MEMBER JUAREZ: Okay. So if you do all five, you get the full credit.

DR. CLAPPER: If you do all give, you would get the full credit.

ACTING COMMITTEE MEMBER JUAREZ: But if you don't, you'll get partial credit.

I'm sorry, Kathy?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Let me just clarify that a little bit. We have

designed this such that whether a member needs surgery or not, if they engage with the primary care physician, they get the benefit of that engagement plus all five. So whether you're -- you don't need surgery, if you engage in terms of say the flu shot or alternative, you go online, you certify, any member can gain the five. They don't have to have a chronic condition to get the credit, so it's available to all.

ACTING COMMITTEE MEMBER JUAREZ: But engagement with a physician is key to gaining the credit?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I'm sorry?

ACTING COMMITTEE MEMBER JUAREZ: Engagement with the physician is key to gaining the credit?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yes, that's the key, engagement with the physician.

ACTING COMMITTEE MEMBER JUAREZ: Okay. Just second question, I went through the entire presentation. We talk in acronyms. It mentions in one of the tables about PCP. What is PCP?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Primary Care Physician.

ACTING COMMITTEE MEMBER JUAREZ: Care Physician. Okay.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Apologies.

ACTING COMMITTEE MEMBER JUAREZ: That's reaching out. I looked through the entire document and could not find the definition of it. I appreciate that.

DR. CLAPPER: That's a good question.

ACTING COMMITTEE MEMBER JUAREZ: Thank you.

CHAIRPERSON FECKNER: Ms. Mathur.

COMMITTEE MEMBER MATHUR: Yeah. Thank you.

Well, I think this is a really exciting option that you've created -- designed here, particularly because, as you noted, in the rural area -- in many of the rural areas, we are unable to offer an HMO option. And to me, this closely replicates what an HMO provides, which is really more coordinated care through a primary care physician, and helps to ensure that members are getting both -- the best care, the appropriate care, that they require, at the earliest point in time.

I mean, that's really what we want is for people to get early interventions, appropriate interventions, so that whatever they might be suffering from does not escalate and become a really severe chronic condition, or if they do have a chronic condition, that it's appropriately managed, and that they're not taking drugs that have weird interactions or other problems like that.

So I think this is an exciting option for our members. And thank you so much for all the time and energy and effort that you put in to designing it.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Thank you.

CHAIRPERSON FECKNER: Mr. Miller.

COMMITTEE MEMBER MILLER: Yeah. Thank you for the presentation. It was very helpful.

When I look at this from kind of a very simplistic view, I agree with Ms. Mathur, I think having something like this new PERS Select, these features are very important for folks who, especially in areas like rural areas where we don't have an HMO, and where over the careers we've lost, for example, with -- a lot of State employees lost their rural subsidy for their premium, so it's been very challenging.

On the other hand, there's a lot of people who have chosen PPO options, because they do not want to be in the HMO plans. And so from the perspective of customer satisfaction/dissatisfaction engagement, for those people who have chosen PPO plans for reasons, other than just pure cost or availability, I like incentivizing things that relate to health outcomes as you've done with this new option, and for people who that will be of value.

But the drastic increases the aversive nature,

kind of the -- we're going to try to drive people to that, or punish them if they don't go, really concerns me, particularly with the PERSCare some what PERS Choice. And I think that's something that for those members who are in those plans, this idea that, oh, that plan is too attractive. We've got to make it unattractive to push people toward that choice, because in such a dramatic fashion with the increased out-of-pocket, so many of those members would be seeing, especially if they're relatively strained on their income situation already, because those plans are expensive and they've chosen them for good reasons, whether it be for themselves or their spouse or other dependents. So I really want to express my concern about that.

DR. CLAPPER: I really -- I appreciate that I. I think one thing that, you know, when I'm up here as a physician and trying to think about, you know, those interactions with members when you see them, I think that we -- that's why we have three plan -- PPO plans. And the other ones are -- so trying to provide choice, and even in the PERS Select there's choice on if you select a PCP or not. There's choice whether you, you know, want to go directly to your specialist you can still do that without even the change in copayment.

So I think the idea is to incentivize them but

there's not anything more that's in this. I don't know.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I'd like to add to that as well. Actually, we're not -- we're really not trying to, as you put it, drive members to go this way or another way. When you think about it with the five incentives and it coming down to what they're currently paying in terms of their cost share, we may have care members who want to go to this plan, because they like the idea of having their care managed. And they're going to be the ones with chronic conditions and that chronic condition care management would actually be good for them.

We don't see a lot of migration in the Choice plan, which is our biggest plan. Those members tend to stay there. On the other hand with that generous 90/10 benefit, they -- you do see some movement from Choice to Care as well, because they're getting an added benefit with the same level of the deductible. So we're not trying to design something in which we want members to go one way or another. They will make those choices themselves.

And I think the -- the -- not just health and wellness, but the screenings, pre-diabetic screening, which would come through the biometric screening side, alert them to conditions that they would need to engage

with their physician. Again, with chronic conditions if you have a care member deciding that they're ready now, and this looks like an attractive option for them, you actually could see members stay where they are, or decide to go to the Value-Based Insurance Design product.

CHAIRPERSON FECKNER: Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you, Mr. Chair, a couple of questions. First on the PCP, the five areas, if someone already has a primary care physician, then they don't have to do anything, is that correct?

DR. CLAPPER: They would need to go during enrollment, they would need to select that physician.

COMMITTEE MEMBER JONES: If they have already have it.

DR. CLAPPER: If they already have it. So they're -- pretend they're in PERS Select now, they would just go in and find them. If for some reason, their doctor is not in there -- I can't imagine it, because, you know, they're in an Anthem program now, right? They're in PERS Select. But there is -- there would be an option and we have that currently that they could request to have a physician. But it's the same physician network that's currently there. So if you're in PERS Select, there's no change or narrowing of the network.

COMMITTEE MEMBER JONES: Okay. And the next

question is the estimated cost reduction of this plan is $46 million. Where does that savings go?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Are you asking where does the savings come from?

Oh, where does the savings go?

COMMITTEE MEMBER JONES: Who benefits?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Oh, Cal -- the employer and the employee benefit from the savings.

COMMITTEE MEMBER JONES: So the employee, meaning active and retirees?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Early retirees, yes.

COMMITTEE MEMBER JONES: Early retirees meaning what?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yes. Yeah.

COMMITTEE MEMBER JONES: Early retirees meaning?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Oh, those 55 to 64 that are not eligible for Medicare but have retired from CalPERS.

COMMITTEE MEMBER JONES: Okay. So -- and then when Medicare kicks in at 65, then it's not -- they're not -- those members are not affected by this plan.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Correct, they're not -- Medicare members are not affected by this plan.

COMMITTEE MEMBER JONES: And they're not affected by any of these -- I'm looking at this chart that talks about deductibles, maximum, they're not affected at all?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: No. Our PPO is a supplement to Medicare. So Medicare designs benefits for the Medicare population.

COMMITTEE MEMBER JONES: Okay. Okay.

CHAIRPERSON FECKNER: Mr. Lofaso.

ACTING COMMITTEE MEMBER LOFASO: Thank you, Mr. Chair. Two questions. The first is related to this theme about PPOs in rural areas. A couple clarifying questions. Did I understand you to just say that the new PERS Select product needed to choose a primary care physician that wouldn't be narrowing any networks beyond what they are now?

DR. CLAPPER: Right.

ACTING COMMITTEE MEMBER LOFASO: And --

DR. CLAPPER: You do have to make -- just to clarify, if you want to have the $10 copayment, so you don't have to select someone, but if you want the lower PCP copayment, then you would need to go in during enrollment and select -- or after enrollment. But at the

time you select a PCP, then you would have a lower copayment.

And that does a couple things for us. Like, we can't provide data to a doctor unless we know that you have a relationship with them, because of HIPAA. So when you -- so that's an important piece. When you select a physi -- you know, you tell Anthem, I want Dr. Jones to be my doctor, then we can tell -- we can give care gap data to that doctor. We can do things like that. But we couldn't provide that data unless you tell us that's your doctor. So that's what that starts to do.

ACTING COMMITTEE MEMBER LOFASO: But that clarification is not about the network. That's about the timing of my decision.

DR. CLAPPER: And then in the network, the PERS Select network, that you've had since 2008, that's the same network that is in the plan. There's no change from 2008 PERS Select till now.

ACTING COMMITTEE MEMBER LOFASO: Got it.

DR. CLAPPER: The only -- the only change is with the hospital. We're not -- we're removing the tiering.

ACTING COMMITTEE MEMBER LOFASO: Okay.

DR. CLAPPER: So you actually have more options on the hospital.

ACTING COMMITTEE MEMBER LOFASO: Another

subquestion. If I sign up for the five incentives, am I still allowed to bypass my PCP and go to a specialist, or is it so HMO like that I no longer could do that.

DR. CLAPPER: You can go directly to a specialist. That's still there, which -- and the copayment is the same. What's changing is if you select a PCP, tell -- you know, do the active select a PCP, then you got a lesser copayment.

ACTING COMMITTEE MEMBER LOFASO: Okay. Appreciate that.

DR. CLAPPER: That's what's changing. So you use -- it's still a PPO, you can still go to a specialist, but we're trying to incentivize you to see your PCP. I've worked with a couple employers, where they actually even -- they had this concept of like giving some PCP visits away. With the -- I know -- I'm seeing a couple -- but the idea, I would -- I'd give four PCP visits with no copayment.

And what they found was that people went to the ER less, because you know you have to go pay if you go to the ER, but I could go see my PCP. And this is trying to do that, right, to give a lower copayment so you're more incentivized to go talk to your regular personal doctor before you go to urgent care, the ER, something like that. It incentivizes you to go see the regular doctor.

ACTING COMMITTEE MEMBER LOFASO: Appreciate that. So with those qualifications -- excuse me, clarifications, the question I really wanted to ask is just do you all have a sense as so to what the -- what the demand or interest in these rural areas is for this more HMO-like product? Maybe it's unfair for me to suggest that rural members don't want the same HMO options that urban ones do. But just -- do we know what the desires are out there and how our potential change is going to satisfy them?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Well, we have not -- I think through Anthem, our relationship with Anthem and their relationship with our members and the physicians I think that there is a desire, in terms of not just the -- the amount of premium that they pay, but really engagement. We have done some studies, especially in looking several years back at new mothers and how they do or do not engage with an OB/GYN physician. And we think that this is going to be something that is going to be very attractive to families out in the rural areas. We think it's going to be attractive to employers who have been asking us to help them with prevention and wellness. And this is a more comprehensive approach than trying to work with, you know, individual contracting agencies.

I think most importantly, which I am excited

about, because I think the physicians in the rural areas are going to be interested in this, and -- as part of our communication plan, we would want to engage those physicians and let them know that this is an opportunity for them to engage more with their patients. And they have their patients actually benefit from that engagement from a plan design perspective.

So we are -- we are getting interest from physicians. And we believe that this is a product that will work well for families, and employers, and employees in the -- in areas where HMOs don't serve them.

ACTING COMMITTEE MEMBER LOFASO: Appreciate that. My cold has scrambled my brain and I forgot to compliment you on how much this has shaped up since the many sessions you identified in your slide, Dr. Donneson.

The last question I wanted to ask is two or so years ago, we were talking about wellness programs. And you commented about aligning with Healthier U initiatives. One place -- one off ramp we took about two years ago was what are the responsibilities employers relative to purchasers on wellness programs?

I'm assuming we haven't changed our view on what a purchaser's responsibility is. But with that, with that -- that commented on, can you explain a little bit more how it aligns with carrier responsibilities visa the

employer responsibilities on the wellness program?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Well, I'd like to just touch a little bit on Healthier U and its origins in the Controller's Office and the Treasurer's Office were the two agencies that helped originate a Healthier U in collaboration with Kaiser and in collaboration with the SEIU.

And the goal was -- and it also -- expanding to healthy California, these goals align. And that is that members take -- that our patients or members take responsibility for engagement in their health and wellness. And so if you look at the five things that we've identified as incentive-ready, the most important, I think, in that list that applies to everyone is that biometric screening. And you don't have to go to a lab, a Quest Analytics Lab. If one is available and you want to go give the necessary specimen to the lab, and it's available, that's a choice.

But with these kits, with the biometrics kits, you can actually take I think it's a blood specimen and send it off to the Quest Analytics Lab and you get a readout of, you know, your hemoglobin A1c or -- you tell them.

DR. CLAPPER: Your cholesterol, and the -- so I think, you know, it really does, I think, give the

opportunity for making wellness accessible to all members, because I -- CalPERS has really done a great job at bringing work-site wellness, where we have clusters of employees at different places at the prison sites, and at the Cal State.

But we still couldn't bring, you know, Anthem and CalPERS together, bring this kind of biometric screening, you know, available to everyone. And so we've worked with Quest to design a plan that would allow us to bring biometric screening. Really, you could participate whenever you live.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Right. And it also includes height, and weight, so BMI can be calculated. And so the kit is really about a -- sort of a comprehensive first-line assessment, which we ask our work-site wellness nurses that go to these sites to do.

So in a way, it's more comprehensive because instead of sending a nurse team to -- to the CSUs, for example, to have a health and wellness day, this can be engaged by the member themselves through this plan design. And we can't get to all rural areas or even urban areas.

So the Healthier U started as an initiative Healthier U to do very Similar things as have other work-site wellness programs. They all sort align to try

and do this same thing, biometric screening in terms of prediabetes, or cholesterol, height and weight, BMI for measuring being overweight or obese or normal size.

And then part of that is engaging in health and wellness exercise programs. So we think that this actually expands upon the early initiatives that was the desired outcome through Healthier U. And it makes it even more possible to reach more employees and employers.

ACTING COMMITTEE MEMBER LOFASO: Appreciate that. My predecessor, Ruth Holton-Hodson from the Treasurer's Office is smiling down. Thank you.

CHAIRPERSON FECKNER: Thank you.

Ms. Taylor.

VICE CHAIRPERSON TAYLOR: Yes. Thank you.

Thank you for the presentation. I think -- I feel like I have a better understanding finally as we've gone through this for the last year of what's going on. I just -- I think I wanted to kind of dig into the copays, et cetera. So maximum co-insurance out of pocket is going to be $3,000 all the way across, that's even for PERS Select?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: No. Let's --

VICE CHAIRPERSON TAYLOR: Because that's what it says on your table.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: So if you look at slide 7, which aligns -- it's the three out there, the deductible -- the individual -- oh, you asked about the co-insurance, yes.

VICE CHAIRPERSON TAYLOR: Maximum co-insurance.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: The maximum co-insurance has existed at that amount forever.

VICE CHAIRPERSON TAYLOR: Forever. So I just want to figure out if you get the deductibles or the -- not the deductibles, but the incentives to reduce the deductibles, does that -- that lowers that, is that correct?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: The maximum co-insurance --

VICE CHAIRPERSON TAYLOR: Yeah.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: -- is that the question does it lower it?

VICE CHAIRPERSON TAYLOR: Yeah.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: That's an amount that if you get -- if you -- in your use of health services, that's the maximum that you can go up to that you're going to be held liable for. So they don't really --

VICE CHAIRPERSON TAYLOR: So that's not the

deductible. That's your 80/20.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: That's the max -- yes. You won't -- you can't exceed that --

VICE CHAIRPERSON TAYLOR: Right.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: -- in terms of your cost share. It's a cap.

VICE CHAIRPERSON TAYLOR: Okay.

DR. CLAPPER: It's like deductible plus co-insurance.

VICE CHAIRPERSON TAYLOR: Plus co-insurance, gotcha. Okay. I just wanted to clarify that.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Can you say that again for him -- the court reporter.

DR. CLAPPER: Oh, yeah. The maximum co-insurance out of pocket is the deductible plus any co-insurance, and then it's the max out of pocket. So it's the two together.

VICE CHAIRPERSON TAYLOR: So that would include your pharmaceuticals and everything else, right? Your copays for your pharmaceut -- is it your copays?

DR. CLAPPER: It's your copays. I -- since we don't -- I'm going to let Kathy talk about the medical pharmacy accumulator.

VICE CHAIRPERSON TAYLOR: Cumulative is that what you said?

Right.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: So it would be medical pharmacy, because our PPO pharmaceutical program is managed by OptumRx. So this is the -- so if you have expensive medical necessity needs, in terms of say medical pharmacy, cancer, other expensive pharmaceuticals, and you're paying these cost shares, then it -- that's the maximum that you're going to pay.

VICE CHAIRPERSON TAYLOR: Okay. So -- and then I just want to make sure -- so if you're seeking -- if you've got -- accepted of primary care physician, then anytime you go in to see that physician for your screenings, which your physician should be ordering anyway -- your primary care physician, it's a $10 co-pay.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: It is a $10 co-pay to see the physician. Under the ACA though preventive care itself has zero cost share. So if you have an annual physical as a preventive service --

VICE CHAIRPERSON TAYLOR: That's zero.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: -- that's zero.

VICE CHAIRPERSON TAYLOR: But say it's -- maybe it's not your annual, your doctor saw something in your biometric screening and wants you to come in every three months for --

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: That would be a $10 copay.

VICE CHAIRPERSON TAYLOR: That's the $10 copay. Do you pay for the lab on this program? Do you pay to go into the lab for that?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: If it's a preventive screening, the answer is there's no cost share. If it's follow-up for some type of condition that has been discovered, yes, that is a --

VICE CHAIRPERSON TAYLOR: Then it's part of the 20 percent --

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yeah.

VICE CHAIRPERSON TAYLOR: -- of your cost share?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yeah.

VICE CHAIRPERSON TAYLOR: Okay. So that's what I'm trying to clarify. And then I think I had -- wait, where is my -- I think my other question was the second surgical opinion. So your primary care physician says -- I don't know -- you need surgery for whatever, the

requirement to go to a second surgical opinion, even though your primary care said -- is that the case, you have to have a second surgical opinion for this?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yes, and let me --

VICE CHAIRPERSON TAYLOR: Okay.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yeah.

VICE CHAIRPERSON TAYLOR: And I'll --

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: A surgery could be quite expensive --

VICE CHAIRPERSON TAYLOR: Sure.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: -- so it's good to have a second opinion --

VICE CHAIRPERSON TAYLOR: Yeah, as -- yeah.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: -- as we encourage.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: And, Ms. Taylor, I just want to point out it's per elective surgeries. If you're going to --

VICE CHAIRPERSON TAYLOR: Oh, that's elective surgeries.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Yeah, if you end up in ICU, that you do not need a second opinion on.

(Laughter.)

VICE CHAIRPERSON TAYLOR: I would hope not.

Okay. So it's the determination of Anthem of what that all -- what that is if that's elective. So your doctor says you need to -- I don't know, whatever the surgery is that you don't think is elective, your doctor didn't think is elective, but Anthem is saying no, you need a second opinion on this.

DR. CLAPPER: So I just want to clarify surgeries are coded actually by provider, if it's elective or emergency. So if you go into The emergency room and you get admitted, Anthem doesn't code it. That actually is coded on the --

VICE CHAIRPERSON TAYLOR: By the doctors.

DR. CLAPPER: -- by the doctors and the provide -- through the hospital.

VICE CHAIRPERSON TAYLOR: Okay. I just want to make sure --

DR. CLAPPER: So that's -- that would -- that's how it's coded. If you -- so it would be that your doctor -- usually, a primary care doctor wouldn't be doing surgery, and they would send you like, it seems like you, you know, happen --

VICE CHAIRPERSON TAYLOR: No, they'd send you to a specialist.

DR. CLAPPER: You may need a hip replacement. I don't know. We've been watching your hip arthritis for a long time, and they'd tell you to go to an orthopedic surgeon. And if you talk to an orthopedic surgeon, they might say, you know, there -- nowadays it's gotten so much more complicated, should you do it? What kind of procedures should you have. They would -- the idea is that you would have a second opinion at that point about, is it the right time --

VICE CHAIRPERSON TAYLOR: Got it.

DR. CLAPPER: -- what kind of procedure, like resurfacing versus total replacement, or there's, you know, multiple decision trees, and what kind, and when, and things like that.

VICE CHAIRPERSON TAYLOR: So and that one might result in a second opinion --

DR. CLAPPER: That would be a second opinion.

VICE CHAIRPERSON TAYLOR: -- because of -- even though you need that surgery, because you're not walking very well anymore or whatever, it's the type of surgery?

DR. CLAPPER: It's maybe the type of -- the type of procedure, so you're still going to get a hip replacement, but it would be the type of surgery within that. There's different thoughts about whether it's, you know, the type of arthritis. I mean, I'm not a -- I am a

board certified pediatrician. I'm not an orthopedic surgeon.

VICE CHAIRPERSON TAYLOR: Right, right, right.

DR. CLAPPER: -- But it's the kind procedure some now providers are doing hip replacements as outpatient if you're low risk. So you potentially might want to talk to them about what kind of risk you think you have from the procedure, and what's the right place for you to have the procedure, those kind of discussion points.

So I think that's important for people to really -- you know, how much -- honestly like what kind -- what to expect from the procedure, and what kind of help you're going to need at home, or all those kinds of things you could get from talking to a second person.

VICE CHAIRPERSON TAYLOR: Okay. And are you responsible for that cost or is that part of -- you know what I mean, is that part of the 20 percent?

DR. CLAPPER: That would be another specialist visit. So you would make another copayment.

VICE CHAIRPERSON TAYLOR: So it's another copay. So that's -- it's not like 20 percent. Okay. Hold on.

DR. CLAPPER: Right. You'd have another copayment.

VICE CHAIRPERSON TAYLOR: So it's 35?

DR. CLAPPER: Thirty-five.

VICE CHAIRPERSON TAYLOR: As long as it's in --

DR. CLAPPER: But then you would get the -- in some ways, you're getting paid back for it, because you're getting the -- you're getting the deductible reduction, the credit.

VICE CHAIRPERSON TAYLOR: Oh, I got you. I got you.

Okay. A flu shot, no smoking, condition care, disease management. So once you are diagnosed with the disease, then you're saying obviously, keep coming to the primary care physician making sure that your disease is managed, take your medication on time, et cetera. How does that get -- how does that get credited? How do you, as a patient, say, okay, I did that?

(Laughter.)

VICE CHAIRPERSON TAYLOR: I did all of this.

DR. CLAPPER: So my -- the way I was thinking about I'm going to -- I can remember -- but that we have both the, you know, providers, if they're providing condition management as well as Anthem, where you have a disease management program called Condition Care. They're outreaching to the members, calling them, saying we want to talk to you about your condition.

And so if I -- if you've been identified for the program, and I reach out to you, and you say I don't want

to participate, then that would be that you didn't. So you -- you -- we would know we tried to reach you, and you told us no.

That --

VICE CHAIRPERSON TAYLOR: Okay. But say I -- oh, okay. So say --

DR. CLAPPER: If we don't try to reach you, then you get the credit.

VICE CHAIRPERSON TAYLOR: Okay. So it's not something that is automatically done through your physician once you've gone in and --

DR. CLAPPER: Right, it could be. And that's -- I think we want to make sure the maximum people get credit. But if you're -- like, pretend you have high blood pressure and that's actually the one thing in biometric screening that also includes blood pressure. Pretend I'm identified as having high blood pressure. I go to my doctor and he says you're both -- you know, we're -- start this medication, and we're going to keep working with you. Your blood pressure looks good. You might not be identified for like a Condition Care program, because you're at low risk and you're managed. So someone might not be reaching out to you. In that instance, you would get a credit.

VICE CHAIRPERSON TAYLOR: Okay.

DR. CLAPPER: Pretend you go and then your blood pressure is not managed, and now you have to take another medication, and different things are happening. Maybe you go to the ER for a headache and they think it's from your blood pressure. So now you're starting to get higher risk. A nurse is probably -- is going to call you, and say, hey, can we help you? You know, can look and see if you're taking your medicine. Those kinds of things. That if you say, I don't want to talk about it, then --

VICE CHAIRPERSON TAYLOR: Well, yeah, you're not participating.

DR. CLAPPER: -- you're not be par -- then you would not be participating.

VICE CHAIRPERSON TAYLOR: Okay. Wow.

DR. CLAPPER: If you're --

VICE CHAIRPERSON TAYLOR: I'm sure that happens, but yeah.

DR. CLAPPER: You would not believe it, but it does -- it does happen.

VICE CHAIRPERSON TAYLOR: Okay.

DR. CLAPPER: It's really hard, and I want -- to Kathy's point about the healthy moms and babies, you -- you know, we've had this future mom's program. It's a great program. But, we don't have enough people participating, even with people calling and trying to

participate. And I know that CalPERS has been a great leader in working with the different provider hospitals about reducing C-section rates.

But really, the next frontier besides maternity, morbid -- you know, mom, death, or mortality, which we're all focused on too is really reducing pre-term delivery. And I think, you know, the March of Dimes has been doing a lot for working on pre-term delivery. And why I'm bringing that up is we really need to engage moms in their pregnancy, so we know if they have risk factors and we can work with them. You know, do they have a history of pre-term delivery? Do they have, you know, twins or other multiples? Do they have blood pressure that's not being controlled? Different -- are they smoking and we want to work with them to stop smoking?

Those kinds of things that are all associated with pre-term delivery. That that's really -- we want to make sure everyone is educated, so they know to be, you know, wise. Good to have a vaginal delivery a normal delivery, and all those -- you know, be educated about breast feeding and all those kind of things.

But we also want to start making an impact on pre-term deliveries and reduced NICU stays, both for the mom and baby.

VICE CHAIRPERSON TAYLOR: So I'm a little

shocked. Are you saying that you're having trouble getting people to participate in that?

DR. CLAPPER: Right, yes.

VICE CHAIRPERSON TAYLOR: Well, it's been a long time since I've had kids, but wow.

DR. CLAPPER: Yeah. No, that -- we're having a hard time getting people to participate. People call and they're like they don't want to be bothered. So that's really what this has to do if people participate, then they will have their co-insurance waived.

VICE CHAIRPERSON TAYLOR: Okay.

DR. CLAPPER: So it's giving an incentive.

VICE CHAIRPERSON TAYLOR: But we will have some refusal, is what you're ultimately saying, okay. I

DR. CLAPPER: Right. Yeah. So --

VICE CHAIRPERSON TAYLOR: I just -- wow. Okay. I do appreciate this, and thank you for clarifying. I would hope that we have much more participation as somebody who's lifetime had an HMO. It's foreign to me not to have all of this. So I'm glad to see this, but I hope to see good participation as well. And I'm hoping that the cost isn't counterintuitive to that. But let's hope that driving some of that cost down with their deductibles will help.

Thank you very much

CHAIRPERSON FECKNER: Mr. Slaton.

COMMITTEE MEMBER SLATON: Thank you, Mr. Chair.

I really like this alternative. I think it takes us obviously in the right direction. I'm also happy to see that the maximum out of pocket has not changed for those who have severe chronic conditions. It's very important to have that maximum out of pocket. You mentioned about pharmacy in relationship to this plan being part of the maximum out of pocket, but you seem to differentiate certain types of drugs or treatment. So I want to clarify what's in and what's out in terms of being under the maximum out of pocket per year.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: So this is -- this is related to the medical benefits, rather than the outpatient pharmacy where you have retail mail and specialty drugs. That has another out of pocket that's not related to this.

But this is related to the sum of your deductibles that -- and your copays that then go up to that maximum. And that would include medical pharmacy. For example, if you go to an oncologist and have --

COMMITTEE MEMBER SLATON: So an infusion center that kind of treatment.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yeah, infusion center.

COMMITTEE MEMBER SLATON: So, for example, if I'm taking Advair for asthma as a chronic condition, that's in the pharmacy side not in this side?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Correct.

COMMITTEE MEMBER SLATON: And what are the maximum out-of-pockets for that?

You can get back to me if you don't have the answer on the top of your head.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Well, we can certainly -- if you give us a minute, perhaps between this presentation and pharmacy, we'll be able to tell you.

COMMITTEE MEMBER SLATON: Well, maybe I'll just reserve the question to when we get to pharmacy.

One other question for you. And obviously, what this is trying to do is to get people to have their relationship with a primary care physician with a doc, but yet still reserve the PPO criteria that you can go directly to a specialist without the referral.

So my question is if that's what we want To accomplish, why do we even have a $10 copay? What's the -- why would we -- why wouldn't we eliminate that, and have a zero copay?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF

DONNESON: Eliminate and have a zero copay?

COMMITTEE MEMBER SLATON: Yeah, just curious.

DR. CLAPPER: I think that's a great question. I think you don't want to have unlimited visits at zero copayment, because you may have people --

COMMITTEE MEMBER SLATON: Overusing --

DR. CLAPPER: -- using the primary care doctor for other kinds of relationship advice or other kinds of things. When people have them done that, that's what they found.

COMMITTEE MEMBER SLATON: Well, I have a dating problem, so I need to go see my primary care physician?

Yeah, I see what --

DR. CLAPPER: Well -- or problems with their kids --

COMMITTEE MEMBER SLATON: Right.

DR. CLAPPER: -- or different things like that. And so at least someone has to think about it, like I'm going to have to pay $10. I have to park, and I have to make an appointment. And I have to have $10. It puts some value for going to the -- going there.

COMMITTEE MEMBER SLATON: Yeah, it seems like the time and the parking or -- may be a bigger issue than the $10 copay, so...

DR. CLAPPER: But you -- you have to think about

it. I think that's what the idea was. But to make a bigger difference between the primary care doctor and the specialist, and a bigger difference between the primary care doctor, and urgent care, and ER that we do know that if you have a bigger differential, that people will be more thoughtful consumers.

COMMITTEE MEMBER SLATON: So the -- so the specialist visit is 35. If you go to the ER, what happens?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: That has a 20 percent co-insurance for an ER visit.

COMMITTEE MEMBER SLATON: So it's just pure 20 percent.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Correct.

COMMITTEE MEMBER SLATON: So that gets expensive pretty fast.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Correct.

COMMITTEE MEMBER SLATON: Okay. All right. Thank you.

CHAIRPERSON FECKNER: All right. Before I go to the next speaker we have three more Board requests and two from the audience. We're at our two-hour mark, so I'm

going to take a 10-minute break for the court reporter, and we will reconvene at 10:40

(Off record: 10:31 a.m.)

(Thereupon a recess was taken.)

(On record: 10:43 a.m.)

CHAIRPERSON FECKNER: Take your seats again.

So the next request to speak is Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you, Mr. Chair. My iPad is locked.

(Laughter.)

COMMITTEE MEMBER JONES: So I need the chart --

CHAIRPERSON FECKNER: There went his questions.

(Laughter.)

COMMITTEE MEMBER JONES: -- that I was looking at, but it's the -- I don't know if I can -- okay. Yeah. Thank you.

Yeah. I'm going back to the chart, the page 711 of the report, and what triggered an additional question is I heard a response to the question about the $3,000 that has been there forever. But then I start looking at the shaded areas versus the white areas. And I'm thinking, well, are the shaded areas where the changes are? And if that's the case, then the $3,000 for PERSCare is that a change?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF

DONNESON: Yes, that's correct. What we did is we looked at that 90/10 benefit, and the value of that versus the 80/20. So the benefit in the Care is a richer benefit. And so between the -- we increase that from 2,000 to 3,000

COMMITTEE MEMBER JONES: So that is an increase then?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yes.

COMMITTEE MEMBER JONES: Okay. And so then that drives the next question looking up at the deductibles where you have the PERSCare and the PERS Select. Those are changes also.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Correct.

COMMITTEE MEMBER JONES: And what were those numbers?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: The -- they were all -- if you look at that original slide, they were all 500 and 1,000. So we've left the choice at where it is, and then we made actuarially equivalent to the 90/10 benefit to the Choice. So that increased the deductible from 500/1,000 to 750 and 1,500, and increase the co-insurance from 2,000 to 3,000. And that actually equilibrates the benefit design of the richer Care plan to the Choice plan.

COMMITTEE MEMBER JONES: So if I look at the select then of the individual 1,000, and family 2,000, that's an increase.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Correct.

COMMITTEE MEMBER JONES: And then right below that, after the increase, then you got a deduction. So the net effect on the member is --

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: What it is today. That if you reduce -- if you do your five incentive credits, it takes it from 1,000 to 500. And that's where it is for the single plan.

COMMITTEE MEMBER JONES: Yeah, but why would we go through that process if the numbers -- I mean, in order to get to the same number, you got to go through this additional process. And I understand the Care part of it. But it seems that we're using numbers to drive change, as opposed to just Care

DR. CLAPPER: I think to the -- I think that's a really good question. The idea is to incent -- create a program that aligns and engages both physicians and members. And that's why the idea is that create an opportunity for members to engage, and reduce the deductible. We hear -- and just like what I was speaking earlier about, it's hard to -- I know people are busy, but

it's hard to engage members in their care. And so this really creates an incentive to do it. And the reason why it's in the deductible is because CalPERS is a trust. This is a good vehicle for you to be able to do that, you know.

COMMITTEE MEMBER JONES: Yes. And, you know, I always look at also the fact of what's the impact on individual members especially our retirees, who on average, I don't know, is maybe $3,600 a month in retirement. And that's a fixed income. So I always look at what's the impact on those individuals.

And that's why I always ask what's the impact on an individual so that we could assess that impact? So perhaps when you come back, Mr. Chair, if we could have run a scenario to see what's the impact on a member for these changes.

CHAIRPERSON FECKNER: Very well.

Anything else, Mr. Jones?

COMMITTEE MEMBER JONES: No, thank you.

CHAIRPERSON FECKNER: Okay. Ms. Mathur.

COMMITTEE MEMBER MATHUR: Thank you.

A couple points. One is that I think these proposed PPO changes they're combining two things. One is this VBID proposal, which is the PERS Select proposal. And the other is a rationalization between the PERS Choice

and PERSCare to ensure that they're more actuarially equivalent offerings, is that correct?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yes, correct.

COMMITTEE MEMBER MATHUR: So we -- I don't want to confuse the two that a decision on one does not necessitate a decision on the other.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: That's correct.

COMMITTEE MEMBER MATHUR: The other thing that I wanted to just follow up on was Dr. Clapper you mentioned that some purchasers will offer, let's say, four free PCP visits. Did we look at that in this -- for this VBID, and did we, you know, do any analysis or assessment around what the cost or benefit of that might be? It's an intriguing idea, so...

DR. CLAPPER: I think what -- we did talk about it, and we were -- I think we were worried about confusion. This seemed cleaner to the point of, you know, keeping how -- they already have to earn 5, you know, work on engaging around five things. That this kept it really clean. You don't have to say did I use it up? I didn't use it. Oh, that visit was a preventive visit, you know, under ACA or not. This just made the $10 is simple to understand. If I choose a doctor, I pay $10.

COMMITTEE MEMBER MATHUR: And did you find in other plans where -- programs where it's been offered. Did you find confusion occurred? Did you have any way of gauging that?

DR. CLAPPER: I mean, we don't really -- I didn't really have a good way of gauging it. But I think that -- you know, I think that you do -- someone has to be tracking it, and their causes confusion that way. So this seemed really simple and clean.

COMMITTEE MEMBER MATHUR: All right. Okay. Thank you.

CHAIRPERSON FECKNER: Thank you.

Ms. Brown.

BOARD MEMBER BROWN: Thank you. Hi.

So I appreciate Mr. Jones pointing out that the changes are highlighted in gray. So that's great for me, as someone who's not been on this -- that's on this Committee.

But I do have a question with respect to the savings. I know another Committee member said, well, there's going to be anticipated $46 million in savings. And so those savings goes to CalPERS, but that means the increases though go to the members. And I'm not sure if that's a good tradeoff.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF

DONNESON: Actually, the savings go to the employer and the employee through the reduction in the premiums. So there's going to be reduction if premiums differ between the plans. So if the members choose to go to the Select product, there is a -- they do save in their premiums.

BOARD MEMBER BROWN: But let's say I'm a PERSCare member, I don't have an option to do the five little things to get my deductibles reduced, is that correct?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: That's correct. For keeping the plan designs for PERS Choice and PERSCare.

BOARD MEMBER BROWN: So why could -- why -- what would the savings be if we did offer that? I mean, what if we didn't go -- when I look at the areas that are in gray, why wouldn't we offer the PERSCare people the incentives so they could get their deductibles down and then keep their urgent care and specialized visits at $35? How does that -- how does that impact the savings? Because really what we're talking about is increasing costs to our retirees.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: We can bring back some figures to show what the premiums savings might be in these designs, because it is -- these designs are pretty much the same and especially with Care and Choice as they are today. Now,

when we work with the premium, however, and if we have a member that chooses to leave care, and go to the new select VBID, they're going to have a reduction in their premium. They will save money in terms of their premium as will the employer.

BOARD MEMBER BROWN: Except they have go to 80/20 from 90/10 is that correct?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Correct. That's how it's designed. And it has been actually since the eighties and the nineties.

BOARD MEMBER BROWN: I'm just looking for an opportunity to get -- to have people who want to stay on PERSCare at 90/10 than give them the option, because you're talking about getting people to work with a primary care physician, and basically do the biometric testing and do all those things, so why can't we offer that also for the PERSCare?

I'm sure you'll still have savings. And that way the savings -- the costs aren't all put back on the members.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: We designed the VBID really as a pilot. This is the first time we've had the opportunity to do something different than just have co-insurance and copays. We actually -- this approach is a carrot approach

versus other plans that we presented a year or so ago, like Connecticut and like Minnesota, where there were stick incentives, especially with the moms and babies program.

There are -- there are ideas in the health plan world that you penalize mothers for C-sections, if they're elective. We prefer not to try to do that. We think that, as Dr. Laura said, get the new moms and babies engaged and waive that 20 percent deductible.

And that is a, we believe under the value approach, a positive incentive like that is -- and I think that this Committee has -- that's been their direction for all the years I've been talking to this Committee, that it's really incentives for positive behavior change, rather than negative incentives for what you want to be positive change.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: And, Ms. Brown, I also wanted -- I know Ms. Mother had pointed it out. I think sometimes we're -- we have confused the Committee because really there is two things going on in this agenda item. One is the PPO, which PERS Choice, PERSCare, and then also talking about a pilot for VBID. And we're all kind of commingling it.

So one thing is none of these have been changed 10 years. As such, PERSCare is a 90/10 plan, which is a

much richer plan. Actuarially, regardless if did VBID or not, we needed to increase the deductible to be actuarially sound. So that -- that put to the side, we do want to do a pilot with the PERS Select. We believe in promoting value.

If that is successful, I see that we would potentially look at, you know, rolling that out to the other PPOs. But I think we've -- we've done a disservice, because I think we've commingled two different topics. And it makes it look like we could almost take all the PERS Select design and spread it across all the PPOs, when that really has not been the focus for the last two years. It really has been just on PERS Select.

CHAIRPERSON FECKNER: Anything else?

BOARD MEMBER BROWN: Thank you.

CHAIRPERSON FECKNER: All right. Mr. Miller.

COMMITTEE MEMBER MILLER: Yeah. I just want to reiterate that I really do like and it's music to my ears the incentives for PCP enrollment. That type of -- piloting that type of approach. But I guess what I'm having a hard time kind of sussing out here is the basic ideas when we do that stuff, the primary focus is better health outcomes. But it just also happens to be something that will generate savings, that predominantly fall to the employer just because of kind of the split of things.

And I'm trying to sort out with the PERS Select that's being proposed, the increases to the deductibles as juxtapose to the incentives to reduce those deductibles.

It almost seems like we're kind of hedging here. If we really believe that those incentives to enroll and that will generate cost savings, why would we need to increase those deductibles? What portion of that would relate to that versus trying to drive premiums down?

I'm just not seeing how the moving pieces relate from a -- you know, what our financial expectations of those changes will be. It seems a little like we're raising the price so that we can have a sale.

DR. CLAPPER: Those are important questions. I think the idea is how do we define something that is market leading? And I think there's been a confusion about the savings. The savings would be in reduced premium. So, yes, there's a savings for employers, but theirs would be a monthly savings for the employee that signed up for it.

So kind of to tie into the sales, you know, the membership report that was the agenda item before us, as you look at different employer groups throughout the State who are looking for this more high deductible plan, this starts to give you something that would be in that area, but at the same time protecting the member, giving them

choice, giving them so they can earn it back, so it starts to give the kind of a new model that is maintaining things, but engaging the member and the physician.

COMMITTEE MEMBER MILLER: So I guess in those terms, in terms of this new PERS Select proposal would what that will be.

And we know that some folks who elect that plan will benefit fully from those incentives, others won't. So do we know of that premium reduction, what part of that will we attribute can associate with the incentives, and what part of it can we attribute to going to a much higher deductible, and how much of that is known? I mean, I would think we know pretty much to the penny what the contribution to that premium reduction of going to high deductibles will be just depending on participation. But I don't know that we know at all what, if any, contribution come for those incentives. We have faith. We believe. And I think it's a good thing.

But it seems like we're kind of saying, oh, let's also raise the deductibles. I'm just not sure I understand that if they were two independent decisions, would we make them both on a financial basis?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Well, I like the idea that Liana and actually Priya acknowledged that the VBID is separate and apart.

The decision making on the VBID is really separate and; apart from anything related to Care and Choice. So I'd like to go back to the VBID.

COMMITTEE MEMBER MILLER: I'm talking strictly about --

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: The VBID.

COMMITTEE MEMBER MILLER: -- PERS Select.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yes.

COMMITTEE MEMBER MILLER: The new PERS Select.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: So we do -- we have run numbers in terms of this benefit design -- this VBID benefit design package, because there are -- there are costs associated with lowering the deductible to $10. That has a tendency to raise premiums. There are costs associated with other aspects of this package, in terms of keeping the -- you know, using the incentives to keep a member, not only make them healthier, but keep them where they are.

So we do -- have run the numbers on these packages, and we can come back and show you next month where some of those details are in terms of the VBID.

So did that answer your question?

I mean, can I. --

COMMITTEE MEMBER MILLER: Yeah, because I guess I'd like to know what would the impact on the premiums be of just doing the incentives without increasing the deductible and kind of vice versa?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: We could -- we can -- we can run those numbers.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: And just as a reminder, we -- the goal is if we did vote in March to approve this, the rate development process and the premiums go from February to April. So negotiating premiums is a several-month process with the carrier during negotiations.

So I think some of them are projections, but typically the PPOs have done fairly well compared to some of the HMOs historically in premiums, but I don't think we could actually come back with a premium projection next month. We could -- we want to make sure that the rate development process is proceeding its ownself.

But what we can do is come back and give you the math on how we projected the overall savings to the system, and then maybe equate that on what that means to a member. Is that fair? I just want to make sure --

COMMITTEE MEMBER MILLER: Yeah, that's very helpful.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: -- I

clear that up.

Okay.

CHAIRPERSON FECKNER: Thank you.

Mr. Lofaso.

ACTING COMMITTEE MEMBER LOFASO: Thank you, Mr. Chair. Just as a quick follow-up, do we have any experience of whether we've offered any of these programs on a purely voluntary basis, and whether they've moved the needle. And I guess one other thing I'm not clear on is do some of those programs actually require the tutelage of a primary case physician to work?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: As an architect designing this for several years now, or two years, what I would really like to see happen is that members who enroll in this Valude-Based Insurance Design in January after they've enrolled, they do all the things they need to do to meet those five incentives. That would be so much easier to administer.

If everyone was incented to just, you know, go in, press the button that you're a non-smoker or tell the doc you're a non-smoker and have the doc or the health plan, press the button.

To me, the incentives -- the engagement piece is really if they select this plan have it -- do it -- do it all at once, so you already know early on in the year that

you've got those five deductible incentives.

So it is going to take some engagement by CalPERS and by the providers, and through a good communication campaign to let our members know if they do this, they don't have to wait to see am I going to have a surgery this year?

They can just go in and certify. And terms of having met the incentive pieces, and it is available for families as well.

DR. CLAPPER: I think when -- just to -- as a follow-up comment. For the programs like Condition Care, and Future Moms, we do -- we do have results that show that they're impactful, but the participation, you know, particularly in Future Moms, tends to be lower. And we have data that shows that when an employer provides an incentive to participate, it does go up in the ROI increases, right? Because people -- but it's hard to say like I'm going to give you a car seat, when you're acting as a trust with multiple employers. And so that's why the idea is to waive the -- if you participate, then you would have your co-insurance waived to try to have incentive for someone to participate in the program.

ACTING COMMITTEE MEMBER LOFASO: Thank you.

CHAIRPERSON FECKNER: Okay. Seeing no other requests to speak from the dais, we have three requests

from the audience. Al Darby, Tim Behrens, and Stephanie Hueg.

Please come forward. The microphones will be turned on for you, state your name and affiliation for the record, and you'll have up to three minutes for your comments.

MR. BEHRENS: Thank you, Mr. Chair. And congratulations on your new status --

CHAIRPERSON FECKNER: Thank you.

MR. BEHRENS: -- and your co-chair.

I'm Tim Behrens, president of the California State Retirees. We've reviewed the reviews proposed increase in costs for Anthem basic plan members -- that's combo families and pre-Medicare -- as part of the VBID strategy for 2018. Although the increases in deductibles and other member out-of-pocket costs have been reduced from the initially propose dramatic increases, we believe in light of new information, no shift in cost burden to member is warranted at this time.

The latest proposal would still increase PERSCare deductibles by 50 percent, and PERS Select by 100 percent, which disproportionately affects members in 18 rural counties and other locations where Anthem PPOs are the only health plan left available to members.

In some cases, the newly proposed $1,500 and

$2,000 per family may prevent some from following through with their needed care. And I think a couple of the members of this Committee asked really the right question. And maybe we'll get a better answer than the one I'm about to give you. But it seems to me like if these proposed increases occur, an average retired stakeholder will be paying out of pocket at least one month of their retirement pay for the deductibles.

So now I'm going to be living on 11 months retirement instead of 12 months retirement based on my information on this proposal.

Some other things that I think need to be brought to your attention. Since this proposal was introduced, the health insurance tax landscape has dramatically changed. With passage and signing of the Tax Reform Act, major corporations' federal taxes have been reduced from 35 percent to 21 percent, which means now they're going to make a profit of at least 15 percent. Each company will decide what they're going to do with these profits. But some of the percentage should surely go to reduce premiums and not just to the shareholders.

It's important to note the tax breaks and profit increases to insurers will take place in 2018, thus affecting 2018 rates. Anthem has already adjusted for ACA markets which were not as profitable to them by pulling

out. So we fully expect CalPERS to have good leverage to have reductions in premiums without having to resort to charging members more to obtain their health care.

We do support the health incentives for rebates in the VBID proposal and support efforts to control health care costs. We just think that you should leave our already high deductibles for basic plans alone. And I'm out of time or I'd tell you some more stuff.

(Laughter.)

CHAIRPERSON FECKNER: Thank you.

MS. HUEG: Hi. I'm Stephanie Hueg, California State Retirees.

I shared with the Board, I hope you got copies, of Larry Woodson's statement, which reiterates a little bit of what Tim was talking about, the profit margins that have increased greatly with Anthem and United Healthcare.

This presentation today is different than the presentation that we received at stakeholders the other day. The biggest difference that I noticed was to get the incentives, we have to call Anthem and say, yeah, not a smoker. Yeah, I did a second opinion. You don't do that with your doctor.

We suggested that they go do that with their doctor on their thirst doctor visit of the year, whichever -- whenever that may occur.

So this is a little bit different. The premiums, they're talking about PERS Select. Yet, all of sudden, the PERSCare premium goes up or deductibles go up. So they mix the apples and the oranges. So that leads to the comment I heard I believe from Mr. Slaton, that they're leading us to go to PERS Select, rather than just dealing with the rural communities. This also does not increase the number of physicians available in -- or our facilities in rural communities.

So we're having -- already have issues with patients not having availability of doctors. Now, we're saying, well, not only do you -- you have to go pick a primary care doctor. It doesn't exist. So how are they going to do that?

It's -- there's no mechanism for it. PPOs already ask you to find a primary care doctor, so this is really not different. It just costs more. And for a retiree, I heard Mr. Jones say, you know, you might be living on 3,000. Well, guess what, look at 2,000. A lot of retirees live on less than 2,000

So this to me is not a very good idea.

Thank you.

CHAIRPERSON FECKNER: Thank you.

MR. DARBY: Al Darby, Vice President, Retired Public Employees Association.

I echo the remarks of the other speakers. And there are potential administrative issues related to this VBID program. Disputes over whether the -- all of the five requirements have been satisfied or not will be an issue. Most patients are pretty passive about getting things done that have to be done. And then they struggle at the end of the year to get it done. When they do it, then they'll be in the situation of trying to get copays refunded, deductibles refunded, and other costs that they may be entitled to, that they did not receive by not having all of the requirements recorded.

Medically unnecessary doctor visits may be required to solve these administrative problems. Patient care issues are complicated by whether you have an enrolled physician in this program. There may be none in the area that you're in.

Passive verification of the five requirements could lead to deception and inaccuracy in the wellness program results. Initially, there was a program reduction to members in premium. That seems to be lost in this whole process, a significant decrease in premium.

There are elements of education to VBID that must be produced by either CalPERS or Anthem, otherwise members are going to be uninformed on what the requirements are to meet the VBID requirements, and get the full benefit of

the discounts that come from that.

And then the question is how proactive will the doctor or the insurance company be in member compliance. Members are often apathetic and passive in completing these requirements.

Thank you.

CHAIRPERSON FECKNER: Thank you.

Does staff want to respond to any of the comments made there, please?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: I'd like to start. So Stephanie was -- one of her -- the things that she said during stakeholders, she basically buys in to keep it simple. And so one of the things that we wanted to make sure is when we look at the incentive is, is trying to keep it simple.

Specifically, related to when you go see your doctor, if you do not have a chronic condition, and you have no surgery, that is automatically a credit given to the deductible. The one thing that the member does have to do is they have to either call and/or they have to go online. And they simply click a button saying that they are non -- a non-smoker. Anthem stated at the stakeholder meeting that they do not validate that. It's on -- you know, on your own accord that you're doing -- that you are a non-smoker.

And then for the others, there is some interaction obviously for your physician, but I think it's a combination. And a part of this is if it moves forward, it's really about communicating, so that people know how to get the incentives to offset that, and it's as simple as possible. We don't want our member having to go to doctors' appointments and paying copays when they don't have to.

So we believe it's fairly simple. There will be a lot of things that Anthem does automatically. Like I said, if you have no surgery that year, they automatically credit that. You automatically get that. There is no interaction on the member on that part.

So we apologize if they felt like that we gave one piece of information at the stakeholder meeting and one here, but we -- we were trying to clarify that there is -- there is some confusion still about incentives, and we need to provide a much clearer roadmap on how to get each of those to maybe basically offset the deductibles, so the deductible ends up being the same amount that they're paying today.

CHAIRPERSON FECKNER: Thank you.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I have just one more point to add to Liana's comments. And, yes, we did hear the -- we did hear what

the stakeholders were telling us about how do you keep it simple in terms of getting your five incentives?

On page four of five of this agenda item, there is a table that we prepared. And we just didn't speak to it. And so apologies if we didn't convey that there are ways that these don't involve the member, for example, with the biometric screening. Once they go to the lab or once the kit is sent in and it's analyzed, that then becomes part of the record for the doctor.

And if you look at this chart, the member action says annual biometric screening at the doctor's office, the lab, or in the home with a kit. And then automatically through the claims adjudication system, it is processed. And then the results made available to the primary care doctor.

For the flu shot, for example, if they can't take the flu shot -- if they do -- first of all, if they do take the flu shot again, that goes through the claims system, so it's automatically recorded. If they do not, all they have to do is call the health plan and say I can't take it, or tell the doctor that -- to notify the health plan that they can't take the flu shot.

Smoking cessation, that does require -- and actually it's interesting how when you talk about going on the computer and clicking the button certifying yourself

as a non-smoker. In talking to others about this, they say, well, if I saved $100, and if it's my dad who's having trouble, I'll just do it for him, and you know, walk him through it.

And so that's you can either do it quick with a press of the button on the computer or through the physician or the health plan.

Second opinion. Again, because these are elective surgeries, they're often pre-certified, in terms of scheduling through the PPO. And if you're pre-certified as an elective -- for an elective surgery, you have the opportunity to obtain a second opinion.

And that's actually, even without this, we have the Welvie product. We encourage members to look at alternatives to care through the Welvie product. And we actually have members not have surgery in terms of what they've -- they discovered on their own, what the benefits and risks are associated with having surgery or not surgery.

Again, if there is surgery, it's done through the claims system. And the claims system will look for that second opinion through coding.

And then the Condition Care management, I think Dr. Laura explained that to you. They outreached to you. They ask you to engage. It's either through letter -- I

believe it's through letter. If you engage, then again it's an automatic process.

So apologies to the retirees, if we did not point this out. We did hear them and we did put this table in. We just didn't speak to it.

CHAIRPERSON FECKNER: All right. Thank you.

Ms. Mathur.

COMMITTEE MEMBER MATHUR: Thank you. Stephanie raised I think an important point, and that is the availability of primary care physicians. And have we Done an assessment of the adequacy of the availability in the region throughout the network?

DR. CLAPPER: We did. And I -- and we feel that there is adequacy. In fact, there's multiple types of physicians that can be selected as a PCP. And, I mean, I -- we can't solve the issue through plan design on if you live in a county that has limited primary care doctors, but there's no -- if they're in PERS Select, they still would be in this VBID plan design.

It doesn't limit any primary care doctor that's -- you know, it's the same -- the Select network is staying the same. So there's no -- the only thing that it does is actually if you select one, they know that you selected them, and you would be able to pay a lower copayment, but it doesn't remove any primary care doctors

from the current Select network.

COMMITTEE MEMBER MATHUR: So we looked both at how many primary care doctors there are, and also whether they have availability in their --

DR. CLAPPER: It's hard to look at availability, right?

COMMITTEE MEMBER MATHUR: Yeah.

DR. CLAPPER: -- because you could decide that as a primary care doctor and PPO, not HMO, that you're going to work four days a week, or you could get a health problem yourself, or different things like that. So availability does change by the, you know, physician's situation.

COMMITTEE MEMBER MATHUR: Sure.

DR. CLAPPER: But we had -- we looked at open panels, and we looked at availability. It's interesting, because in HMO you know you have a much -- you know, you have that connection in you. You know more about availability than in PPO. And I think that's what we're starting to be able to -- once you know how many members someone has, then you can start looking at panel size and things like that.

But we don't have that data when people are not selecting --

COMMITTEE MEMBER MATHUR: Right.

DR. CLAPPER: -- a PCP. So this I think that if you approve this, this will actually help us start to get the kind of data to understand about PCP panel size in rural areas, and, you know, be able to maybe do something about -- you know, or talk about that.

COMMITTEE MEMBER MATHUR: Okay.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I would like to point out on page -- the footnote on page three of five in the agenda item. And that is primary care, a lot of folks think that it's a family practitioner, a general practitioner. But there's actually eight specialties that can serve as primary care, rheumatology, pulmonology, internal medicine, OB/GYN, pediatrics, et cetera.

So we are though -- to your point, Ms. Mathur, we're looking at the rural areas, not just what the physicians are, but what is the composition of the physicians. And we also think that perhaps -- that's why outreach to the physicians about this is important as well to address making sure that maybe there's a physician not taking new patients, but maybe this would encourage them to take new patients, because they're going to get a member who's engaged, who will do these things, and actually, you know -- it would be more of a partnership than not, as it might be today.

COMMITTEE MEMBER MATHUR: Okay. Thank you.

DR. CLAPPER: I was just going to say one more thing when we think about it, we've actually been putting a lot of thought into educating the providers to Kathy's point around population health, and quality metrics, and things like that, and looking at how do we do combined panels, how do we have WebExes to talk to them about these kind of quality metrics, and how to improve the workflow at your practices to help people make sure they get the flu shot, and talk to them about things like that.

So I think it's -- there's a lot of opportunities about how do we both support the providers and the members in rural counties.

CHAIRPERSON FECKNER: Ms. Taylor.

VICE CHAIRPERSON TAYLOR: Yes. Thank you. I just wanted to go on one of Stephanie's point as well. She said that in these PPOs, generally speaking, you have to have a primary care physician. Is that the case? Am I. --

DR. CLAPPER: No, in PPO, you can choose to go to see a doctor or go and see a specialist. There's -- you don't select the PPO. That's one of the differences that now you would select a primary care physician.

VICE CHAIRPERSON TAYLOR: So -- okay. So --

DR. CLAPPER: That currently doesn't exist now.

VICE CHAIRPERSON TAYLOR: It does not exist. So there's -- okay.

DR. CLAPPER: And I guess I should clarify that. In -- in our -- I think there's a way in EP -- in the ACO where you could call and say this is my doctor, but it's not really a set. But it's not part of plan benefit design. So I think this is --

VICE CHAIRPERSON TAYLOR: Right.

DR. CLAPPER: You could let us know, like I usually see Dr. Smith or we can see in the -- in our claims system that you usually see Dr. Smith, but it -- there -- it's not some -- it's not as part of the benefit design, right? This is different because --

VICE CHAIRPERSON TAYLOR: Right, but there -- what I'm understanding is that she's required -- wherever she goes, she's required to have a primary care physician. So whether or not it's part of the benefit design just mean -- I don't know why --

DR. CLAPPER: Yeah. And PPO, Mrs. Taylor, the -- you're not required to select a PCP currently in PPO.

VICE CHAIRPERSON TAYLOR: Okay. And then I wanted to address the cost shift. I know we're raising it from -- I keep forgetting which one is which, from PERS Choice and PERS Select by 500 -- yeah, by $500 and $1,000. And then you get your incentives.

I believe it was Mr. Behrens that brought up the fact that may -- is it -- and I think even Mr. Miller brought it up. Is it possible actuarially, and that's maybe where we need to explain this better. Is it possible actuarially to start at $500 and $1,000, and then give the credit? Because it does appear initially that it's -- it is a cost shift to our members, and would be most hurtful to our lower paid employees or our retirees who are on a fixed income.

So I don't know. I know that this has changed. I know that it was much higher than it was originally, or it was much higher than it is now.

So I'm wondering is that an option, or because of all of these incentive co-pay reductions, is that not actuarially possible, and can we kind of explain that at our next meeting, and why that wouldn't work?

And then additionally, I think it was brought up in both the letter and in Mr. Behrens' statement, I don't believe -- I don't believe the tax cut that these insurance -- doesn't really have anything to do with our insurance -- you know, the risk pool, et cetera, that doesn't have anything to do with that.

But what I do -- what does concern me is on many occasions, as someone who has -- I've said this before -- has had an HMO all my life -- all my adult life, it

doesn't seem to contain the costs like we say it will. So if we don't see that $46 million reduction or even if we do see a $46 million reduction, and we don't see a reduction to our members, as well as the employers, then I'm not sure that this is worth putting a cost shift onto our employees.

And, of course, we won't know that until we institute it, but that's where my concern lies is because, you know, for -- on many occasions, we've, you know, thought that these HMOs as we do this or we do that, it should bring our costs down, and it doesn't seem to do that. We always have a cost increase.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: What we can do is come back in March and model the financial aspects to this proposal in terms of whether you would -- in terms of using, for example, the -- if we're in the 2018 premium, those are known. We can take a known premium and model it and show you some of the things you're asking for.

VICE CHAIRPERSON TAYLOR: That would be great.

DR. CLAPPER: That's what I was thinking.

VICE CHAIRPERSON TAYLOR: All right. Thank you.

CHAIRPERSON FECKNER: All right. Seeing no other requests. Thank you. I think you heard quite a bit of questions and concerns today, and stuff to bring back for

the future. Anything else, Ms. Bailey-Crimmins?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Not on this agenda item.

CHAIRPERSON FECKNER: All right. Thank you.

That brings us to Agenda Item 9, OptumRx Program Administration. Ms. Bailey-Crimmins.

(Thereupon an overhead presentation was presented as follows.)

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Good morning or it might be good afternoon by now.

(Laughter.)

CHAIRPERSON FECKNER: Almost.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Liana Bailey-Crimmins, CalPERS team member.

Believe it or not, January marked the one-year anniversary that we migrated to our new pharmacy benefit manager OptumRx. And over the past 12 months, Optum has worked hard to overcome challenges. And you will see through today's report that there has been significant progress.

But there's a quote that says, "Progress means getting nearer to the place you want to be". And the data will show progress, but I also want to put a disclaimer that OptumRx still has room for improvement. And CalPERS' team members meet at least weekly to address any member

concerns.

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CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So today's information item highlights progress in four areas, which we actually covered in November. The first was customer service, because the member is at the heart of everything that we do.

The second is prior authorizations. We wanted to look at system and process improvements. There was a significant spike and so we wanted to make sure we looked at that. I will be providing an update in that area.

The Medicare formulary. The retirees had asked for us to compare the 2016 CVS Caremark formulary against the current 2018 OptumRx formulary and do a comparison, because their -- their question was can we go back to the CVS formulary, so we will provide you and update today.

And then lastly is on technology. Technology gee is the face of an organization. And when OptumRx systems fail, our members can't log on to the web portal to do refills, see what's going on with their mail orders. And so there have been improvements made on the technology. Not on just availability, but also there's been enhancements into the system that I'd like to cover with you today as well.

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CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So for customer service, we are pleased to report as of January of 2018 that the CalPERS customer service satisfaction rating, specifically for the OptumRx call center is 94 percent. They collect this by doing post-surveys with all the members that call. And we are currently in the 90 percentile which is good. Always still can get better.

And then one metric we pay close attention to is the call transfer rates. And the reason this is -- it basically measures how often our members get the information on the first point of contact, and -- versus having to be escalated to a leader or supervisor.

And so over the past seven months, we have seen CalPERS call transfer rate go from 10 percent to two and a half percent, which means our members are more likely to get their answer the first time around, which is extremely important.

We also want our members to get the right answer the first time. And so we had asked, and Optum delivered an adopt-a-member advocacy program. So if one of our members calls multiple times about this same concern that has not been addressed, Optum will automatically escalate that call to an advocate who will research and actually resolve this, because the last thing we want is multiple members calling multiple times. So that's been improved.

And then I also wan to thank the retiree association, because -- because of their request and then ultimately our fulfillment, now Optum has a dedicated team that specializes in Medicare. Anybody who's ever dealt with Medicare there's a lot of intricacies with Medicare.

And so if a Medicare member basically self-identifies, says I, you known am a Medicare member, they basically transfer straight to that team. Someone understands those nuances and also understands the CalPERS EGWP program. So I think that's extremely important.

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CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: And prior authorizations. Prior authorizations are not inherently bad. I think sometimes we think they are, but they are usually clinically driven. If there's a narcotic, an opioid, they must be cleared through a prior authorization. Also, it can be benefit design required.

But a few months back, again our stakeholders spoke and we listened, and we looked at the data, and we saw a significant spike in prior authorizations, and also a high overturn rate. And why the high overturn rate was something we were paying attention to, as a prior authorization comes into the system, it's appealed, and if that appeal is overturned, then basically it tells me that the member potentially went through a bunch of extra steps

and hoops that they shouldn't have had to go through.

So we researched and found three areas that were causing this huge spike. One is CMS requires a 72-hour -- they have a 72-hour denial requirement. So basically, if a Medicare member was putting in their prior authorizations on Thursday or Friday, because the clock -- because CMS actually uses the calendar week, not the business week, the clock is still ticking on Saturday and Sunday, even though no one is there processing it. Then Monday morning there's an automatic denial, and now someone -- a member has to go through an appeal process.

So we -- because we've been working with the stakeholders getting communication out, a lot of our retirees are now focusing on getting their prior auths in either Monday, Tuesday, or Wednesday, so we meet the 72-hour window. So you'll see that the denial rates have really gone down.

The other was lack of information. There was a lot of denials because the prescribers weren't -- which the member doesn't know that, but the prescriber was submitting basically incomplete prescriptions. And so we've done quite a bit into improving that.

And then also, EGWP improvements. We talked about this early on, when you're on Medicare or your 85 years old and you've been on the same medication for 20

years, unless CMS is requiring it, why are we messing with it?

So we have put a lot in place in that area as well. So improvements made has been proactive. So 30 days prior to a prior authorization expiring, Optum actually is proactive and reaches out to the prescriber, and tries to extend that and without any member interaction.

And I have to say that at this point, the data shows 98 percent of the prior authorizations are being renewed without any member action, which is positive.

Also, because we have this system and we're reaching out to prescribers, the lack of information denials have gone down significantly, because now they're -- they're having this dialogue that necessarily they weren't having before.

Call agents now have a prior authorization decision tree. We want to make sure that our members are getting consistent and accurate information, and so they now have that available.

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CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So over the past year, prior authorizations -- I know our focus has been on EGWP and Medicare, but we wanted to show our actives as well. So basic approval rates have increased

from 53 percent to 77, and for EGWP approval rates have gone from 45 percent to 84. So for Medicare prior authorizations, we have also directed OptumRx to use only the CMS guidelines. So this means basically streamline the require -- the process requirements. And unless CMS requires it, it should be approved.

Now, I will do a disclaimer. That does not mean that prior authorizations won't occur, but it just means that it is going to be CMS directed.

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CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So for the formulary improvements, there have been significant changes. For example, the was a whole list I think that went out to our retiree stakeholder groups and to you as well, but I just want to give a quick little snippet of some of the formulary improvements.

For HIV and transplant medications, they were removed from specialty pharmacy and added to the maintenance and medication, and are available at any network pharmacy, which is obviously increasing the convenience for our members. All tier 2 and 3 generic drugs were now down-tiered to tier 1, which means it's costing our members less.

And then for drugs excluded from a formulary, this is where you're kind of reaching on more of new

medications that just haven't been added, members can now request a medical necessary review of the benefit, which now allows us to see if we want to add that to the formulary.

So when CalPERS compared OptumRx's Medicare formulary against the CVS Caremark, we found 2,000 differences. Sixty-three percent of those differences were positive. Optum has 581 more drugs than CVS Caremark. And 395 of those are a lower cost. So we -- I still have to look at what the difference between the other ones for the lower cost.

And then the other area for improvement is 30 percent of the changes showed that CVS Caremark actually had more drugs with less restrictions. So this is an area we will be working on again trying to make it easier for our members. So there's still work to be done on the formulary.

CalPERS is projected to save both members monthly premium cost and save the overall system $63 million in the first year of the contract. In 2017, CalPERS actually saved $68 million. And for OptumRx, specifically for our members, PPO Medicare members save $50.58 on their monthly premiums by going to OptumRx. PPO basic members saved $14.31 on their monthly premiums by going to Optum.

Now, HMO spent $1.23 more, but what we were

seeing in the CVS Caremark trend, it was actually even going up higher. And so we actually somewhat plateaued it. So that was obviously a very positive outcome.

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CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: And then technology. We know technology directly affects our customer service. And so there was a large outage Optum had in September 2017. And they have done quite a few steps in bringing that uptime, so that our -- when our customers log in, that they -- it can be reliable.

And then in addition to reliability, over the past several months, they've done three things. Now, they have real-time monitoring, so if a call is getting to 15 minutes, it's automatically flagged, and a supervisor is then working with the agent to see if they need to interact or to intervene to make sure that that resolution occurs, and that happens in a timely manner.

Also, we have real-time chat for prior authorizations, so that there is real-time inquiries and updates, which is very helpful, if everyone -- anybody has ever used a chat feature.

And as a January 1st, Optum implemented a virtual hold. Time means a lot to a lot of folks. And so where a member wants to have an option of basically leaving their information and having an agent call them back, that is

now available.

So in conclusion, CalPERS continues to work with OptumRx to identify changes that will improve member experience. And the CalPERS health plan member survey went out and as a reminder, it includes questions about satisfaction of our pharmacy benefits. So once we receive the 2017 results, CalPERS team members will be comparing that against the 2016, which we had CVS Caremark, and we will be bringing those results back to you. The goal is to provide the PHBC another update in June.

Thank you, Mr. Chair. This concludes my presentation, and I'd be happy to answer any questions.

CHAIRPERSON FECKNER: Thank you. Thanks for the presentation.

Mr. Miller.

COMMITTEE MEMBER MILLER: Just a question. You know, early on, prior to my time on the Board, there seemed to be real outcry of about customer service from OptumRx. And I see steps are being taken and looks like things are improving, but what's being done in terms of service recovery for all those folks who were so unhappy early on, who may have just kind of disengaged with us at some point?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: I will check with Optum on that. But I do know, at least at this

point, normally when you're dealing with medication, it's not just a one-time. It's an ongoing relationship with a PBM, and we are at 94 percent, but I can see if they've gone out and proactively looked at anybody that was unhappy and gave them an unsatisfactory rating, and what they're doing to improve that.

COMMITTEE MEMBER MILLER: Thank you.

CHAIRPERSON FECKNER: Thank you.

Seeing no other requests.

I have two requests for the James Anderson and Donna Snodgrass. Please come forward, state your name for the record and you affiliation and you'll have up to three minutes for your presentation.

MS. SNODGRASS: Thank you, Mr. Chair. I want to request more than three minutes, please, so that I can read excerpts from the package that you have in front of you.

CHAIRPERSON FECKNER: Well, we already have the package in front of us.

MS. SNODGRASS: Yes.

CHAIRPERSON FECKNER: So let's not take too long. We're very late today.

MS. SNODGRASS: Okay. Donna Snodgrass, Director of Health Benefits for Retired Public Employees Association. Because of the continuing and unresolved

issues of our members' experience with OptumRx, the board of directors of the Retired Public Employees Association of California unanimously supported a vote of no confidence in OptumRx and this PBM contract.

For over a year, we have had meetings, discussions, promises, and were made for improvement, and we now have no hope that the improvements will be made. To continue to handle each situation as it arises is no longer an acceptable response. The RPEA members who have asked for assistance are not all covered by CalPERS medical plan. This indicates that the problems are not unique to CalPERS contracting agencies.

OptumRx has a system-wide problem of properly servicing their clients, not just CalPERS. RPEA is publicly requesting that CalPERS begin the steps to end the Optum contract and provide a PBM that has the experience and the will to service the members who rely on their primary benefits.

A member from Gig Harbor Washington writes to us and says, "During the course of several phone calls to the Optum call center, I had a conversation with a very nice representative. During the call, the rep apologized to him for the inconvenience and time it had taken to resolve an issue that he had. He was told, 'It's not you'. It's us. Optum has taken on more than we can handle. We are

spread too thin. We have taken on Kayak as a client, and personnel have been diverted to the Kayak account".

A member from Redding, California. In December, it escalated extremely. "A new prescription was written for her husband who has dementia. And Optum refused to fill it because they had no record of the -- this is emotional for me. Sorry -- no record of the durable power of attorney that was required for her to take care of him, and he was in a care facility. The representative of the care facility, his primary physician, and herself had several conversations to no resolve. They insisted they did not have the power of attorney and it had been sent a month and a half earlier. She says I find this service to be very irresponsible, inconsistent, and very confusing".

Sierra Vista, Arizona. A medication, diclofenac sodium, she had been on that medication for years for rheumatoid arthritis. When she received the package from Optum, with the abridged formulary list, that medication had been removed from tier 1 to tier 3. With a phone call to Optum, they said we don't know why it was moved. A super called back a couple days later and said that because CMS was moving diclofenac sodium -- excuse me, potassium. I'm getting them backwards -- that the sodium was just put into tier 3 to match CMS. And I'd like to point out, and the abridged is in there, to show you in

tier 3, but in the other two lists for the formularies, that drug is in tier 1. They did offer to send her a partial waiver of premium, which would have taken it to $70 instead of $10.

Scotts Valley, California. This member still is waiting for a prescription to be approved. It was actually denied because it took place over the Christmas Holidays. He was on a mega antibiotic because of an infection due to a massive hematoma that occurred. The doctor could not reach Optum for the prior authorization. Long story short, they filled it at CVS for $814. On December 29th, they tried again to get approval on January 2nd, and Optum's supervisor told them it was too late, a new year had begun. The process had to be started anew.

I'll finish with that. There's others in the packet. Please read the entire package that I supplied to you.

CHAIRPERSON FECKNER: Thank you.

MR. ANDERSON: Mr. President, members of the Board, I'm James Anderson. I'm the Legislative Director of RPEA, the Retired Public Employees Association.

I'm asked to add some things that Ms. Snodgrass covered, because we had a new issue that came in by fax yesterday. Apparently, Optum has disenrolled one of our members from Medicare Part D. They sent a letter last

year asking for detailed information about their address. Why a cold call, a cold letter to a member asking for an address change, when the member is a member of CalPERS. They have the addresses, and things work out. I've made changes to my address. CalPERS warrant didn't come because CalPERS had made an error in the address. When the warrant doesn't show up, you get very interested.

This member didn't respond to the letter, because it was a potential scam. I got a cold call phone call from Optum asking for detailed information, my Social Security. I hung up on them.

I was told Optum does not make cold calls. Eventually, this thing progressed over the last year, and in December, Optum, on their own effort, canceled Part D. The member cannot get their prescriptions.

There is penalties for not having Part D under Medicare. It seemed like if that was going to be disenrolled, it would be up to CalPERS to disenroll them, not Optum on their own initiative. So we haven't investigated this in detail, because it just came in yesterday. But we will investigate it. We hope someone from CalPERS can assist us with this and get these people back on their proper medication.

CHAIRPERSON FECKNER: Please share that information with our staff and we'll make it gets taken

care of.

MR. ANDERSON: Yes, we will.

CHAIRPERSON FECKNER: Thank you.

All right. Ms. Bailey-Crimmins, anything in response?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS:

Obviously, we would love to investigate. One is they shouldn't make cold calling. Two is Optum does not have the authority to disenroll one of our members from Part D, so we will get to the bottom of that.

And as for the Donna Snodgrass's comments, we take -- any time an escalation that it is sent to us, we take it with the utmost -- you know, it's the highest priority. We get right on it. We look at phone calls. We look at the data. We make sure that the member is taken care of. I don't -- I don't believe I have personally access to all that information, but I think Donna has recently shared it with Dr. Sun, so I will be looking at that personally and getting to the bottom of what is going on with those specific members.

CHAIRPERSON FECKNER: Great. Thank you.

Seeing nothing else on this item.

Item 10, Pharmacy Pricing Strategies. Ms. Donneson.

(Thereupon an overhead presentation was

presented as follows.)

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Good afternoon, Mr. Chair and members of the Committee.

Last month at the off-site, we had a panel present pharmacy strategies, and we talked about the complexity of managing pharmacy programs. This item brings forward some of the things that we have started working on and will be working on throughout the next year, in addition to providing some future strategies that we want you to think about.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: So moving on. The 2018 and '19 pricing strategies that we are considering, and we want to bring forward to you. Some we have already begun, and some we're thinking about.

I want to talk about the California Pharmaceutical Collaborative. This is a collaborative of multiple State agencies working together to explore direct purchasing from the manufacturer certain specific and high cost drugs, such as hepatitis C.

And the Collaborative includes both general services, our sister agency Covered California, it includes Department of Public Health, Department of Health

Care Services, the California Veterans Association, and Department of Corrections.

So collectively, we represent a significant number of not just State employees but Californians. And so that is one of the things that we started working on this last year and will carry forward.

We have a pilot that we're getting ready to launch, in terms of academic detailing. And that is where pharmacists go out to our provider groups to educate physicians about the formulary, and which many of the physicians do not understand what the financial burden is to their patients.

So we have been trying to do something in academic detailing since Dr. George Diehr was on this panel, and we finally have the opportunity to launch a pilot.

We're also looking at a potential pilot for reference-based contracting with select drugs. This is a concept that's coming forward in the industry that you work with the manufacturers -- or through the PBM you work with the manufacturers to identify a drug. And if the manufacturer is willing to value-base contract, if the drug doesn't work, you're actually paid back. So that's one of the items that we're looking at.

In terms of adding numerical tiers, we have

currently generic, preferred brand, and non-preferred brand. It's easier systematically to go to a numbering system, but all that means is instead of using a descriptor, you're using a number. So when you hear tier 1, tier 2, tier 3, that's the design that we've been working with for at least two decades.

We also want to look at reference-based price approach by therapeutic class. There are 70 therapeutic classes. Just as we would not take on every reference price for a medical procedures, we don't wish to take on 70 therapeutic classes. But we do, as we did with hips and niece, and arthroscopies, and colonoscopies and all the things we did reference price, we want to be thoughtful in terms of exploring the opportunity to reference price by therapeutic class. It's similar to a member pays the difference, except that it looks across the class, and it looks based on evidence, recommended pharmaceuticals within that class. So that's another opportunity that we are exploring.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: For 2019, as I described to you in terms of how do you deal with the cost of high priced specialty drugs, the ICER approach was something that we presented in July, which is the Institute for Clinical Economics. And this

little flow chart was presented by James Robinson, in which it looks at a reference pricing approach, as well as a value-based purchasing approach.

We would look at evidence-based value in terms of specialty drugs. And that's something we're just continue -- we'll continue to explore through next year.

And again, many of these activities, if we're working on it in '18, we would try to have it ready to go in '19. If we're working on it '19, we'd try to have it ready to go in 2020. So we're always a year ahead in terms of exploring these options for improved benefit designs.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: In terms of the future, we have -- one of the ideas that's coming out of the industry now relates to carving out the formulary, so that you have a standard formulary. And if it's -- it would be managed by a separate company.

And then -- and then if you do have to change PBMs, the formulary is already -- is already being managed. So that is something that we would look at for 2020 and potential implementation in 2021.

Finally, on page four of five of your agenda item, we still face many of the challenges that the panel

presented in July. And this is just a list that we call continued seeking solutions.

The pharmacy benefits programs are complicated. And it is one -- actually, it's one of the most complicated industries. And that even beats long-term care. It is one of the most complicated industries that I've ever had to work in, and I actually had to learn.

And so anyway, that concludes my presentation, and I'm happy to take questions.

CHAIRPERSON FECKNER: Thank you.

Seeing none.

We will move on to Agenda Item 11, Summary of Committee Direction.

Ms. Bailey-Crimmins.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Mr. Chair, I documented -- this is a very robust conversation that we had today. So I have three and I also have a few operational ones that had come up.

So first is we want to bring back a high deductible low cost research to the committee looking at cost to the system, cost to members, and then making sure that we're looking at that from two lenses, both retirees and actives.

The second was Mr. Jones's related to the sponsoring agencies. And we focus on the pension side,

but once, you know, someone leaves the system, what the impact would be to actives and retirees. So there was a request for us to show some analysis in relation to that. Did I capture that correctly?

COMMITTEE MEMBER JONES: (Nods head.)

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Okay. And then three, a lot of on the VBID. So bring back a VBID. Basically, the savings we want to -- you know, what is the savings, where is it going? A lot of information relating to that. Also, the PERS Select specifically related to the actuary possibilities. So if -- without any deductible increases what that would look like. So really about the alternatives on that.

And that was what I captured. Mr. Chair, was there anything else that I potentially missed?

CHAIRPERSON FECKNER: I think that's good.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Okay.

CHAIRPERSON FECKNER: Thank you.

That brings us to Item 12, Public Comment. Anyone from the public that wishes to address the Board at the Committee at this time?

Seeing none.

Then we are going to adjourn the open session, and we'll go into closed session in five minutes. So we'll start closed session a 12:00 o'clock.

Thank you.

(Thereupon the California Public Employees' Retirement System, Board of Administration, Pension & Health Benefits Committee open session meeting adjourned at 11:55 a.m.)

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

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

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

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

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

IN WITNESS WHEREOF, I have hereunto set my hand this 20th day of February, 2018.

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