MEETING

STATE OF CALIFORNIA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

BOARD OF ADMINISTRATION

PENSION & HEALTH BENEFITS COMMITTEE

OPEN SESSION

ROBERT F. CARLSON AUDITORIUM

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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. Matthew Saha

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

Mr. Charles Asubonten, Chief Financial Officer

Ms. Liana Bailey-Crimmins, Chief Health Director

Mr. Matt Jacobs, General Counsel

Ms. Donna Lum, Deputy Executive Officer

Mr. Brad Pacheco, Deputy Executive Officer

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

STAFF:

Dr. Kathy Donneson, Chief, Health Plan Administration Division

Ms. Jennifer Jimenez, Committee Secretary

Mr. Gary McCollum, Senior Life Actuary

Ms. Karen Páles, Assistant Chief, Health Policy Research Division

Mr. Anthony Suine, Chief, Benefit Services Division

Mr. David Van der Griff, Senior Staff Attorney

ALSO PRESENT:

Mr. Brian Allison, American Federation of State, County and Municipal Employees

Mr. Tim Behrens, California State Retirees

Mr. Neal Johnson, Service Employees International Union, Local 1000

Mr. George Linn, Retired Public Employees Association

Ms. Emma Gere Millis, California State Retirees

Ms. Donna Snodgrass, Retired Public Employees Association

Mr. C.T. Weber

Mr. Larry Woodson, California State Retirees

I N D E X

P R O C E E D I N G S

CHAIRPERSON FECKNER: Good morning, everybody. We'd like to call the Pension and Health Benefits Committee meeting to order. The first order of business would be to call the roll, please.

COMMITTEE SECRETARY JIMENEZ: Rob Feckner?

CHAIRPERSON FECKNER: Good morning.

COMMITTEE SECRETARY JIMENEZ: Theresa Taylor?

VICE CHAIRPERSON TAYLOR: Good morning.

COMMITTEE SECRETARY JIMENEZ: Matthew Saha for John Chiang?

ACTING COMMITTEE MEMBER SAHA: Good morning.

COMMITTEE SECRETARY JIMENEZ: Richard Gillihan?

COMMITTEE MEMBER GILLIHAN: Here.

COMMITTEE SECRETARY JIMENEZ: Henry Jones?

Priya Mathur?

COMMITTEE MEMBER MATHUR: Here. Good morning.

COMMITTEE SECRETARY JIMENEZ: David Miller?

COMMITTEE MEMBER MILLER: Here.

COMMITTEE SECRETARY JIMENEZ: Bill Slaton?

Alan Lofaso for Betty Yee?

ACTING COMMITTEE MEMBER LOFASO: Here.

CHAIRPERSON FECKNER: Thank you. And please note for the record that Ramon Rubalcava and Margaret Brown have joined us at the Committee meeting today, and we

thank you.

That brings us to Agenda Item 2, Executive Reports. Ms. Bailey-Crimmins and Ms. Lum, please.

DEPUTY EXECUTIVE OFFICER LUM: Good morning, Mr. Chair, members of the committee. Donna Lum, CalPERS team member.

This morning, I have three updates to share with you. And first is related to some impacts that we've been experiencing within our customer contact center. In the past few months, members and our business partners calling the contact center may have been impacted by some technical difficulties we've been experiencing, and primarily due to some outages related to our phones.

There was a significant multi-day outage that occurred in December, when our service provider's fiber cable was cut during construction in the downtown area. CalPERS was one of several State agencies that was impacted by this loss of the connectivity of the network.

Since then, we've also experienced four other outages lasting approximately two hours each. And it was identified that there were flaws in our network provider's resiliency and redundancy design. Our Information Technology Services team is working with our existing carrier to redesign the network paths to our facilities to ensure that we have uninterrupted services should our

services fail.

Additionally, we have submitted a work order to a secondary provider to establish redundant services. This will provide carrier diversity and resilience to our contact center connectivity from West Sacramento to Lincoln Plaza. We anticipate that these new diverse circuits will be up by the end of April.

And lastly, as part of our fiscal year budget request, we will be pursuing new technology and new initiatives centered around cloud technology, which will further mitigate impacts to our members and our business partners should we experience any network failures.

It's important to note that our teams do take great provide in the level of service that we provide to our customers. And we recognize that these serve interruptions may have impacted them. And so for that, we'd like to apologize to the customers who did experience any inconvenience to -- related to these outages.

Despite the outages that we had, as soon as the systems were up and available, we moved into what we call an all-hands-on-deck mode. And so while the queues were very large, once the phone lines opened up, we had all available resources answering the phones. And therefore, we were able to immediately come back to meeting our services levels.

So I just wanted to share that with you, in case there was any -- any questions that you may have had, any inquiries from your constituents regarding some of the outages that we experienced.

Secondly, I just wanted to share an update on the proposed regulations that the Committee approved last month to move forward into the regulation process. This was related to defining full-time employment. The package has been completed and signed internally. It was sent over to GovOps last week. We anticipate that GovOps will be signing the package, and it will return for submittal to the OAL next Monday -- or next week.

Assuming that everything stays on schedule, we anticipate that the comment period will run from April 6th through May 21st, depending on whether or not we have a lot of questions, or if a hearing is requested. If not, we expect that the earliest time the package will come back before this Committee for final approve -- adoption will be in August.

And then lastly, as I do every month with my executive update, I just wanted to share an update with you regarding our CalPERS Benefit Education Events.

First, we did have an event that was held in Visalia on March 2nd and March 3rd. We had a total of over 735 attendees join us over the two days, which again

breaks the record that we had in this area previously of a little over 400.

As the case with most of our events, and in fact all of our events, we continue to see that the attendance at each of these events has increased.

In addition to that, our next event will be held March 23rd and 24th in Redding, California. The second update on the CBEEs that I wanted to share is related to the fact that we do have three more events to wrap-up 2018. So we will be in Bakersfield, California, July 13th and 14th. Then La Jolla from August 10th through the 11th. And finishing the year in Irvine at August 24th and 25th.

We are in the final stages of working through contracts and negotiations for the first half of 2019, the calendar year. And as soon as we have those venues secured, and -- we will go ahead and bring the schedule back to you. And for those of the public that's interested in seeing the remainder schedule of our Benefit Education Events, those are listed on the CalPERS online website.

That completes my report, and I'm happy to take any questions.

CHAIRPERSON FECKNER: Thank you.

Ms. Mathur.

COMMITTEE MEMBER MATHUR: Thank you very much, Mr. Chair. You know, issues arise. And what really sets an organization apart is how they respond to problems as they arise. And I am just so impressed by the response that our team had to this phone outage.

Clearly, you, number one, identified what was the key issue behind it. And you've taken steps to address that. But also putting, you know, mitigation efforts in place that drove to quick recovery, I think, is a testament to our team. So I want to thank you, Donna, and your team for your quick response, your effective response.

And then I have a question as well.

DEPUTY EXECUTIVE OFFICER LUM: Certainly.

COMMITTEE MEMBER MATHUR: So we have a risk map and a -- you know, we've been doing a lot of work around risk. Clearly, this was a risk that perhaps wasn't identified in our current risk processes. Is there anything else that you have been thinking about or that maybe -- maybe I would just suggest that we think about are there other things that -- I know it's hard to know what you don't know, but has this triggered any reflection on what we might -- we might add to the risk matrix?

DEPUTY EXECUTIVE OFFICER LUM: Certainly. So in addition to the work that we did on the customer service

side, I also do want to acknowledge that our information technology team was very swift in working with the vendors and identifying what the issues were and coming up with mitigations.

I think one of the things that we're going to see in terms of part of our contingency plan is as you are well aware, we are bringing the contact center back to the Lincoln Plaza campus. And so we do know that we have very strong redundancy and capabilities here that will protect the systems in terms of failure.

In addition to that, what we did experience this was some flaws in the design. And so as I mentioned earlier, the technology team is working with the vendor and relooking at the overall design of the network along with the secondary vendor that we're bringing on board for redundancy.

As far as the risk, we are working with Information Technology. We know that there is an effort underway related to our disaster recovery, business continuity. And so as we proceed through that project, we will be looking at ensuring, for the time being while they are still in West Sacramento and when they come onto the campus, that we have all of the assurances we need for connectivity.

COMMITTEE MEMBER MATHUR: Terrific. Well, let me

add my kudos to the technology team who I know was key to resolving the problems. So thanks very much.

DEPUTY EXECUTIVE OFFICER LUM: You're welcome.

CHAIRPERSON FECKNER: Thank you.

Seeing no other requests.

Ms. Bailey-Crimmins.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Good morning, Mr. Chair and members of the Committee. Liana Bailey-Crimmins CalPERS team member. For my opening remarks I have three items that I'd like to provide you an update on.

The first is on the CalPERS 2018 health benefit open enrollment period. I'll be sharing with you some dates and outreach and communication efforts that are currently underway.

The second is automation improvements that we've made for the CalPERS health benefit plan enrollment forms.

And the third that are changes that are happening at the Centers of Medicare and Medicaid Services, and how those changes affect our members.

So for the first item, open enrollment, planning is underway and consistent with previous years. The CalPERS 2018 open enrollment period will be from September 10th to October 5th. And we want to make sure our members and employers have accurate and timely information, so we

are going to be leveraging numerous communication channels, including customized health plan statements, social media outlets, warrant messages, so putting a nice little statement at the end of a pay stub, various member and employer articles and publications.

And as a reminder, a dedicated open enrollment web page is available at the CalPERS website. This year, which is different than prior years, we are actually going to be calling out significant changes, in addition to including those changes in the evidence of coverage. So we'll make it easier for our members to locate.

And CalPERS is also exploring additional automation opportunities between now and September 10th. And we plan to keep you, the Committee, and the stakeholders apprised of our progress between now and then.

For the second item, I am pleased to report that the CalPERS health benefit enrollment forms are finally online. We've heard feedback from our members and employers. And so for the actives, this form is HBD 12, and for retirees it's HBD 30.

So through surveys and customer feedback that we received, we wanted to make sure that the new forms were user-friendly and improved the member's experience. So they're clean, they're fillable PDF formats that can be

done on the computer and printed out, and it makes the overall process easier.

In addition to automation, what we've also done is consolidated two forms into one. So the active forms used to have 12 and 12A. And so we merged them into a single form for -- now we just have 12.

If you are an employer, the good news is if you have a 12A form that's on file for your employee declining coverage, you do not have to have them resign that. CalPERS will grandfather that form in.

Further improvements are right around the corner, so we are actively pursuing e-signature, so employers will be able to receive these forms electronically and have it e-sig'd on the HBD 12 form. And we expect this to be delivered before open enrollment.

And my last update is for our Medicare members. The Centers for Medicare and Medicaid Services is moving away from Social Security numbers, which a lot of companies are. And what they're going to now be providing is a unique Medicare beneficiary identifier. And this is an effort to improve security. So they'll better protect our members' health information and financial information.

And so new cards are going to be mailed out between April 2018 through April 2019 out from Medicare. California is one of the first states, so I'm assuming

that our members will be receiving these in the next few months.

And it's also important to note that members that are enrolled in the CalPERS Medicare plan do not need to send us their cards. We are working directly with CMS to get that data electronically, and be able to import that automatically into my|CalPERS, which will be an additional advantage to our members.

And we're also assisting CMS to get the word out. So information will be available in the following venues: So the spring 2018 PERSpective there will be an article; the CalPERS online Medicare page; the my|CalPERS member self-service, there will e a banner ad; the health plans that are working with our Medicare members will be sending out information; and, last, but not least, is the retiree stakeholder outreach. We believe working with the associations -- the retiree associations, they have additional communication channels that we can leverage.

Mr. Chair, that concludes my opening remarks. I'd be happy to take any questions.

CHAIRPERSON FECKNER: Thank you.

Ms. Mathur.

COMMITTEE MEMBER MATHUR: Yes. Just a question about the open enrollment materials. How -- to what degree and how do we highlight what mental health benefits

are available to our members?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS:

Currently, it's in the evidence of coverage, unless it's specifically a change.

COMMITTEE MEMBER MATHUR: So I guess one of the things I've heard from members is that they don't -- they fully understand. And maybe it's they just need to go look at the evidence of coverage. But if they're trying to compare between different plans, they don't have a good appreciation of what the differences might be between the different plans. And maybe they're -- they no longer exist. But at one time, there were quite significant differences between some of the plans in terms of what they offered for mental health.

So I guess I just raise it, because it's been raised to me a couple of times by members that they don't -- that -- so in order to compare across plans when they're making their decision. So I just raise that. Maybe it's something we can think about highlighting in some fashion or communicating in some fashion.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: And I know through my|CalPERS we do have a compare tool, which actually allows our members to compare plans side by side and actually save those. But I looked, it's more on the rate side. So what we'll be doing, I'll look into

specifically it sounds like more benefits. You want to be able to compare benefits across the plan.

COMMITTEE MEMBER MATHUR: Yes.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So that is something that I'll take back for us to investigate.

COMMITTEE MEMBER MATHUR: Thank you.

CHAIRPERSON FECKNER: Thank you.

Seeing no other requests, thank you very much.

Brings us to Agenda Item 3, the action consent calendar. It's the -- the only item today is the approval of the February 13th Committee meeting minutes.

What's the pleasure of the Committee?

COMMITTEE MEMBER JONES: Move it.

VICE CHAIRPERSON TAYLOR: Second.

CHAIRPERSON FECKNER: Moved by Jones, seconded by Taylor.

Any discussion on the motion?

Seeing none.

All in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries.

Item 4, the information consent items. Having no requests to remove anything, we'll move on to Item 5 on the action agenda items.

Item 5 is Review of the Pension and Health Benefit Committee Delegation.

Ms. Bailey-Crimmins.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Mr. Chair and members of the Committee, this is your annual opportunity to review the Pension and Health Benefits delegation. And I would like to call out that there are no changes from the prior year. So as an action item, we are looking for your approval.

COMMITTEE MEMBER MATHUR: Move approval.

COMMITTEE MEMBER GILLIHAN: Second.

CHAIRPERSON FECKNER: Thank you. It's been moved by Mathur, seconded by Jones -- oh, Gillihan.

Any discussion on the motion?

Seeing none.

All in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries.

Item 6, Approval of the PERS Select Value-Based Insurance Design.

Ms. Donneson, Mr. McCollum.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON:

(Thereupon an overhead presentation was

presented as follows.)

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: As they're getting situated, I'd like to set the stage, Mr. Chair.

CHAIRPERSON FECKNER: Please.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So today's action item requests your approval for a PERS Select value-based insurance design pilot. Over the past two years, the health program, industry experts, and representatives from other states have come and shared their insights with this Board and stakeholders on a value based insurance design.

One expert even told us, not in jest, but it was -- in reality is that if you've seen one VBID solution, you've only seen one VBID solution. This shares with us that there are variants on how organizations actually implement value-based insurance design. CalPERS is an industry leader. I will -- and as expected, you will see here today that the way we are implementing value-based insurance design aligns with our strategic goal of health care affordability.

We also believe that members will benefit from having engaged coordinated care, working with a personal physician. And if a member chooses PERS Select during the 2018 open enrollment period, 100 percent of them will be

auto-assigned a primary -- or a personal physician.

They can choose to stay with that physician, they can choose to change physicians, and/or they can choose to not participate in the VBID incentive option, if -- the choice is ultimately theirs.

The VBID design, you will see here today, is expected to reduce the PERS Select monthly member and employer premium, which is something that comes out of people's paychecks on a monthly basis. It also reduces copays if a member agrees to participate with a personal physician.

It offers an HMO-like option for rural areas, because there is that coordinated care. And it still gives members choice between the three PPO plans that we offer if VBID is not for them.

Presenting to you today is Kathy Donneson, the Chief of the Health Plan Administration Division, and also Gary McCollum, our Health Actuary. In the -- at the back of the room and was recently included in your packet was an updated handout. And the reason it has been updated is to reflect -- typically, when we put public agencies we roll in the schools together. So we were asked to highlight the schools and the public agencies and separate them.

And retirees had also asked us to include the

combo family. So as we're going forward and making this decision, you are aware of everyone that's being impacted by this particular design.

So with that, I will go ahead and turn the presentation over to Kathy Donneson who's going to walk us through the design, and also share with you the data that you had requested at the last meeting to help in the decision-making process.

So with that, I'll turn it over to Kathy.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Good morning, Mr. Chair, members of the Committee. Kathy Donneson, CalPERS team, and Gary McCollum, CalPERS Actuary, who is part of our team.

We seek the Committee's approval for the PERS Select value-based insurance design for the 2019 plan year. This request culminates two years of research and presentations of VBID designs. You will find the design that we ask you to approve in attachment 1.

It is important to note that the value-based insurance design for PERS Select applies to the Basic PERS Select PPO plan and Basic members in combination plans. It is proposed as a two-year pilot, and the team will monitor and periodically report back on its progress. At the end of two years, we will evaluate it and come back with a report.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Today, our agenda item is focused in three areas: the goals of the proposed value-based insurance design; the benefits and incentives for engaging with a personal physician; and the results of our analysis in the premium savings as directed by the Committee in February.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I feel it's important to review the goals of the value-based insurance design that we are trying -- we are striving to accomplish. We want our PPO members to have the choice to engage in a personal physician, who will help coordinate their care for a very complex -- through a very complex system.

It also provides economic incentives for members to engage in their care. And when economic incentives are provided, members tend -- are more likely to engage.

Finally, VBID aligns with statewide efforts to improve the health of California through both the CalHR Healthier U program, and the Department of Health and Human Services Let's Get Healthy California.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I want to talk about the personal physician

model, because this is the heart of the value-based insurance design. It's really about having a personal care physician, who can do a number of things for our members and their families in terms of engagement.

As Liana said, we will provide 100 percent of the members with a personal physician. And there's a few ways that, as she said, they can engage with that physician. Anthem will look at physicians that they routinely see, and offer that physician as the primary care physician.

The member could also then, in the Affordable Care Organization that Anthem has, there are physicians that could be assigned that member, or they can look at available physicians and select their own. And it's actually not difficult to change physicians with this Anthem model.

In this way, we are providing all members, once they select and use that physician, to have a $10 co-pay. And we believe this is really important, especially for those who live in areas not supported by a Health Maintenance Organization.

Now, this slide shows you five benefits of the value-based insurance program. First of all, we think that with a primary care physician, or a personal physician, members can have greater coordination of care. And if they do need to see the specialist, they will

engage with their personal physician and have that conversation.

We also believe it helps our members navigate a complicated health system that is often fragmented, and care is not coordinated between different medical care options.

We want a facilitated personal physician engagement. And this VBID provides that for families and for our members. And it reinforces the most important aspect of patient care, and that is engagement in decision making. One of the goals of this program, through a personal care physician, is that our members will engage in their own health, and engage with the provider.

And it builds bridges between the physician, the family, the services offered, as well as community services. Oftentimes our members may seek out support from a -- from medical care, which often could be also provided in community-based services.

In summary, the PERS Select VBID is designed to improve care coordination and reduce health care costs. And now, I'll turn it over to Mr. Gary McCollum, who will walk us through the financial aspects of the VBID.

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SENIOR LIFE ACTUARY McCOLLUM: Thank you, Kathy.

Good morning, Mr. Chair, members of the

Committee. Gary McCollum, CalPERS team member. For this analysis this month, we removed any migration assumptions between the PPO plans, and looked only at the premium savings for the VBID plan alone.

Now, we're looking at calendar year 2018, and what that would look like, if the current Select plan premiums were not risk adjusted. Compared to the 2018 premiums, if the VBID plan was in effect for this year. We're using unadjusted premiums, because next year in 2019, the premiums will not be risk adjusted.

So to walk you through the estimated savings and cost for the VBID alone, I now want to direct your attention to the written agenda item. I'll start with the table on page three. And that actually has been replaced by the hand-out that you all received, that Kathy just mentioned.

It was requested that we split out the school members from the public agency members, and also include the combo plan members. And those are shown on that table.

The primary purpose of this table was to show you that approximately 50,000 members are enrolled in the Select plan currently. And there's a difference between the original numbers and the table, which were based on February, and these numbers on the handout, which are

based on March. So that's why they won't match exactly. It's just the difference between the March enrollment and the February enrollment.

So there's about 50,000 members, as I mentioned, and they're split approximately 60/50 between State and public agencies. And these members, I want to remind you, do not include any Medicare members, because is a basic plan only. So the combo plan members that are shown there are the basic plan members of a combo plan.

So now if you'd turn to the table on the top of page four. This table shows the 2018 unadjusted premiums for PERS Select in the first column. The next column shows the estimated premiums if the VBID plan was in effect for this year.

Now, the difference would be the estimated premium savings for a single-party member. As you can see, those savings vary between $18 and $23 per month. And that's equivalent to $221 to $277 annually. In total, it's estimated that the proposed VBID plan will produce a premium savings of $10 million.

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SENIOR LIFE ACTUARY McCOLLUM: Now, the table on the bottom of page four takes those estimated savings from the table above and we split them between the employer and the employee contributions. For State employees, and

fully vested early State retirees, there's no savings shown to the employee. This is because the State contribution, which is based on the weighted average of the four largest basic plans, is larger in 2018 than that unadjusted Select premium.

So naturally since the full premium is being paid by the State, the full amount, the $5.5 million of estimates savings would all go to the State.

Now, public agencies, on the other hand, have varying contributions depending on the agency toward their employees' premiums. On average, 69 percent of the savings goes to the employee, and 31 percent goes to the employer. So employees and public agencies would save approximately 3.1 million annually, and the public agency employers would save about 1.4 million.

So now, on a personal level, let's take a quick look at a public agency employee with a spouse and three children. So assuming the employee pays the 69 percent of the premium that the average is, the annual savings to that employee would be $498. Now, if they had three -- and this is just a guess, but if they had three physician visits per child, and they each had one physician visit themselves, they would save on those 11 physician visits another $110 on copays, since the copays are being reduced from $20 to $10 And that's a total savings therefore of

$608 for the year.

So now in the table on page four up at the top, we included the average pension information for a State, a public agency, and a school employee. So you can see these employee savings in relation to the average pension amount.

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SENIOR LIFE ACTUARY McCOLLUM: Okay. Finally, the table at the top of page five, it shows where the $10 million savings for the VBID plan comes from. Now, again, this is VBID only, assuming that the VBID plan was in place this year in 2018. There are no migration assumptions factored into this estimated savings.

If you'll recall in February, we showed an estimated savings of 46 million, but that calculation included all three plans Care, Choice and Select, and it included migration assumptions that might happen between the plans to come up with that 46 million.

So to avoid confusion, we've now modeled just the VBID plan for Select without any input or migration from Care or Choice. This allows us to show you the estimate of savings and costs associated with the proposed changes from the Select plan currently to the proposed VBID plan.

So the first line, the plan design savings reflects the change in the benefit design of the product,

including the change in deductibles and copays. And that's estimated to save approximately $8 million in premium savings. Now, if you want to think just real quickly about auto insurance, where you have a choice of deductibles, and the deductible level impacts the premium, the lower the deductible, the higher the premium, the higher the premium -- or, excuse me, the higher the deductible, the lower the premium.

Next line, the five VBID incentives for member engagement, those have an estimated cost of 3.8 million. Now, we have assumed 50 percent of the members will participate in these activities. If we change that assumption that all members will participate in all five activities, that cost would increase to $5.8 million.

And then finally, the network savings includes the changing the designation of tier 2 hospitals to tier 1. And then also, there's more advantageous contracting with the doctors who are contracted with the accountable care organizations. So this generates a savings of 5.7 million, and that totals the $10 million.

So I will turn it back to Kathy now for next steps.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: We've spent -- we have spent two years nearly

working on the value-based insurance design. We believe this is an innovative plan design that is unique and specific to CalPERS. It gives our PPO members the opportunity to select a personal physician to help navigate through a very complex -- complicated system.

Our goal is to provide the opportunity for every PPO member and their families to have a personal physician in which to engage their health. If VBID is approved by the Board this week, it will be incorporated into the 2019 rate-setting process, which is now underway.

We have a commitment from Anthem for a full communication plan that would reach not only our members, but the providers, especially providers in the rural areas. We believe it is very important that we provide information widely, and we broadcast it as widely as possible, not to mention that we would be working with the open enrollment team, and internal team members to make sure we are communicating how this design works.

As I said, we will monitor and periodically report on our progress. And at the end of two years, we will provide an evaluation.

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

CHAIRPERSON FECKNER: Thank you. And we have a number of questions, as well as a number of requests from

the audience.

I have a question first. I now you did stakeholder briefings and meetings about this, can you explain what the actives response was to the meetings and the stakeholder meetings?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: When we reached out to the actives, they felt because the premium, especially for the public agencies and schools, was 69 percent covered typically from on their behalf. Monthly premiums come out of their pockets. And so anything we could do to reduce that monthly premium and copays, they saw it as an advantage.

Also, looking at the statistics, only 27 percent of our members ever reach the deductible. So the lower the premium, the more money in their pocket. So we actually saw a very positive response from the actives.

CHAIRPERSON FECKNER: Okay. And how about the employers side, was there any reaction from the employer side?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: I have not heard from the employers.

CHAIRPERSON FECKNER: Okay. Thank you.

And I only differentiate that, because we've heard from the retirees in a letter and we're going to hear from them today too, so I just wanted to hear the

active percentage.

Mr. Jones.

COMMITTEE MEMBER JONES: Yeah, thank you, Mr. Chair. It's kind of what you just made reference to the retirees. And we do have a letter from the retirees. And one of the comments is that they were told -- about the personal physician, that they were told that they would be able to have -- keep their personal physician. And now, based on this information, they're saying that a physician will be assigned to them. So I'd like clarification on that.

And also, if a person has a physician, are you suggesting that they will be designated another physician when you implement the program?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: No.

COMMITTEE MEMBER JONES: Because I thought you said that all will be given a physician, so I want clarification on that.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Thank you, Mr. Jones. The answer to your question is that if they are currently seeing a personal physician, they will stay with that personal physician. If they are not currently signed a personal physician, what we did is to automatically give our members credit, they are being auto

assigned a physician, and they could change that physician at any time.

COMMITTEE MEMBER JONES: Okay. Another question I have is the -- I've been advocating for years, and we need to have an evaluation component on any new strategy or initiative that we implement. And I see that you have an evaluation component in here after two years to evaluate. So my question is what if it's determined it's really not working, that you -- would you be recommending that it be disband?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: CalPERS is very innovative. And in circumstances where it is not in our members' best interests, we have no problem recommending rescinding just like we did with risk adjustment.

COMMITTEE MEMBER JONES: Okay. Thank you.

CHAIRPERSON FECKNER: Thank you.

Ms. Mathur.

COMMITTEE MEMBER MATHUR: Thank you. Thank you, Mr. Chair. I just want to confirm on page six of eight of the presentation, you identify employee savings and employer savings breaking it out by State and public agencies. And this is -- this refers only to the premium savings, is that correct? So what I heard Mr. McCollum say was that there might be other savings that would

accrue to the member, even a State member, through copays, et cetera that are not included in these savings numbers. Is that -- did I understand you correctly?

SENIOR LIFE ACTUARY McCOLLUM: Yes. The chart on page six is premium savings.

COMMITTEE MEMBER MATHUR: Yeah.

SENIOR LIFE ACTUARY McCOLLUM: And additional costs that net out to the total estimated savings of $10 million on premium. And as I said in my --

COMMITTEE MEMBER MATHUR: Sorry, six is the one that has the VBID savings vary by employer -- employee/employer.

SENIOR LIFE ACTUARY McCOLLUM: Oh, I'm sorry. You're --

COMMITTEE MEMBER MATHUR: I think you have different page numbers perhaps than we have.

SENIOR LIFE ACTUARY McCOLLUM: No, no. You're referring to the premium savings on page five. I'm sorry. I --

COMMITTEE MEMBER MATHUR: Yeah, it says -- well, we have it as page six, maybe you have it as page five. I think -- so I think that might be the disconnect. Sorry.

SENIOR LIFE ACTUARY McCOLLUM: Yes, I'm sorry.

COMMITTEE MEMBER MATHUR: But this is the chart that I was referring to, yeah.

SENIOR LIFE ACTUARY McCOLLUM: And it -- you're right. Those are premium savings estimates, and there are additional savings involved in the copay being reduced from 20 to 10.

COMMITTEE MEMBER MATHUR: Thank you. So I just wanted to make that clear, that there -- there actually could be savings that accrue to the members, even in the case of State workers -- State employees and retiree -- early retirees due to copay savings.

SENIOR LIFE ACTUARY McCOLLUM: That's correct.

COMMITTEE MEMBER MATHUR: Okay. Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Gillihan.

COMMITTEE MEMBER GILLIHAN: Thank you, Mr. Chair.

First, I want to thank the team sincerely for bringing this proposal forward. I know it's taken a lot of work. And as at least one of the voices on this Board that's been asking us to move in this direction, and look in this direction, I'm appreciative that it's here before us today for a decision.

I did have a question though with regard to, as I believe Mr. McCollum stated, the last time this issue came before the Board we had a $46 million savings estimate. And now that's $10 million. And I guess I'm just trying to understand what the process -- what the thought process

was relative to bringing one set of assumptions to the Board, and then the next time this comes before the Board for a decision, we switched our assumptions. And I'd just like to understand that thought process a little more.

SENIOR LIFE ACTUARY McCOLLUM: Well, prior to this, that $46 million that you're referring to, that was an attempt to show you the impact over the whole PPO program, and what might happen, based on the assumptions that we made, of members moving from -- primarily from Care to Select.

This here is an attempt to show you just the impact of this proposed change in the Select plan, assuming no migration at all.

So these numbers obviously would change, based on what actually happens in the enrollment process when members choose to either stay with the plan they have or move to another plan.

COMMITTEE MEMBER GILLIHAN: So when the prior set of assumptions of movement between plans, do we still think that's a likely occurrence or what was behind that -- the prior assumptions.

SENIOR LIFE ACTUARY McCOLLUM: Yes, we will -- we will think -- we do think that there will be movement. And if this plan is approved, we would factor those assumptions into the premium pricing.

COMMITTEE MEMBER GILLIHAN: All right. And so in the end, there's a significant upside potential for increased savings across the Board.

SENIOR LIFE ACTUARY McCOLLUM: That is correct.

COMMITTEE MEMBER GILLIHAN: Thank you.

CHAIRPERSON FECKNER: Thank you.

Ms. Taylor.

VICE CHAIRPERSON TAYLOR: Yes. Thank you, Mr. Chair.

I also want to just thank the staff. This has been a long time coming. You guys have worked really hard. You've been very responsive to our requests for more stakeholder engagement, bringing back different information for us. So I just want to thank you guys for the hard work that you've done on this. I -- on -- in addition though, I had a couple of questions. And I think I had them answered, but I just want to make sure.

The retirees were bringing up in their letter that choosing -- choosing a personal physician for them takes away their choice. But they -- even if you choose -- and I will use my own HMO experience as an example. If I change my insurance, I always end up -- they just pick one for me, and I have to go call or get online and pick my own doctor. So at any time, they can do that, right? So it's the same thing.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: That is correct, Ms. Taylor.

VICE CHAIRPERSON TAYLOR: Okay. And then if they want to avoid having themselves automatically signed up, and this is going to go into effect for January of 2018, right?

CHAIRPERSON FECKNER: Nineteen.

VICE CHAIRPERSON TAYLOR: Nineteen. Oh, so they have plenty of time to pick a doctor, and have that on file. And that would be the doctor that would get chosen, right?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: That is correct. If they go -- if they're part of PERS Select today and choose a personal physician, that will rollover into 2019. All they'll be looking at is auto-assigning anybody who does not currently have a personal physician assigned.

VICE CHAIRPERSON TAYLOR: Okay. So -- and it still gives them choice, so they don't have -- they're not stuck with that personal physician. That's one of the things I wanted to make sure.

And then when it comes to the State employees, because of the way we're covered, this doesn't impact really our premiums, right? So we don't get any money back? We don't get to share in that, because there's not

anything left over for us?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: The employer covers the premium, but there are obviously options for savings, such as copays, and then also the incentives that will reduce their deductible.

VICE CHAIRPERSON TAYLOR: Okay. And so let me clarify, so that in case we have some folks listening. The employer covers the premiums for a single as it goes up, then -- so say they have a family, does that -- that's not covered, right, so then they do get to participate in the savings?

SENIOR LIFE ACTUARY McCOLLUM: No, the State -- are you talking about State employees?

VICE CHAIRPERSON TAYLOR: State employees.

SENIOR LIFE ACTUARY McCOLLUM: Yeah. The contribution by the State is an amount for a single member. It's double that amount for a two-party. And it's essentially 2.6 times that amount for the family member.

VICE CHAIRPERSON TAYLOR: So it's all covered either way?

SENIOR LIFE ACTUARY McCOLLUM: It's covered undercurrent 2018. There's no --

VICE CHAIRPERSON TAYLOR: We don't for sure if it will be in '19?

SENIOR LIFE ACTUARY McCOLLUM: -- guarantees about '19, but --

VICE CHAIRPERSON TAYLOR: If it is, they'll get -- if it's not, they will get some savings then --

SENIOR LIFE ACTUARY McCOLLUM: That is correct, yes.

VICE CHAIRPERSON TAYLOR: -- out of the premium, is that correct?

SENIOR LIFE ACTUARY McCOLLUM: That's correct.

VICE CHAIRPERSON TAYLOR: Okay. Okay. I just wanted to make sure.

And then I think there was -- you guys were talking about that the doctors will -- there were a couple of things. They get to pick their own doctor. Their copays are going down. And there was one other thing I think I missed. Coordinated care, I think, that you were talking about in your presentation, that was advantageous, just the coordinated care, I guess, adds to the cost savings?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Right. The coordinated care relates to the fact that they will have a personal physician that will manage themselves and their families. Oftentimes, our members wind up in a fragmented system, they may go to a specialist when really they could be handled through a

personal care physician relationship. So that's part of the coordinated care.

VICE CHAIRPERSON TAYLOR: Okay. Okay. That's where I got a little bit confused when you were talking about it. So, I mean, I think I would love to have a $10 copay for myself, so I think this is a very good plan. Thank you very much.

CHAIRPERSON FECKNER: Thank you.

Mr. Saha.

ACTING COMMITTEE MEMBER SAHA: Thank you, Mr. Chair. A couple of quick clarifying questions but for -- also, thank you to the staff for all your great work on this. Just with the auto-assign, is -- can you clarify, is that really a way just to ensure that there's a full savings with regards to this?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: As we were stating, there's still full choice. So if a -- which is different. A primary care model means that a primary care physician is kind of the gatekeeper. That is not this model. This model is you're assigned a personal physician, you'll still have choice to go straight to a specialist. It just means you pay the higher copay at the -- the $35 copay at the specialist.

What we believe is that by going through a personal physician having coordinated care, you may never

need to see that specialist. And so that's -- that's assumption is that hopefully we get it done at the point of dealing with a general practitioner or an OB/GYN getting your services addressed there, and never necessarily needing to see a specialist.

But again, our members can choose. They do not have to go to a personal physician, if they do not want to. It just means they pay the higher copay.

ACTING COMMITTEE MEMBER SAHA: Right. Got it. Okay. Thank you.

Really just a quick follow-up question. Just for clarification too, so the 10 million in savings from premiums, that's in addition to the potential 46 million from member movement, or -- I just wanted -- sorry.

SENIOR LIFE ACTUARY McCOLLUM: No, the 46 million was an estimate of the whole PPO program, assuming members move between the three plans.

ACTING COMMITTEE MEMBER SAHA: Right.

SENIOR LIFE ACTUARY McCOLLUM: This $10 million is just the VBID plan with the current membership, the 50,000 members that are there. If we just changed -- for 2018, if we changed the current Select plan to the VBID plan, we would save approximately $10 million this year. So it's part of the 46 million.

ACTING COMMITTEE MEMBER SAHA: Thank you.

SENIOR LIFE ACTUARY McCOLLUM: Yes.

CHAIRPERSON FECKNER: Thank you.

Mr. Miller.

COMMITTEE MEMBER MILLER: Yeah. Again, thanks for all the hard work. I'm -- I wasn't here for all that ramp up for all those months, so hopefully I'm not retreading on ground that's been well covered. But I have one kind of big general question, and then a couple little more specific ones. And the big general question is if we're piloting, and the idea is we're trying to give our members and employers more value, more options, more choices, this doesn't seem like a choice. It seems like if you are in the Select plan, we're changing the plan.

You're not being given a choice of, oh, here's a pilot that may add value to you, to your employer, particularly if you're say not served by an HMO, and you would have wanted one, but otherwise couldn't have had one versus someone who does not want to be in an HMO-type model, and chose a PPO for those reasons when they had an HMO option. And I don't see that anywhere in the discussion thus far.

So as a pilot that people could choose, I would be like 100 percent green light, let's try it, and let people who will benefit from those premium. And let's see if we have real savings in other ways that would accrue to

members or employers. So that was my first question is why is it just a change to the plan versus, you know, a pilot of something that people could choose to opt into.

And then my other questions relate to -- I've got a lot of specific little questions I won't go into. But it looks to me, and just correct me if I'm wrong, that the VBID plan design savings are pretty much due to driving people toward this physician-managed care-type model. And the savings, to some extent, must be coming from some anticipation of better rates, whatever, in negotiations in future.

The incentive costs, if those VBID items are really strictly cost items, where is the savings coming from them, in the long run, if they're not saving us money, or saving our members money, or saving employers money? It seems that the folks who will be benefiting from that would be low-acuity people who are able to do all those. And it only really saves them money if, in fact, they hit those caps, because we're not going to a -- you know, a zero deductible model, where it could bring them to zero deductible.

And then finally, the network savings, again it seems pretty much strictly a matter of trying to move them toward that physician-assisted care model.

So I'm trying to really get a grasp on why this

isn't an alternative to the plan we have, and why it's just strictly a redesign of that plan into something that's quite different?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Mr. Miller, I'll take an attempt. And then when we get down to the numbers, I'm going to rely on my actuary. So currently, CalPERS has three self-funded PPO plans, Choice, Care and Select. We chose Select as the pilot, looking at age, demographics, and -- you know, again, they're all self-funded. We felt that there's three areas of savings, premium, copay, and incentives.

Premiums, everyone benefits from normally, employer and member. Copay is if someone decides to do a personal physician. If they decide not to, they can choose to go straight to a specialist and pay the higher copay.

And then we incentivize, through five means. One -- you know, we've gone over those before. But if someone actually does all five incentives, they can benefit as a single party or they can go up to $1,000 in savings for their family.

And so we believe there's choice within Select. We're not making someone go to their personal physician. They can go to some -- not go to them or go to somebody else. And they have options between the three, the other

two. So they have options of choice across all three PPOs. If VBID is not for them, they can choose Care or Choice. That's purely up to them.

COMMITTEE MEMBER MILLER: Right. I guess that's my question. We're also planning to particularly impact them with Care. So it seems like they really don't have the choice of that basic plan anymore, the Select plan. We're putting this new one in place and experimenting over the next two years to see how -- but in terms of the impact on the satisfaction engagement -- dissatisfaction factors for our primary customers, where does that fit in? They chose those plans because they liked those plans. We're changing them. We're going to have to guess about how that will affect them on migration, those type of things. I think we have a good sense of what dramatically increasing premiums in PERSCare will do. That will certainly drive people to this option, the more HMO-like option, that most people who chose PPOs were trying to avoid.

So I'm just wondering why -- my biggest question is why isn't this really an option, a stand-alone option versus just changing that basic plan kind of out from under people?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Well, we would have had to create a fourth PPO in order to do this.

So staying within the three PPOs. We also -- we realize the first time we presented this to you in February was we were combining all PPOs, which was very confusing. So what we did is said if there was any -- which is commensurate with what we normally do. If there are changes to PPOs, we normally do that to the rate negotiation process, which we're right in the middle of, which you will have an opportunity to talk to us and decide if there is any changes to the other two PPOs.

But this specific decision today is just for the value-based insurance design within the Select product.

COMMITTEE MEMBER MILLER: Okay. Thank you.

CHAIRPERSON FECKNER: Thank you.

Ms. Mathur.

COMMITTEE MEMBER MATHUR: Thank you, Mr. Chair.

I think it might be instructive to sort of review the history of the PERS Select program. It wasn't always offered here at CalPERS. In fact, when I started back in -- 15 years ago, we had the PERSCare and the PERS Choice products. And then we added PERS Select as a way to -- as a way to reduce the net -- you know, reduce the network, encourage members to go to doctors with better referral patterns, et cetera. I think those were part of -- partly -- correct me if I'm misstating anything, Kathy, but it was really intended to be the product that

drove to the lowest possible cost for the member, while preserving high quality access to care.

And so that is the purpose of the PERS Select product. And I think this is another step in the evolution of that product. I think we've learned that the PERS Select product, as it was constructed, hasn't achieved all the things that we wanted it to achieve. And we're still hearing from members that they want a lower cost product. In some -- in many cases, an HMO-style product in areas where HMOs are not offered.

And so I -- I think this is -- this is a phenomenal offering for our members. I think it's going to be really attractive. Right now we have, what, 50,000 members or so in PERS Select. I imagine that this could over time become more attractive to members, particularly those who are living in areas where there are no HMO products available. So we could see the enrollment increase, I think, in this product.

So I want to add my thanks to the team for, you know, really doing a lot of due diligence around this product to devise a product that can meet a number of objectives, including savings, driving to better care, better habits on the part of our members in some cases.

And with that, I will move the staff recommendation.

COMMITTEE MEMBER GILLIHAN: Second.

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

We still have quite a few requests to speak.

Ms. Brown.

BOARD MEMBER BROWN: Thank you. I want to thank the staff for meeting with me a couple weeks ago. I was one of the Board members who was very confused with PERSCare, PERS Choice, and PERS Select all on one sheet, some -- all doing different things. And so this is much simpler for me to look at and just showing the savings.

But could you just reexplain to me, especially after Mr. Miller's comments I'm a little more confused, plan design savings, the $8 million comes from what or what are plan design, just tell me a little bit?

SENIOR LIFE ACTUARY McCOLLUM: The plan design is benefit structure, which is -- it consists of the deductibles and the copays and the coinsurance.

BOARD MEMBER BROWN: And will -- and CalPERS will save $8 million?

SENIOR LIFE ACTUARY McCOLLUM: The plan will save $8 million. So that --

BOARD MEMBER BROWN: So the less we have to pay out? Eight million dollars --

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Ms.

Brown, all savings -- CalPERS is a not-for-profit. All savings that we get from benefit designs either goes into reserve in order to ensure that there isn't problems with our plans or goes directly back to savings in the premiums.

BOARD MEMBER BROWN: Okay. So -- okay. So you said the incentive cost savings are based on 50 percent people -- 50 percent of the people participating, so -- and that's what we expect? The $3.8 million in incentive costs, is if 50 percent participate, is that what I heard you say?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Yes. Kathy would love 100 percent. She kept pushing for 100 percent. The actuary tried to bring her back to 50 percent.

BOARD MEMBER BROWN: Okay. And so if it's 100 percent, then we just double it and we would get 7.6 million in savings, right, which means -- sorry, 7.6 million in cost, and then the savings would be lower if everybody participates.

SENIOR LIFE ACTUARY McCOLLUM: That's correct. But just to clarify, it wouldn't exactly double. It's not a linear relationship because of the fact that deductibles and costs -- you know, if they hit their deductible, costs continue to rise, and the plan pays for it, and the --

it's not a linear --

BOARD MEMBER BROWN: It's less than 7.6.

SENIOR LIFE ACTUARY McCOLLUM: It would be less, yes. We are estimating it a 5.8.

BOARD MEMBER BROWN: If we had 100 percent participation, would plan design or network savings change as well or no?

SENIOR LIFE ACTUARY McCOLLUM: No.

BOARD MEMBER BROWN: Those are fixed.

SENIOR LIFE ACTUARY McCOLLUM: No, because the plan design is set. The networks --

BOARD MEMBER BROWN: And network savings are fixed?

SENIOR LIFE ACTUARY McCOLLUM: Yes.

BOARD MEMBER BROWN: Okay. I want to say that I did read the retiree's letter here, and I do have some concerns. So I'd like to hear them speak, and then reserve some more comments for later. So I am happy that you separated it out. But I still do have concerns that we're going to come back and PERSCare and PERS Choice, the premiums may be going up without the option for the VBID. I do like the pilot idea, but I'd like to also give all our retirees chances to have the same savings.

Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Rubalcava.

BOARD MEMBER RUBALCAVA: Thank you.

I think it's a very innovative approach. You're preserving choice, which is what members want or expect in a non-HMO plan. And you have identified savings from premiums, copays, and incentives.

But wouldn't also the engagement -- encouraged engagement with your physician lead to better health outcomes, and that would also lead to savings in the long run, wouldn't it, because if people start seeing the doctor more often because of the incentives or wellness programs, you may be able to discover some preexist -- you know, pre -- situations that can be improved or if you're in a situation you could be stabilized. And long term, there will be better outcomes health-wise for the employees and the retirees, is that correct?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Mr. Rubalcava, you actually answered your own question, but yet.

(Laughter.)

BOARD MEMBER RUBALCAVA: I was trying to be helpful. Thank you. Thank you, sir.

CHAIRPERSON FECKNER: Thank you.

Ms. Taylor.

VICE CHAIRPERSON TAYLOR: Yes. Thank you.

I forgot to ask earlier -- and again, thank you, guys, for your presentation. You guys -- you had said that you will be monitoring it and bringing it back to us, but you didn't really give us a timeframe. Like, are you going to do it like every other month, quarterly, just to let us know how it's going.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: It's a full-two year pilot, but we will -- obviously, in a year, we'll give you a checkpoint of where we are in relation to engagement, satisfaction, outcomes. And then be able to decide as we get -- I don't want to wait till the end of the two years for you all of a sudden to get the information. So we'll be sharing it with you at least at the one-year point. I don't know, Kathy, do you have a timeline on that?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Well, we would like to report back to you on the implementation piece. So perhaps as we get beyond January 1 after we've actually implemented, we'd like to give you a check-in on --

VICE CHAIRPERSON TAYLOR: I'd like that too, yeah.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: -- probably about the same time, the first quarter of the next year, so -- and then as we go into the

rate renewal process for 2020, hard to believe, we would also be updating you probably at that time as well.

VICE CHAIRPERSON TAYLOR: So I think that maybe in addition to moving this, that, if it pleases the Chair, maybe we should outline that we want to hear about the implementation, and then again about the follow up at rate renewal process, as well as the annual, if that's okay?

CHAIRPERSON FECKNER: That will be the direction if it passes.

VICE CHAIRPERSON TAYLOR: And then lastly, I just want to -- I understand it feels like -- I just want to make a comment. I understand it feels like that choice is being taken way, but I think you still have the option in this plan of just not participating, and maintaining the plan. I will use the information that I got from you guys earlier, which is people keep asking why we don't lower the premium and then get us down to zero?

But that's like my car insurance. Right now, I'm at $1,000 deductible. If I went to zero deductible, I don't even know how much my monthly premium would be, but it wouldn't be something I could afford. Yeah. So, I mean, it's just -- I think we need to look at it as you don't have to participate. You can participate. It's still the same design.

As always, our insurance premiums go up, so this

plan, and I think some of the other plans have -- under the PPO have increased anyway. Plus, we were getting rid of our risk mitigation issues that we had before.

And then finally for my employees who work at RJ Donovan in -- you know, way past San Diego at the border, they don't have any options. So I think if they have the PPO, this is helpful for them. So I'm pleased to be able to say to them, hey, you guys participate in this, you're going to save a whole bunch of money. So I do appreciate that.

CHAIRPERSON FECKNER: Thank you.

Mr. Lofaso.

ACTING COMMITTEE MEMBER LOFASO: Thank you, Mr. Chair. Again appreciate all of the work for the last two years. We've been sort of dealing with this issue at two levels. And the one that I'll start with is, you know, we started in this how do plan design influence member behavior discussion?

And, you know, we were on the cusp of that -- and I don't want to rile everybody up -- but that high deductible health plan discussion. Where I'm ultimately going is this question of influencing member behavior. This has prompted some robust discussions in the Controller's office. And Controller very much appreciates that we've moved away from the high deductible health plan

discussion. And again don't want to rile everybody up. But the key issue there, of course, is the large system trend toward cost shifting against employees, and what the data shows in terms of how that impacts employees' decisions negatively as it relates to accessing the high-value care that we want to -- that we want to access -- we want them to access, I should say.

But the back-end, I might call it, where we're influencing employee behavior seems to be the part that we've had less opportunity to discuss as we sort of moved less away. I understand that we're -- fundamentally, we're taking a step here that relates to using benefit design as a tool to influence consumer behavior, and that's the key decision. The -- some of the details on the back-end that I think leave the Controller a little not ready to go today as a -- as from a decision-making standpoint, and I'll -- you know, I'll itemize a few.

One, we talked a little bit about wellness last time, but there have been a lot of changes in at least the State's approach to wellness, since we last had a thorough discussion of this about two years ago. I'm going to revisit in a moment the metrics issues that a couple members have brought up, and as with the provider -- excuse me, the primary care provider issue.

And finally, I think there's a question about our

contracting cycle I want to ask about.

But backing up on my issues. If I understand the metrics we're going to look at, they're going to be related to three submetrics related to enrollment in the various programs, and then a sort of look at population health in general. And I'm sure everybody has read the detailed population health statistics in the consent 4d.

But can you -- can you explain a little bit more in detail what the -- what the metrics are going to look at and maybe what they might not be looking at?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Well, first of all, yes. One of the things we would look at is in enrollment. We would look at the population after open enrollment in 2019 to see what the plan looked like in terms of that population.

We would also be monitoring -- first of all, we would want in the first quarter of 2019 to have all of our enrollees in that -- in the VBID plan go through the exercise of meeting the five criteria so that they get the incentives.

So we would be looking at a metric related to not just who's enrolled, but how we're communicating and getting them enrolled. I think the communication and the outreach would be an important metric for us to report to you, how many physicians contacted, which would -- we

would expect to be all, especially in the rural areas. We'd want to make sure that how many members were reached in terms of 100 percent of those that are subscribers enrolled in the plan. That would be another type of metric. So some of these are going to be implementation metrics.

And then as we go through the actual launch and implementation, we would look at metrics in terms of the -- some of the five different components of the incentives, especially the biometric screening. And one of the things that's really important about the biometric screening is they can mail their kits or they can go to any Quest Analytics Lab and just provide -- so those are the types.

It would be partly communication metrics, implementation metrics, but also health metrics and population -- the risk within that plan for that population, and how well this design is meeting improving that health within that population.

ACTING COMMITTEE MEMBER LOFASO: Appreciate that. And I'm not trying to make the bar unachievable, but I'm seeing enrollment in certain programs, and then at the back end hopefully there will be some improved outcomes. But I guess I'm trying to understand how we're bridging the -- bridging the gap between the stats on enrolling in

the programs and the context, and that outcomes at the back-end?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Well, you mentioned our population health -- our population health agenda item. You can see that we are making -- we have made progress in terms of that series of measures where we started in -- you know, as we launched to 2015 to '16. But I also want to remind you that we did look at the statistics associated with Select, Care and Choice between 2013 and '17.

And that's where you start to see I think some of our efforts paying off in terms of working with our health plans to improve the populations along the six different categories of chronic condition. So it's going to take time, and we would build in measurement systems to track over time in terms of population health.

ACTING COMMITTEE MEMBER LOFASO: Appreciate that. One of the things we're looking for is just a little more clarity and structure, so we can follow it as it goes forward.

My second big issue is, and this has been alluded to with the issue about the enrollment, and I think some of the stakeholder comments speak to this. And I'll be candid, I haven't fully appreciated the evolution of PERS Select. And I don't know if it's appropriate to use the

term "narrow network" in a PPO context. And we're sort of taking an old set of PERS Select innovation principles and applying a new set of PERS Select innovation principles, and sort of following that's been a challenge.

But the bottom line I'm trying to get to is if physician engagement enrolling with a primary care physician is sort of a central tenet of the program, what does that mean for how we've looked at the network where the new design relies so much more substantially on the access to a primary care physician, the old, can you put that in context?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Actually, I did look at the network, especially in the rural areas. It's not a matter of overlap with the networks in rural area. There's nearly 100 percent overlap, but it is the availability of physicians themselves. So in the far corners of California, we do have to worry about making sure that not just this plan is supported but Choice and Care are supported as well, because even though we have 100 percent overlap in the county, we want to make sure we have enough physicians in the county for all three plans, not just Select.

ACTING COMMITTEE MEMBER LOFASO: Appreciate that, especially back to the interaction. Just continuing the theme on physicians for a moment, Mr. McCollum, there's, I

think, also a question that I had early related to the savings from -- the network savings, the 5.7 million, in that table. And I think I came in this morning thinking this related to that hospital tiering matter that you mentioned, but you said something about contracting with HMOs being a part of that savings component. Can you elaborate?

SENIOR LIFE ACTUARY McCOLLUM: Yes, it wasn't HMO's though. It was ACOs.

ACTING COMMITTEE MEMBER LOFASO: I -- my notes said ACOs and my tongue -- thank you.

(Laughter.)

SENIOR LIFE ACTUARY McCOLLUM: Yeah, the attributing physicians, or the physician network, are related to the Accountable Care Organizations. And the contracting that Anthem has with those organizations is better than their contracting they have with just non-Accountable Care Organizations.

So there -- there will be a savings involved in individuals who -- who attribute to those physicians and go to those physician groups, as opposed to going to another physician groups.

ACTING COMMITTEE MEMBER LOFASO: Can I simplify that by saying that's what we pay them, not how many we have?

SENIOR LIFE ACTUARY McCOLLUM: I'm not sure I understand.

ACTING COMMITTEE MEMBER LOFASO: Okay. It's too simplistic. Forget it. I won't do that. I appreciate that.

The final issue I wanted to raise is so we all decided to delay the contracting cycle for PPOs by a year. And we have a two-year pilot. And our third-party administrator for the first year is going to be Anthem, and then we're going to be in the middle of the solicitation for the five-year cycle for the PPOs. How are -- how are we going to deal with that?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Mr. Lofaso, you're correct that we are going to be putting out our solicitation for a PPO. We -- this is one of the reasons we've left the requirements fairly broad. Originally, several states do a more complex VBID design, because we felt that we wanted to still be competitive so that any third-party administrator interested in doing business with CalPES could still bid on something of this magnitude.

If we went to -- into the weeds, as you always say, it would have been much more difficult. And we wanted to make sure that it stayed competitive in the market.

ACTING COMMITTEE MEMBER LOFASO: Thank you. Still listening. Still concerned. Appreciate the comments.

CHAIRPERSON FECKNER: Thank you.

Mr. Slaton.

COMMITTEE MEMBER SLATON: Thank you, Mr. Chair.

Just a couple of questions. So on the selection of a physician, and you've talked about the issue of the rural areas and the difficulty there. But if they don't select, they're going to be assigned, is that what I understood to hear?

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

COMMITTEE MEMBER SLATON: So how would they be assigned, if you don't -- I mean, is there a geographic maximum distance, or how is that going to work?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So if they're currently using a personal physician, they will automatically use that personal physician. If they do not have a personal physician --

COMMITTEE MEMBER SLATON: Right.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: -- they will be assigned. And what they do is they look at their zip code. And remember, it's not just a general practitioner. It can be an OB/GYN.

COMMITTEE MEMBER SLATON: Other -- sure.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: There's a multitude of -- and at this point working with Anthem and looking at our membership, we have -- Anthem is confident that we can cover everybody.

COMMITTEE MEMBER SLATON: Okay.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: And we felt that auto-enrolling allowed everyone to automatically start with a credit versus having to opt in. We thought that was a much better approach and more customer centric.

COMMITTEE MEMBER SLATON: Right. So -- but now let's talk about the other five things that you can get credit on your deductible.

And by the way, I -- you know, I like the concept of what we're doing, because the ultimate objective of this is better health. I mean, we can talk about money all day long, but we're trying to make sure people stay healthy, and that ultimately hopefully results in reduced costs for everybody.

So on those five things, they don't happen on day one. There's a credit to your deductible. So help me understand let's say I get my flu shot, and it's X number of months after I've already met the deductible, do I get a check in the mail? What occurs? If I now get a credit after I've already met the full deductible, I've now done

one of these steps and have $100 credit.

SENIOR LIFE ACTUARY McCOLLUM: Anthem would refund the amount of the deductible or the amount of the credit.

COMMITTEE MEMBER SLATON: So the member would receive a check from Anthem.

SENIOR LIFE ACTUARY McCOLLUM: Yes, um-hmm.

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

CHAIRPERSON FECKNER: Thank you.

Ms. Brown.

BOARD MEMBER BROWN: Mr. Slaton asked my question, how are primary care physicians automatically assigned? What create is used? And I assume you said it's distance? But then you said something about OB/GYNs. And so I would hope that Mr. Feckner wouldn't automatically be given an OB/GYN as his primary care physician.

(Laughter.)

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: That's correct. In our agenda item we had -- I know in February we listed a whole list of, you know, types of doctors that can be a primary care physician. And, yes, Mr. Feckner would not be assigned an OB/GYN for his primary care physician, unless he wanted.

BOARD MEMBER BROWN: Okay. Good to know.
CHAIRPERSON FECKNER: That's fairly presumptive.
(Laughter.)
CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: It's your choice.
CHAIRPERSON FECKNER: Thank you.
BOARD MEMBER BROWN: That's a very good choice.
The follow-up question was I will tell you when -- in the past, when I had been auto-assigned a physician in my HMO a long time ago, the doctors were either really not accepting new patients, even though you were assigning as a new patient, or you had to wait 30 to 45 days just to get that first appointment.
So I'm telling you, I know that's an issue, and we need to really try and work that out, and tell members if you're automatically assigned to -- we need to just make sure that those physicians are available, and appointments are available, because you can wait a very long time to see your new physician, and then what happens you don't see them. You just call your specialist and you go, or you go to urgent care, because you can't see your doctor. And that's the problem.
CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Ms. Brown, yes, if any of our members that sign up to do a personal care cannot see their physician and they don't

have appointments, please contact us immediately and we will get to the bottom of it, and we will also make sure that they get a credit, because they've attempted to participate in the program.

BOARD MEMBER BROWN: Thank you.

CHAIRPERSON FECKNER: Thank you.

Seeing no other requests from the Board, we have a number of folks from the audience who wish to speak. So I call you down two at a time. Please take the seats over here on your right, my left. The microphones will be turned on for you. You'll have up to three minutes, so please speak your name for the record, and your affiliation. First, we have Emma Millis and Tim Behrens.

Ms. Millis, please.

MS. MILLIS: Hello. Thank you for listening to me. My overriding emotion listening to this discussion has been that you -- it appears to be an overriding attempt to lower expectations in the future for the future retirees who are now the employees.

My first point is there's a specious comparison among the plans, and the expectations, and the results. I wasn't going to add this, but you hit my hot button with the last couple of statements. I went through a similar situation in 2017 with being assigned a physician, because that was the only one who was accepting new patients. It

took me eight months to get an incorrect diagnosis through the system to get proper treatment. It was very painful, and it still is.

One of the things I see is that it's an attempt to -- also to waterdown the benefits that can be received by the employees and later the retirees, by the system being so complicated and convoluted that it will become more and more difficult to navigate this system, as it has been for some of us in the past.

Second -- let's see. I had to number these, because I wanted to keep my amount of time that I take down. I don't see enough oversight of this system coming in. I remember, and I have been a retiree -- well, I've been a State employee pretty much since 1982, and then I became a retiree. There's not enough oversight with the individual in mind, the human being, the biometrics, the statistics, the dollars. You still are dealing with human beings. And human beings age and become disabled at different levels.

The system that is coming through right now, what you're describing, is what they're trying to set up through all of the plans. I do have the Anthem Blue Cross. I've had the experience of HMO. And I was very lucky to have had a primary physician who was able to shepherd me through the system. When he retired -- it was

very difficult anyways. But when he retired, I fell through the hole.

The watering down of benefits is what I see is occurring. Everyone, as I said, ages at a different level. Now, I don't know if any of you have AARP, but the latest newsletter had a little blurb that the fact is that of retirees with Medicare, 65 or older, 30 percent are considered disabled, and of the total of retirees with Medicare, 40 percent are mobility challenged.

All of these -- well, you might call them acquired conditions. And most of them are from inadequate medical contact in earlier years.

I can give you more details if you want.

CHAIRPERSON FECKNER: Can you please -- can you please wrap-up?

MS. MILLIS: Fourth, it is not a proactive system. It designs people to become passive.

CHAIRPERSON FECKNER: Ma'am, can you reach your conclusion? Your time is up. Thank you.

MS. MILLIS: Yes, I'm -- I've got two more sentences.

MR. BEHRENS: Your time is up.

MS. MILLIS: Assumptions are pro -- that you need active engagement. It's not being followed through. It stinks.

CHAIRPERSON FECKNER: Thank you.

Mr. Behrens.

MR. BEHRENS: Thank you, Mr. Chair and members of the Committee. Tim Behrens, California State Retirees.

California State Retirees opposes the latest value-based insurance design proposal before you this morning. While we believe it has some positive elements, those which include -- encourage good health practices and wellness, but we strongly object to the Select basic plan having the deductibles double. It also increases the copays for mental health services from $20 to $35, and copays for urgent care and specialist visits from $20 to $35, and charges 20 percent coinsurance for all lab work, which we think could be a great financial hardship on many stakeholders.

The staff are hoping the wellness incentives rebates, which credit members $100 for each of the five items are so easy to obtain that they will be fully complied with by most all members. We have seen a University of Chicago study of wellness programs, which shows the health perks neither lower costs nor improve health very much.

Even after considerably increasing the amount of credits, the study found a maximum 63 percent participation. Though staff has made these incentives as

hassle-free as possible, we think members will not take advantage at expected levels. When people are sick, facing surgery, and just have busy lives, they aren't necessarily thinking of researching and meeting requirements for rebates, assuming they all even know they're available.

We also believe that the current levels of deductibles of 500 and 1000 already act as deterrents to some members seeking needed medical care, especially those at or below the median pension levels of $30,000 annually.

There is an easy solution. Leave the out-of-pocket expenses at the current level for the pilot study, and allow Select plan members to participate in the incentives and receive the rebates. There will still be at the same wellness benefit, but members would be -- not be penalized with doubling their deductibles if they fail to participate. And they still must pay 20 percent on that policy, even if it doesn't cover another distinctive -- I mean, disincentive just seeking care.

We met with CalPERS staff last Thursday, and we appreciate their willingness to hear our continuing concerns and answer our questions. This proposal does drop deductible and other increase for PERSCare plan members. We were initially thankful for this, until we discovered they plan to reintroduce out-of-pocket costs

for that plan when the new preliminary rates are released. And affected members will have no opportunity to reduce the incentives with rebates. We'll be back. Same objections. Same time.

Thank you for allowing me to speak.

CHAIRPERSON FECKNER: Thank you.

Next up is Donna Snodgrass and Larry Woodson.

Ms. Snodgrass.

MR. WOODSON: Okay. You want me to go first. Okay.

Good morning. Larry Woodson, California State Retirees. Thank you for the opportunity to comment. I did ask -- requested five minutes. I see the clock is only at 3.

CHAIRPERSON FECKNER: I see your request, but we do have your letter and we have read it, so we'll see how well you do with three minutes.

MR. WOODSON: Okay. Well, intended to cover some things that aren't in my written comments.

CHAIRPERSON FECKNER: Please do.

MR. WOODSON: I want to thank the staff and Board members for addressing some of the concerns we had with the first two VBID proposals, the extreme increases in out-of-pocket costs to affected members have been reduced. But as Tim indicated, we still think doubling them for

Select members will create hardships. And this doubling of the -- of the out-of-pocket costs isn't -- hasn't really been discussed much today.

Mr. McCollum estimates only 50 percent participation in his assumptions. And 50 percent would leave 50 percent of the members with much higher deductibles. As Tim said, we support the wellness incentives and the personal physician component as having the potential to improve health and reduce costs. That said, we have a number of disagreements with the statements and assumptions in the projected savings in the proposal.

In our meeting Thursday, we did thank the staff for dropping the increased out-of-pocket for PERSCare. Tim's already covered this, so I'll skip it.

We do support the personal physician model. There are shortcomings in how it's described, and offered. But we were initially told it's the choice of the member. And then in Thursday's meeting, we were told we would be assigned if we didn't make a choice. And this morning, I've heard a pull-back on that. I'm still a little confused about the assignment process.

The personal physician option has another significant obstacle. In the 18 rural counties where the targets of this -- are the targets of this proposal,

there's a significant shortage of providers. Even where there may be more providers, we've already found most of them are not accepting new patients.

Anthem and CalPERS found this out the hard way in Butte County this year when they offered Anthem traditional HMO. Members selected it, and then were rejected and were told they -- their doctors were not accepting new patients.

Ultimately, staff and Anthem worked hard to correct this, but this same issue exists throughout rural California, and I think will affect the rosy assumptions about the success.

On page five, the estimated cost savings in the table categories and assumptions are not readily transparent. Ms. Mathur's question regarding additional savings besides the premiums on the deductibles isn't really accurate, if you consider that they're doubling them to start with. So they may save on the doubling, but they will only get back to the original level of deductibles.

And then finally, the $5.7 million in the network savings was defined for us as lower negotiated provider rates. I don't see anything in this proposal that would give CalPERS or Anthem leverage to extract over $5 million from providers. But if they were able to, they still

don't need to double the out-of-pocket costs in order to do so.

In conclusion, the proposal, as written, has some vagueness, and we have some questions about it still. We feel like it could be modified by not doubling the deductibles, and move forward with the wellness incentives.

Thank you.

CHAIRPERSON FECKNER: Thank you.

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

And I want to start by acknowledging the work that Kathy Donneson and her staff have done on this. And I appreciate that after listening to our concerns early on, quite a few of our suggestions have been included in this newest version.

That being said, RPEA still has some reservations, and we're still concerned how this plan will ultimately affect PERSCare and PERS Choice. We're going to continue to monitor, as information becomes available. And after premium rates are announced, it's possible our reservations may once again become opposition.

A comment after listening to the presentation, examples given this morning. Families with young

children, especially if they were like mine when they were growing up, we found ourselves in urgent care twice as often as we did a regular doctor's office. So my cost at the time would have gone up probably past any premium savings. So keep that in mind with the $35 copays for urgent care and specialists. Maybe everybody's children doesn't climb trees like mine did and break arms and such.

And I have one question. Will the members who are living outside the U.S. have access to the VBID or they still need to do Cal PERSCare PERS Choice. We've got three members that live in South America, and they're -- they can't get Medicare, because Medicare won't cover you out of the United States. So will this plan be available to our South American members?

CHAIRPERSON FECKNER: Thank you.

Next two, Mr. Johnson and Mr. Allison, please.

Mr. Johnson.

MR. JOHNSON: Oh, Neal Johnson, SEIU 1000.

This has been a long trip since the initial discussion in the July 2016 off-site on the VBID program and subsequent ones. We are supportive of the concept. We have some concerns about how it will actually work. One of the recommendations coming out of one of the other SEIU locals is a -- there has to be some real case management on behalf of either Anthem or PERS to really

make sure that employees get engaged.

Now, it's easy to say this is an opportunity which it really is. And for that, we support it. But to really make it work, there has to be a hands-on approach to really working with the members. And that, I think, is something we haven't really seen. There's a communication plan, but I think it's really got to go beyond the initial communication. It's got to be working with people as you go through.

And another one, which I think brought up is the report -- periodic reporting on progress. We would recommend probably quarterly, and then a real serious evaluation of the program.

And then one comment that actually I think some of the savings from premiums got understated, because there seems to be an assumption that all State employees are covered under the 100/90 formula, which is not true. The majority of us are under either an 80/80 or an 85/80 formula, and actually currently have coinsurance costs with -- under this plan that theoretically will reduce over time and -- anyway.

I guess what I want to really communicate is we need the hands-on work to make it work, and we support the concept. And good luck.

CHAIRPERSON FECKNER: Thank you.

Mr. Allison

MR. ALLISON: Good morning, Mr. Chair and members of the Board. Brian Allison on behalf of American Federation of State, County & Municipal Employees.

We support the concepts of choice. We like what it offers -- what this plan offers in terms of coordinated care and incentives designed to improve health. And again, we like the idea of offering more choice -- more choice to our members, particularly folks in areas where there aren't HMO style plans available. We think it's beneficial to have the choice to have an HMO-like approach to coordinate care.

You know, we understand that the health care system can be difficult to steer through. And having a personal physician is an advocate to encourage members in improving their health. It benefits members -- active members greatly.

We also like the fact that the plan itself isn't prescriptive. It offers people options to decide for themselves. And we're pleased to see that CalPERS is looking at different service options to bring down cost and drive affordability, so -- but the idea for us if -- along with some of the concerns are issues raised by our brother with SEIU Local 1000, if the -- we want this idea to remain as an option. The goal is not to replace the

existing options that are available that would remain helpful to our active members.

But if this is viewed as a long-term replacement, that could become problematic. So thank you for your time.

CHAIRPERSON FECKNER: Thank you.

So seeing no other requests from the audience, I would like staff to reply comments to some of the things that came up from our speakers.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Mr. Chair and members of the Committee, I did confirm that PERS Select does not provide out-of-state currently. So they're not impacted any out-of-state members. Also, just a reiteration, it does not impact Medicare. This is for basic only. And so of the subscribers and dependents, we have a very small amount of retirees. They're just as important, but I want to make sure just from an understanding of impact.

And monitoring and management is important. And one of the suggestions was not only just annually but coming back to look at implementation after we've implemented, and also follow up after RDP.

And then the last thing is just reminding. We felt it was confusing bringing all three PPOs in front of you when we were really focusing on benefit design for

VBID. The other two will be discussed through the rate development process. You will have complete transparency and visibility to it. And any changes will be discussed then.

We just felt like it was -- and also, when you saw our numbers, we had assumed migration. We did not want to confuse you with migration, so bringing it down just to the subset of current PERS Select members. So we were trying to tee up this item in a way that we felt could be, based on the data, based on easy decision making, and making sure that everyone knew that there was opportunities for choice and savings along the way.

CHAIRPERSON FECKNER: Thank you.

Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you, Mr. Chairman. While I would have preferred the concept that my colleague David mentioned a true pilot program, as opposed to the entire program, but I think there are a lot of good things in here. And so I can support it from that side, but I am still concerned about some of the issues raised. And so in that regard, when you bring back quarterly reports in terms of -- an annual report, if you will, for an evaluation related to continue to go forward on all of the items or some of the items, would it be possible, if you feel in a quarterly or annual statement,

that some of these components that people raised concerns are not working, would you be willing to -- would it be possible rather to disband those items going forward?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Every year, we go through rate negotiations. If there is something fundamentally broken about this particular design, we will make sure that we highlight it and address it at that time.

I do not expect -- expect success, but I do want to let you know that we do have safeguards in place. If something is not going correctly, we will address that, based on the oversight of this Board and Committee.

COMMITTEE MEMBER JONES: Okay.

CHAIRPERSON FECKNER: Thank you.

Mr. Lofaso.

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

I also want to echo Mr. Jones comment about sort of how we go forward. But I mean the one core issue I gleaned from all the stakeholder comments is the parts that we all like, we like, which is the engagement, the coordination. If I -- the theme I hear is a lack of trust that that's actually going to occur. And I know -- I can't process in my brain right up here at the moment all of what's going to be incorporated in the metrics. I know

Dr. Donneson said some things about engagement, some other things.

But really what you can do to get at that issue and develop that trust and those metrics in a way that is digestible for us up here, but also if we're going to do quarterly reports, and we're going to consider pulling the plug sooner than anticipated, I wonder if we could go one more step and I'm -- I'm a little fixated on this question of our contracting cycle and your answer about keeping general because we don't know what year two is going to look like with a potential different third-party TPA.

But I'm -- I think through the rate development process and through the contract solicitation discussion, that there's a lot of room to think about what our contract requirements might say that give us more -- more ability to address some of those stakeholder concerns that I heard, a.k.a. we like it in theory, don't believe it's going to happen in practice kind of staff. And if in the middle of the two-year pilot, even if it's working successfully, if through that other parallel process, if we had the ability add more components in the back-end that strengthen our ability to get to where we're trying to get to in the mid-two year pilot process, I hope we'd seriously think about doing that.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So as we

move forward through the rate -- through the two-year cycle, because we're going to go through a PPO solicitation, I wouldn't want to make it more complex. I'd want to make sure that the requirements and my -- the legal team always holds us accountable to the requirements.

So if there are more that we want to do, I probably will not do that until the end of the pilot at the two-year mark, and then we would see where we sat with the PPO, if it be the current PPO or new. I wouldn't want to increase complexity mid-stream.

What I will offer is during the monitoring management of this VBID solution, if along the way we hit the one-year mark and we have not received the metrics that this Board and our stakeholders expect, we will then make a decision on what we then will move forward with. But I wouldn't -- I wouldn't go and make it more complex between now and the end of the two years.

ACTING COMMITTEE MEMBER LOFASO: I hear you. That's -- I -- that's a very responsive comment. I'm still trying to get my head around it, but I appreciate the response.

CHAIRPERSON FECKNER: Thank you.

Mr. Miller.

COMMITTEE MEMBER MILLER: Yeah. Thank you.

I hope also that in going forward and looking at this pilot, we're also looking at satisfaction, dissatisfaction, engagement of the people both participating and who also will find themselves having to choose another path and go to one of the other PPOs, because I still kind of -- just not having kind of a real understanding of what goes into making those premium changes, what goes into making these changes, my sense is the savings are primarily driven by performance improvements that relate to the physician-directed care, and whether you can ultimately tie that to value-added in terms of health outcomes remains to be seen.

But we do know that clearly in the industry that works in terms of managing and controlling costs. And that drives a lot of, I think, the desire to go there. And so I hope that we will really look at how this impacts our primary customers, our members, in terms of their experience with their health care providers, the delivery of the health care, and not just -- you know, it's kind of like we -- we're going to have a sale, so we raise the price so people will come to our sale when we knock some off for doing certain things.

And what I worry about most -- conceptually, I'm all for the ideas, but that our system doesn't ultimately continue to shift more of the cost disproportionately to

people who have the greater need for our health care delivery systems, people who have conditions that will cause them, more than likely, to be over those deductible caps, and who are least likely to be able to take advantage of those discounts for those VBID factors, people who most need out-of-network specialty care, people who most need the ability to be very agile at choosing what physician they see when who may be continually driven to the higher cost plans or options, if this doesn't meet their needs.

So I hope we'll really keep our finger on the pulse for those segments of our member populations, who will be most disproportionately impacted if things don't work out as we hope.

CHAIRPERSON FECKNER: Thank you.

Seeing no other requests, there is a motion before you.

What's the pleasure of the Committee?

COMMITTEE MEMBER MATHUR: I already made a motion, Mr. Chair.

CHAIRPERSON FECKNER: I said there's a motion before you.

So you have a motion on the floor. It's now up to the Committee to vote on the motion.

Ms. Mathur, you want to restate your motion?

COMMITTEE MEMBER MATHUR: Happy to, if that's helpful. My motion was to adopt the staff recommendation.

CHAIRPERSON FECKNER: Thank you.

So the motion now being before you, all in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries.

CHAIRPERSON FECKNER: Mr. Jones.

COMMITTEE MEMBER JONES: The component that we talked about the quarterly report coming back and possibly making changes before the two-year period, is that embodied in the motion?

COMMITTEE MEMBER MATHUR: I think that can be the direction.

CHAIRPERSON FECKNER: Ms. Bailey-Crimmins.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Mr. Chair, I took that as a Board directive --

COMMITTEE MEMBER JONES: Okay. All right.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: -- and I'll all note it as such.

COMMITTEE MEMBER JONES: Okay. Thank you.

CHAIRPERSON FECKNER: All right. This item is over. Thank you very much. Motion passes.

That brings us to Agenda Item 7, Retired Members

Cost of Living Report.

Mr. Suine.

BENEFIT SERVICES DIVISION CHIEF SUINE: Good morning, Mr. Chair.

CHAIRPERSON FECKNER: Microphone.

BENEFIT SERVICES DIVISION CHIEF SUINE: Wrong one. Sorry.

Good morning, Mr. Chair, members of the Committee. I'm Anthony Suine, CalPERS team member. And this agenda item is our annual informational item on the retiree cost of living adjustments, more routinely known as COLA.

And our retiremental law -- our retirement law allows for the payment of COLAs to all eligible retirees on May 1st of each year. And it's based on the rate of inflation as measured by the CPIU, which is the Consumer Price Index for all urban consumers.

To be an eligible retiree, you qualify for a COLA in the second calendar year of your retirement. Therefore, members who retired in 2017 are not yet eligible for a COLA. The rate of inflation, as measured by the CPIU for 2017 was 2.13 percent. More than 95 percent of all our retirees are contracted for a two percent cost of living adjustment. Therefore, all retirees will receive at least the two percent.

Because of low inflation over the last several years, retirees who retired between 2005 and 2015 will receive the full 2.13 percent, because they did not receive two percent in previous years.

For those less than five percent of retirees who contract for a three, four, or five percent COLA, they would receive at least 2.3 percent up to their contracted amount.

This agenda item provides a helpful chart for retirees to determine what their eligible COLA would be, based on the year in which they retired and their contracted COLA amounts.

We shared this information with our stakeholders last week. We also have this information in a fact sheet that's currently on our website. We will produce an article in our upcoming spring PERSpective, which is due out in April. And this informational will be updated on our IVR for members who call during the month of April. And this will also be a message of the month on all retiree checks, both paper and electronic direct deposit statements with the May 1st check.

So that concludes my presentation, and I'm happy to answer any questions.

CHAIRPERSON FECKNER: Thank you.

Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you, Mr. Chairman. Thank you Mr. Suine for the information.

But since now the PPP is also included in the May warrant, could you comment on that provision where the schools and the State receive -- continue to receive at least 85 percent of their purchasing power, and the public agencies 75 percent of their purchasing power, that will be included in that May 1st check?

BENEFIT SERVICES DIVISION CHIEF SUINE: Correct. So the Purchasing Power Protection Act[SIC], PPPA as it's referred to, works in conjunction with the cost of living adjustments. So in these instances where cost of living is catching up with lower inflation, then the PPPA will go down in certain cases, because now these retirees who were being sup -- supplemented for 75 to 80 percent of the purchasing power will now have cost of living adjustments that are catching up that PPPA, instead of PPPA kicking in.

So there's about 17,000 retirees. It usually takes about 25, 30 years of retirement for the PPPA to have to kick in. And so they work in conjunction with each other. And when COLA increases then the amount of PPPA being paid out will go down. And that will also be reflective on the May 1 retirement warrant.

COMMITTEE MEMBER JONES: Could you also provide a

fact sheet on the PPP.

BENEFIT SERVICES DIVISION CHIEF SUINE: There is, actually --

COMMITTEE MEMBER JONES: There is. Okay.

BENEFIT SERVICES DIVISION CHIEF SUINE: -- yes, on the website. Yes.

COMMITTEE MEMBER JONES: Okay. Thank you.

CHAIRPERSON FECKNER: Thank you. Seeing no requests to speak from the Board, I do have a request from the audience.

George Linn, please come forward. State your name and affiliation for the record, and you have three minutes to make your presentation.

MR. LINN: Good morning --

CHAIRPERSON FECKNER: Good morning.

MR. LINN: -- Committee Chair and Committee members. My name is George Linn. I'm President of the Retired Public Employees Association.

The cost of living index has been something that's been on my calendar for some time, and I noticed a couple of Board members shaking their head absolutely.

My concern is, one -- let me back up just a minute. I think the information on the website that has been presented this year is outstanding. And I'd like to applaud how well and interesting that is done, so that our

members can work their way through their calculations. So I think that is good.

However, the problem is that the Consumer Price Index that is currently used is a national one. We all know -- we live in California. We know what our cost of living increases are. They are different than they are in most of the rest of the country.

The State of California, our Governor says that we're the sixth economy in the world. That is obviously a greater economy than the rest of the states in the Union.

I know that this is something that has been attempted to be changed, because it is in law. And in 2002, it was attempted, and staff seems to be reluctant or - yes, I guess that's a good word - to again attack this issue.

I may be confused, but I always thought staff was here to help and be for the members. So I'm kind of confused as to why they are not really anxious to reinvent this issue that needs to be adjusted.

You know, there's a couple of examples. When I look at the salary increases for my staff, what do I use? I don't use a national index. I use what's going on in Sacramento. I don't know if you have this same news that I have in San Francisco, but in San Francisco we had on the news that it's almost impossible to rent a U-Haul

truck and take it out of the state because there is such an exodus from the state because of the cost of living. It's not because of absence of jobs. It's because of the cost of living.

The cost of renting a U-Haul truck to go outside of California is about five to ten times what it is if you're going to drive it from, let's say, Houston into the United -- into California.

So this is something telling me that we're not using the right index here. We need to use an index that is pertinent and appropriate for the retirees here in the state of California, which is 86 percent of the retirees that live in the state of California.

Thank you very much.

CHAIRPERSON FECKNER: Thank you.

Ms. Brown.

BOARD MEMBER BROWN: Thank you, Mr. Chair.

Following up on Mr. Linn's comments about the COLA or fixing the COLA, can we talk about what CalPERS can do to basically get that COLA adjusted, and when is the last time we had a COLA for the retirees?

BENEFIT SERVICES DIVISION CHIEF SUINE: So, Ms. Brown, the -- there has been a COLA last year, every year. There was one year when we did not have a cost of living adjustment, because the rate of inflation was less than

one percent. But other than that, there's been a COLA every year for the retirees.

Regarding the legislation. So this is in our law that we use the CPIU, the urban Consumer Price Index for all urban consumers. Any change to the cost of living adjustment would require a legislative change. And CalPERS -- the CalPERS team does not propose legislation that alters the benefit structure or costs -- retirement benefits structure or costs. So that's why we haven't put forward any change to that.

BOARD MEMBER BROWN: So we never do that?

CHAIRPERSON FECKNER: Never do what?

BOARD MEMBER BROWN: Never recommend legislation that alters the benefit costs?

BENEFIT SERVICES DIVISION CHIEF SUINE: That's our legislative policy.

BOARD MEMBER BROWN: No, I think we do.

DEPUTY EXECUTIVE OFFICER PACHECO: Sorry. Brad Pacheco, CalPERS team.

I believe the question is is if we ever recommend or sponsor legislation to make a benefit change? And our policy is is that we do not. CalPERS is the administrator of the fund. And that's really something that needs to be negotiated between the employee and the employers.

BOARD MEMBER BROWN: Thank you.

CHAIRPERSON FECKNER: Okay. Seeing no other requests to speak, that ends that agenda item. Thank you, Mr. Suine.

We are at our two hour limit. We need to take a break for our court reporter, so we will take a 10-minute break.

Thank you.

(Off record: 10:57 a.m.)

(Thereupon a recess was taken.)

(On record: 11:08 a.m.)

CHAIRPERSON FECKNER: Okay. We're going to call the Committee meeting back to order, please.

And we're on Agenda Item 8, Health Beliefs, First Reading.

Ms. Bailey-Crimmins.

Oh, Ms. Páles, please.

(Thereupon an overhead presentation was Presented as follows.)

HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: Good morning, Mr. Chair --

CHAIRPERSON FECKNER: Move the microphone in front of you, please.

HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: -- Committee members.

CHAIRPERSON FECKNER: There you go. Thank you.

HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: My name is Karen Páles, CalPERS team member.

Agenda item number 8 is an information item. And it's going to be the -- a continuation of our conversation and the development of the CalPERS Health Care Beliefs.

Today, the agenda includes our progress to date, the journey that we've been on, and our reading of the updated Beliefs along with our next steps.

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HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: I want to take just a minute to go over the progress we've made in the timeline. The team began our work last April and May with stakeholder outreach and a request for executive input. We then workshopped with the Board at the off-site in July and provided draft statements for your feedback and consideration.

We took that feedback and we workshopped with the executive team in August to further refine and update the themes and the belief statements. And then that information was used at our January off-site recently to workshop with the Board and executive team to come up with these more refined Beliefs that we're going to share with you today. And that brings us, of course, to today, which is the first reading of these Beliefs.

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HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: As I just mentioned, this journey started about a year ago. It's been an inclusive process, and we've been meeting with stakeholders all along the way. I'm going to spend a little bit of time sharing what we did in January. And then we'll walk through the refined Beliefs that the team is putting through today.

At the January workshop, the Board and executive team were split into four tables. And we were given the updated refined Beliefs from the executive workshop, along with the themes and some scenarios to consider. So each team was asked to consider the Beliefs in the context of some decision point scenarios. And the reason we did that was to help us decide whether the Beliefs were appropriate and complete.

After spending some time at each of the tables discussing the Beliefs, each table reported out to the larger group through a flip chart in discussion. There were some statements that everybody agreed across the room needed some reworking, but then, you know, there was actually quite a bit of consensus and agreement around the room on the theme areas and the general Belief statements.

So today, I'm going to walk through the teams, and then get to the further refined Beliefs after the January off-site workshop. And then I'm going to open it

up for comments from you on these refined -- this first reading version.

Today's discussion and feedback is then going to be incorporated into an agenda item for April, where we'll be able to hopefully finalize and improve the Beliefs.

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HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: On slide 5, we have the seven areas of -- theme areas that were actually brought forward to us through our stakeholder outreach. And we had consensus across the group that these are the right seven theme areas. The only thing that we changed here is that we moved Health Program Sustainability to the top of the list.

While this list is not in order of priority or importance, it was commented that sustainability is foundational for the program, so it really should at the top of the list.

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HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: While we worked to update the Beliefs after the January workshop, a couple of things caught our attention. We found some overlap and some redundancy in our Beliefs. As an example, CalPERS has a set of core values. We noticed that some of the values were actually being restated in our Health Care Beliefs. And restating the

values within the Belief statement seemed redundant and didn't offer the reader any real additional value or usefulness.

So we removed the values language from the body of the Belief statements, and decided to create and introductory sentence to the Belief statements as a whole. And that will help us tie together the core values with the work that we do every day and the Health Care Beliefs.

Looking the Attachment 1 of the agenda item, which is sort of a Health Beliefs one-pager, you'll see that this introductory statement is at the top there above the table, and within the table, you have the themes and their associated Belief statements.

This is actually the anticipated format more or less. We would have the introductory statement, and then the theme areas with the associated Beliefs to help people understand how they're being used.

We also noticed in our work that we had circular logic happening within the Belief statements. In some instances, we were unnecessarily restating the theme within the Belief itself. It's a little bit like defining a word with the word. So we did some clean-up in that regard also.

And since today is the first reading, I'm going to walk through each of the themes and the updated Belief,

including both the January workshop version and then the updated version. After I walk through all seven, we'll open it up for some comments and feedback.

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HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: The first theme area is Health Program Sustainability. So the workshop version reads, "Trustees, administrators, and all other fiduciaries must consider the long-term viability of the CalPERS Health Benefits Program when evaluating proposed changes, will be accountable for their actions, and must transparently perform the duties to the highest ethical standards".

We had consensus across the room that this was way too focused on financial terminology, and that we didn't really embrace the theme of sustainability the way folks thought we should. So and additionally, this is the Belief that has the core value language in it that we removed and put at the beginning to cover all of the Belief work.

So after considering all the feedback that we got at the workshop, we went back and tried again, and we wanted to make sure that it was Beliefs statement and not something that's action oriented, but more Belief oriented.

The revised version currently reads, "The

long-term sustainability of the health program is the foremost consideration when reviewing proposed changes to benefits, coverage areas, and costs".

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HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: The next theme are is High Quality Care. The workshop draft read, "Health benefit designs should help improved health outcomes by maximizing high value care and reducing unwarranted care".

We didn't really get lot of actionable feedback at the workshop on this, but we felt that it was a bit instructional. It really talked about the how through reducing and maximizing rather than the why behind it, which is to improve the outcomes.

So we did a little bit of work around that, and we also noticed that we were falling into the trap of unnecessarily having the theme also embedded in the Belief. So we took a look at that too. I don't know if you noticed, but we -- in the first one we say that for high quality care, we believe in high value care. They're awfully similar. So it seemed kind of redundant and a bit circular.

So we did a little bit of switch on this one too, and we came up with, "Health benefit plan designs must improve member health outcomes".

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HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: For Affordability, we had a lot of consensus across the room on this Belief statement. The original one reads, "Health premiums and out-of-pocket costs must be affordable and sustainable for members and employers".

The only thing we did here was to call out those two different stakeholder groups, because they have different purposes. So the revised version is, "Health premiums and out-of-pocket costs must be affordable for members and sustainable for employers", just for clarity.

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HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: The next theme area is Comprehensive Care. And in the workshop draft it says, "Health plans should provide access to essential and complete health care, and members have a responsibility to utilize it".

We actually got feedback from a couple of different tables on this particular Belief statement. The feedback really was around them wanting us to emphasize the need to promote healthy lifestyles and promote healthy choices, as well as a need to state something in the Belief about "complete" or, "appropriate", or "comprehensive" care.

So the refined statement currently reads, "Health

plans shall encourage healthy life choices and provide access to essential health care in a wide range of health services".

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HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: The next theme area is Competitive Plan Choice. The workshop draft reads, "Members should have access to competitive plan options among health plans, benefits, and providers".

This statement really didn't get a lot of chatter at the workshop, but we did tweak it a little bit to make it a little more comprehensive by adding the why portion. I think we should state in the Belief why members need to have this competitive plan choice.

So currently it reads, "Competition leads to favorable cost trends and increased value; therefore, CalPERS members shall have access to competitive options among health pans, benefits, and providers".

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HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: For the theme area of Quality Program Administration, we currently -- I'm sorry, we initially had, "CalPERS is responsible for quality administration of all aspects of the Health Benefits Program in order to meet the needs of stakeholders".

For the most part, the tables were pretty much okay with this Belief, but we did get some feedback, and it was around the idea of calling out customer service within the Belief. We agreed with that, so we looked for ways to call out within quality administration the quality -- or the customer service component.

So the current version reads, "CalPERS shall meet the needs of its many stakeholders with responsiveness, accuracy, and respectful service".

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HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: The last theme area is Policy Leadership and Advocacy. The original version for the draft -- for the workshop read, "As a leader in health benefit innovation and purchasing, CalPERS should engage in activities that influence health policies and affect the CalPERS Health Benefit Program".

So some of the feedback on this, we got a couple of good items that we should be sure to call out state, local, and federal within this Belief. And then there was also some talk about the need to call out the fact that we should align with like-minded entities in our work.

So the refined statement currently reads, "As a leader, CalPERS Health Program shall engage in activities that influence local, state, and federal health policy

landscape, and align with other entities who share our values". We thought that was a little more inclusive of the way that we really thought about our engagement activities.

So after I've walked through all seven, gave you some of the reasons why we made some of the changes that we made, I'd love to open it up and get some feedback on the current version of the statements.

CHAIRPERSON FECKNER: Thank you.

We have a couple of requests to speak, but I have a question first on -- I believe it's on a your page eight, the High Quality Care. Refined statement, "How Benefit Plan -- "Health benefit designs must improve member health outcomes". How is that measurable?

HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: It would be a population health measurement. But we can consider changing the word if you feel like it's too strong.

CHAIRPERSON FECKNER: I think the "must" in there, I think, throws something in there different for me, because what if my health doesn't improve. It had nothing to do with the health plan design.

HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: Um-hmm.

CHAIRPERSON FECKNER: So how do we use that word

"must", and yet focus on the fact that it's going to improve for everyone, and it may not? I just want to be cautious that we're making a statement we may not be able to support, so...

HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: Thank you.

CHAIRPERSON FECKNER: Ms. Taylor.

VICE CHAIRPERSON TAYLOR: Yes. Thank you, Mr. Chair.

So I'm kind of get -- I think I addressed these already, but I kind of am going to go through them as I marked them.

The Health Benefit -- the High Quality Care one, I agree with Mr. Feckner. I kind of think that, "Health benefit plan designs must improve member health outcomes". The better statement is the other one. I hate -- to me. "Health benefit designs should help improve health outcomes by maximizing high value care and reducing unwarranted care". And I think that that can be tweaked or maybe you can just add a "should" on the other one. I don't know, but I think that "help improve" is better.

(Laughter.)

VICE CHAIRPERSON TAYLOR: Affordability. So the original was, "Health premiums and out-of-pocket costs must be affordable and sustainable for members and

employers". The refined statement, "Health premiums and out-of-pocket..." -- and we talked about this -- "...out of pocket costs must be affordable for members and sustainable for employers".

I'm still kind of stuck on isn't it -- I mean it -- if it's not sustainable for the employers, it's not sustainable for the employees. And that's part of the reason they get out of -- you know, when our public agencies leave, that's part of that reason. It's because the employees are saying we can't pay for this. It's too expensive.

So, I mean, it's sustainability for both, but I mean -- maybe I'm splitting hairs, I don't know. And maybe the rest of the Board doesn't agree with me.

I think comprehensive care, I didn't really have a problem with that. Oh, come on. Am I losing the one that I really wanted to talk about?

Don't you love it when you can't find what you're looking for? Sorry about this, guys.

Somehow I erased it. Yay. I think it was the competitive -- yeah, there it is. The Competition Plan Choice. Members -- the original statement, "Members should have access to competitive plan options among health plans, benefits, and providers". And I think what we were thinking there when we were all working on that

was that, yes, we agree that being able to choose your hospital and doctors is very important. Health plans that offer those change -- you know, those doctors choices is what we want.

You changed it to competition within our health plans, which isn't, I think, where we wanted to go with that. And I'm not sure that we have proof that that is a cost savings, or at least it's never been presented to us that there's proof of cost savings.

And I think we did discuss over the phone when I had my briefing that I've seen research that shows that our cost savings have gone down as a result of the Affordable Care Act enactment, not necessarily the choice that we've instituted.

So I'm not sure that I'm feeling good about that one, because I also don't disagree with the single-payer option, and I've said that before. But -- and I know that's a long way off. And that's not where we're at, but I think competitive model health plans -- having so many health plans also lowers risk pools for everybody involved. It makes it smaller, and it makes cost -- to me, it doesn't necessarily make it as cost effective. So that's where I'm at on that one, and I don't know if I have any agreement with the Board on that.

I think those were all of them. Yeah, that was

it. So those are my concerns, and I don't know how I have agreement with the Board or not.

Thank you.

CHAIRPERSON FECKNER: Thank you.

Ms. Mathur.

COMMITTEE MEMBER MATHUR: Thank you. Well, first, I just want to -- I just want to thank you for the work on this. This is a very complex field, health care. And trying to come to a distilled set of Beliefs is no small task. And you've engaged the Board, and the public, and the executives and -- the executive team, and I know the Health Benefits Program, and -- to really come to, I think, a very strong set of Beliefs. I do have a few comments, however.

On the Comprehensive Care piece, I -- I think -- well, I guess what I'm concerned about is the wide range of health services, because we don't -- I don't think we're in the business of providing any health service that anyone can imagine. It's really about evidence-based services that we think -- that we -- that evidence shows adds value.

And so I think it's a little too broad at the moment. And one suggestion might be, "Healthy plans shall encourage..." -- "Health plans shall encourage healthy life choices and provide access to essential health care

and a wide range of evidence-based health services", or "health services that add value", or something around that I think would tighten that up -- would strengthen that a little bit.

On the -- on -- excuse me. On the High Quality Care, so maybe I'm going backwards, I really liked having the high value care -- "...maximizing high value care and reducing unwarranted care". I do think we have come to the belief that that -- those are key to driving both health care affordability and improved health outcomes. They're not just any strategies that we think will work.

And so I think embedding them into the Beliefs, you know, is important. So I guess I would resist taking that out of there. I think we could change -- you know, so -- whether "should help" is the right terminology or "should drive to improved health outcomes", would be better language, I don't -- you know, I can -- I can live with either one. But I guess I would stick with -- or closer to the original draft on that one.

But again, really -- really good work and thank you for all of your efforts.

HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Gillihan.

COMMITTEE MEMBER GILLIHAN: Thank you, Mr. Chair. I want to echo the comments of my colleagues up here. I know this is tough when you're trying to juggle input from so many different perspectives. And I think we've -- we're getting to a pretty good place.

A few comments. Relative to the High Quality Care slide, I want to agree with Chair, the Vice Chair, and Ms. Mathur. I think the -- where I would land on this is I think the prior version was better. And I'm comfortable with that as written, but -- and with respect to Comprehensive Care, I generally agree with Ms. Mathur's -- Ms. Mathur's comments on that one as well. And then with respect to the Advocacy, can we go to that slide?

HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: Yes.

COMMITTEE MEMBER GILLIHAN: The thing that stuck out at me was that local -- including local. I don't know what local policy is set with regard to health care, and to the extent it is, how it would even affect us. So I was just curious about that inclusion. I like the State and federal aspect of it, but I just question the need for local and -- so if you could explain, maybe I'm missing something.

HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF

PÁLES: We can make that change. It was just an attempt to be inclusive based on some of the feedback. And I believe that when we talk of local, we're thinking of our actual regional or California-specific, but not necessarily at the legislative -- at the legislative elevation, because when you think of advocacy, it doesn't only incorporate the legislation. There's so many things that are advocacy, so it can be us doing outreach even. That's local from our perspective.

So if you feel like it's too many areas, if it's, you know, too focused by putting the local in, it's still something we believe in in the larger sense. I think it's there, but it wouldn't hurt to remove it.

COMMITTEE MEMBER GILLIHAN: Yeah. My two cents is that I just don't know it affects us. And I wouldn't want us to get too diluted in our advocacy efforts when we should be focused on the ones that impact us, but that's all, but thank you for your work on this.

HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Miller.

COMMITTEE MEMBER MILLER: Yeah. I'm really impressed with how these have kind of evolved, and devolved, and evolved a little further to a few steps

further every time. And I really like them. I could pretty much just about say go.

There's a few little things, like everyone else, that I think could be improved. And on High Quality Care, just big picture, not so much a change to this, but to me quality is something that's kind of in the eyes of the beholder or the customer.

And so focusing on outcomes alone, you know, three airlines, they all get me from Sacramento to Pittsburgh, but the quality of the experience can be dramatically different. The same might go for restaurants or health care.

So that's something I think, as an organization, we really should be paying attention to. There's a lot more to the patient experience than, "hey, they didn't kill me. Hey, great outcome".

But as far as this specific statement, I think almost by just removing the word "by" and having it help improve health outcomes maximize health -- high value care and reduce unwarranted care might really make that go for me, for high quality care.

And then finally, competition and choice are not necessarily the same thing. Competition also implies a lot of negative aspects and inefficiencies in the bigger picture. And so I'm a little uncomfortable with the idea

that we just would make a blanket statement that competition leads to favorable cost trends and increased value. Ultimately, sometimes it can have detrimental effects and shake good providers out of the system based on costs and result in less choice for our members in the long run and less satisfaction.

So I almost like the idea of relooking at that whole idea in a way that we make sure we're not just purely focused on just accepting that as a given.

Thank you.

HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Lofaso.

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

Echoing all the comments on sort of what a challenge this is. I'll be honest, as I saw this, I guess I saw all of these getting increasingly high level. And I know that's the purpose of this exercise and I keep reminding me that this is a tiering structure from Beliefs to strategic plan to business plan to individual initiatives.

And when I look at it that way, I -- you know, there's not much to be concerned about. Clearly, there's

an interest in amplifying our focus on better outcomes and high value care. And as we saw in the last hour, the devil is in the details, and it will remain in the details.

I think the one that intrigues me specifically that gets to my second point, which is really the seventh one, because the seventh one doesn't quite have the same superstructure of Belief to strategic plan to business plan to initiative, because it kind of speaks to our advocacy efforts. And I know we've been struggling to sort of contain it. Originally, it was a benefit to the system, then it was a benefit to the member, now it's aligned with other entities who share our values.

But since the first -- the first six feed into the -- feed into the seventh -- I do think Ms. Taylor's observation and a little bit Mr. Miller's on competition is interesting, because in essence, we do have sort of a philosophical grounding is fundamentally a managed competition-based entity. Clearly, that is what aligns us with our -- those other entities referenced in number.

I guess that's true. I don't know if -- I mean, if you don't believe in managed competition, you believe in price regulation or something else. I don't know if reference price is -- reference pricing, is price regulation a competition since you can still go to the

higher non-referenced priced provider, if you want to.

It's sort of a philosophical discussion I only have to have with myself at the moment. But it warrants thinking a little bit about what our approach to competition is, because really the big issue outstanding for me is what's the superstructure that governs the policy leadership and advocacy component in Belief number 7.

Because again, I still think we have a lot of issues here about, you know, how much we get in the federal reports, how we get feedback, and, you know, trying to preserve the flexibility of the staff to be agile on use of resources. That's the big outstanding one.

I will say I appreciate the comment about local. On the hand, there are a lot of people trying to influence the health care system locally. Some examples are, you know, local initiatives to impose higher charity care burdens on hospitals, or, you know, local decisions on hospital districts that affect the provider network.

I can't imagine we'd get bogged down on one of those. But I trust if there was one that was pivotal to something that was important to us, staff should feel free. So again, the bigger picture point is not getting bogged down in detail. But I do think the superstructure

that supports Belief number 7 still needs some thought, not in the wordsmithing of itself, but in the background.

HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: That's an interesting comment, because some of the feedback on this particular one was that this one seems to be an outlier compared to the others.

You know, in the -- one of these things -- you know, like, what is it, six of these things belong together and one of these things is a little different. That's -- this is the one that's a little different, because it is a little bit more ethereal. And we do actually have business initiatives that fall under this, surprisingly enough, because we actually have a current business plan initiative that charges us to engage with the health plans in the community to help improve health outcomes.

So it's very interesting that there is some of the filtering down through the strategic, and the business plan, and the initiatives. Although it's not terribly clear to anyone who's not working right there with it. But, yeah, I think we could probably take another look at this.

ACTING COMMITTEE MEMBER LOFASO: Thank you.

HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: Um-hmm.

CHAIRPERSON FECKNER: Thank you.

Mr. Jones.

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

I'm not going to echo everything that's been said, but thank you for the fine work on this initiative. I kind of, you know, agree with Mr. Feckner about the must. And I think I kind of agree with everything Mr. Gillihan said, except one thing, and that was about deleting local, because I think that remembering when the Los Angeles Community College District was trying to decide whether to join CalPERS Health Program, the Board was asking questions -- and I wasn't there, but they shared with me what's the value proposition of joining CalPERS, and what influence that we will have in terms of sustainability hopefully, and cost measures, et cetera?

So it does have an affect on locals specifically when they're not only deciding whether or not to join, but also to continue to be part of the health plan. So I think that's the only agreement. Otherwise, I accept all of his recommendations.

CHAIRPERSON FECKNER: Thank you.

Mr. Slaton.

COMMITTEE MEMBER SLATON: Thank you, Mr. Chair.

So to build on what Mr. Miller was talking about

on the competition, I think there's a modifier missing there. And so, you know, it's either well thought out or well managed competition. So, you know, something that defines that you've really thought through that -- that we think through that before we just blanket say competition is the right thing. So maybe that's a fix for that particular one.

I want to go back to the first one Health Program Sustainability. And I would suggest that in terms of health care, unlike pension, you take out the words "long term". It's really about sustainability. And that sustainability could be some year-to-year sustainability, particularly in terms of affordability and access for our members and our retirees who, you know, they're not worried about, you know, is it going to be here 10 years from now. They're worried about this year, and, you know, whether they can get the physician they need, et cetera.

So I think it's really about sustainability that applies both in the short term and the long term. So that would be my recommendation on that one.

Thank you.

HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: Thank you.

CHAIRPERSON FECKNER: Thank you.

Seeing no other requests to speak, I have a

request from the audience.

Mr. Neal Johnson

And again, Neal, speak your name and affiliation for the record, and you'll have up to three minutes.

MR. JOHNSON: Neal Johnson, SEIU Local 1000.

Overall, we think this is a pretty good document. There are a couple of things that various Board members have mentioned that were also areas we had big problems -- or had some concerns about. The biggest one probably is the slide on competition. And, you know, unfortunately, I've -- fortunately or unfortunately, I've had the history of 25 years of -- or 30 years of the PERS health programs and how it -- there has been this change in philosophy on plan competition, provider competition, et cetera over that time. And I'm not sure that we have any particular evidence that one method has been better than another.

And then the other issue, I'm not really sure this is essentially a Belief, but more a method of implementing other Beliefs. So I think we would recommend you really think about eliminating it as a Belief.

Then the other issue deals with the High Quality Care one. And I think we feel the workshop -- the workshop draft was a better ex -- or more comprehensive, or better explanation of the Belief than the current refined statement, notwithstanding whether it should be

"must", or "should", or whatever.

But the other one really -- you know, Mr. Miller suggested dropping out "maximizing". I might suggest dropping out "help" and such that it says, "...designs should improve health outcomes by maximizing high value care, and reducing unwanted care". Clearly, that "unwanted care" component has really been important in trying to hold down cost and improve outcomes. You know, part of the adoption of the VBID program is another way to really control or minimize the unwanted care.

So, you know, I would ask you to go -- or whoever, to go back and rethink how some of these things are said. But otherwise, I think it's a fairly good document. Thank you very much.

CHAIRPERSON FECKNER: Thank you. I do have another request from the Board. Mr. Miller.

COMMITTEE MEMBER MILLER: I just -- I realize that I may have been misunderstood or misspoke. When I made my comment about High Quality Care, I was suggesting the workshop draft we should take the word "by", B-Y, out, and just make it, "...improve health outcomes, maximize health care and reduce unwanted care", high value care. So just make sure I didn't misspeak.

CHAIRPERSON FECKNER: Thank you.

Seeing no other requests to speak, thank you and

your staff very much. This is a great product so far, and we look forward to seeing you come back with more.

HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: Thank you very much. We appreciate all the feed back and discussion today. So we'll take all of the suggestions from today back to update the Beliefs and bring it back next month for a second reading, and we'll give it another go.

CHAIRPERSON FECKNER: Thank you.

HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: Thank you.

CHAIRPERSON FECKNER: That brings us to Agenda Item 9, 2019 to '23 Health Maintenance Organization Plan Solicitation.

Ms. Donneson.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Good morning, Mr. Chair, members of the Committee. I'm here to report and update you on the 2019 to '23 HMO health plan solicitation focusing on the contract, provider networks, and county coverage.

The phase 3 portion of the solicitation included a revamped 2019 to '23 contract, which we provided to Aetna, Anthem Blue Cross, Blue Shield of California, Health Net, Kaiser, United, and Western Health Advantage. And I do want to note that in the background of the agenda

item, we did not include Sharp, but they -- they're included. So we're very pleased to have them continue in the network as well.

Regarding the contract, this contract builds upon existing provisions that require pricing transparency in the form of capitation and fee-for-service payments. It also reduces complexity through an 18-month true-up after each contract year of the financial -- financial services.

It can -- for the financial portion of this solicitation, the financial plan consisted of proposed administrative services fees, and fees at risk for performance measures. And it also included information for Blue Shield and Kaiser Health Plan about their pharmacy programs.

Overall, the contractual negotiations have gone well, and we are shifting the team focus to the 2019 rate development process, where we will continue negotiating the financial terms.

Regarding Medicare, we will retain the 2018 lineup for 2019, so that we'll continue to address the combo enrollment issues with the least amount of member disruption.

Provider network coverage areas. Some changes are under consideration or -- for expanding or withdrawing from certain counties as noted on page two of this agenda

item.

I would like to make one clarification about the Health Net statement on page two. Health Net is considering to -- is considering withdrawing its SmartCare plan from Sacramento County, but it is not due to unfavorable provider rates with UC Davis. So I want to be -- make that clear. Health Net's decision is centered around the increasing costs in Sacramento County, and the acuity of the risk that they assumed in the last two years.

I'd like to talk about Aetna, and I'll bring up a map of Aetna's service area.

(Thereupon an overhead presentation was Presented as follows.)

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: While they're bringing that up, Aetna would be a new carrier for CalPERS. It proposes an HMO plan that covers 30 counties, mostly situated in Sacramento or the Bay Area and Los Angeles. The table on page two shows the zip code matches to the Aetna coverage area, which we have mapped and is here for illustration.

I'd like to have us also look at the coverage areas for the plans continuing, so that is the coverage area for our HMOs for this solicitation, at least for 2019.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Our next steps are to continue negotiations based on the financial terms as part of the rate development process.

This concludes my report, and I'm happy to answer any questions that you have.

CHAIRPERSON FECKNER: Thank you.

Ms. Mathur.

COMMITTEE MEMBER MATHUR: I think it would be helpful -- thank you for your presentation first. But I think it would be helpful to understand by what criteria do we consider inclusion of a new plan? And what are the pros and cons of -- I mean, do we want expanded service area -- coverage area? If it's redundant coverage area, what are the pros and cons of including a new plan?

Because it may be that it adds a lot of value in certain coverage areas where perhaps there's not enough coverage, they offer additional network, I don't know. But if they're -- but if it's just bifurcating pool and giving us less negotiating power in a particular area, there might be some cons.

So I think with respect to the -- to Aetna, which has such significant overlap with our existing coverage, I want to understand better what value does it bring to our

plan and to our members?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: And that's part of our ongoing evaluation for 2019, so --

COMMITTEE MEMBER MATHUR: Great. So that will come back.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: -- it was very well taken --

COMMITTEE MEMBER MATHUR: Okay. Thank you.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: -- and we continue to refine our analyses for all plans.

COMMITTEE MEMBER MATHUR: Thank you.

CHAIRPERSON FECKNER: Thank you.

Ms. Taylor.

VICE CHAIRPERSON TAYLOR: So thank you, Mr. Chair. Thanks for the presentation.

I think I'm sort of on the same page as Ms. Mathur. I didn't see on the table that you provided much of a significant difference of the areas that are already covered by our current HMOs by the addition of Aetna. So it doesn't appear that there's any significant difference. I mean, I think the highest significant difference was 90 percent, right?

So -- which brings me back to that competitive

plan choice that we talked about earlier. Why are we bringing in another plan that's not bringing us more choice or more areas to cover, especially for our rural areas? And then we are actually doing what Ms. Mathur said, we're bifurcating this pool. And I think that that takes the risk pool and pulls it apart, and then we don't -- we end up with higher costs, because they don't have as many people there insuring or as many healthy people. It depends on what the costs are, et cetera. But I would like to see if we even need to do this and that is a concern of mine.

But then I also had brought up earlier the Health Net SmartCare. So that wasn't the case that we -- you guys put in our books that it was leaving Sacramento County due to unfavorable rates, and that's not the case.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: It's part of the unfavorable risk that they received in terms of the enrollment that happened in 2017 and '18. So it's not related to the contract with UC Davis. It's just related to the risk that they have taken on in terms of Sacramento.

VICE CHAIRPERSON TAYLOR: So you're saying that --

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Sacramento area, not Sacramento County.

VICE CHAIRPERSON TAYLOR: -- the Sacrament area has a higher risk pool?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yeah, the region of Sacramento.

VICE CHAIRPERSON TAYLOR: It has a higher risk pool, is that what you're saying?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: No, it's not a higher risk pool. It's just that for Health Net, it was -- it's a higher -- it's a higher cost region for them.

VICE CHAIRPERSON TAYLOR: Okay. It's a higher cost region.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Sorry if I wasn't clear.

VICE CHAIRPERSON TAYLOR: Okay. And then the Anthem coverage for their Select was also -- was that also the same or is it -- is it because they're -- they're dropping UC Davis?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Correct.

VICE CHAIRPERSON TAYLOR: Okay. And it's because of UC Davis --

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Correct.

VICE CHAIRPERSON TAYLOR: -- and them not coming

to an agreement.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Correct.

VICE CHAIRPERSON TAYLOR: Okay. So we didn't -- we don't have anybody taking place of those two health plans, except maybe Aetna. We don't know that for sure yet.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Blue Shield traditional, Anthem HMO.

VICE CHAIRPERSON TAYLOR: The ones that we're already accepting.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Right, PPOs, yes.

VICE CHAIRPERSON TAYLOR: Okay.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yes, there's coverage for UC Davis.

VICE CHAIRPERSON TAYLOR: Okay. And I don't know if you want to opine on what Ms. Mathur and I were talking about. But if you are analyzing it already for whether or not you're going to keep Aetna in the pool or not.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Exactly. This is really an update on the contract provisions, not necessarily on the financial provisions.

VICE CHAIRPERSON TAYLOR: Gotcha.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: So we continue to look at our situation in terms of administrative services fees, performance guarantees, and first -- kind of first looks at what the 2019 rates are going to look like. So that has to be part of the calculus.

CHAIRPERSON FECKNER: Okay.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: And just for the Board members that are fairly new, just how this works is every five years we come through a solicitation for HMOs, and we do the terms of the contract, the financial piece is the second phase. And then whoever passes that goes into the rate development process.

So the decision on Aetna they've obviously agreed to the terms, but there's several other checkpoints that they have to get through in order for this Board to approve them as a plan moving forward on behalf of our members in June.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: One other -- one other aspect of the five-year solicitation is we do have provisions that plans can come forward in later years and make proposals. That may be good and beneficial for CalPERS.

CHAIRPERSON FECKNER: All right. Thank you.

Mr. Lofaso.

ACTING COMMITTEE MEMBER LOFASO: Thank you, Mr. Chair. Just a little bit in the same vein. Can you educate me a little bit. Clearly we're -- big issue, we're all focused on is the somewhat inequitable geographic distribution of plan choices. Can you give me a sense as to how much we found ourselves in the driver's seat to say, "Hey, plan, we like you. Do you want to come participate in our pool? But we'd really, really like you to extend out over here, here, and here where we're trying to cover. And we're good over there, because you'll probably be the fourth carrier, and three to four is pretty good. But this county, that county, and the other county, you know, pretty saturated, you know. Prefer, you know, you stayed out of there just to not up-end our pool". How -- how pushy are we in that?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Every year, and this occurred in the last five year contract too. As part of the rate development process, we do go out and ask them to talk about different areas they are thinking of expanding to. And they do. And sometimes they contract. And they did that. It might not have been as noticeable over the last five-year contract.

But we're looking for, from my perspective, from the HPAD perspective, we're looking for options in

multiple geographies in terms of HMOs, because HMOs are regulated by the DMHC. And so it's -- it's difficult to say let's push further north say into Glenn County, because the DMHC regulations just don't provide for that approach.

So we do look at the networks, so -- because it's not just about the plans, but also the provider networks. And part of that examination is not necessarily plan competition, but provider competition. So the providers are also, that are affiliating with these plans, competing for our members.

Now, the beauty of our designs is that it's not really competitive based on HMO plan design, because our plan designs have been aligned and standardized. Our contracts have been aligned and standardized.

So what we look at in network coverage, we look at the mix of capitation to fee-for-service, plans that are high -- more highly capitated. And that includes dual capitation that adds hospital capitation. That's desirable to us. So we look at mix of fee-for-service, mix of capitation, coverage area, competition across California, availability of HMOs in specific areas. Not every HMO is in every area. So that's how we look at it.

ACTING COMMITTEE MEMBER LOFASO: Thank you. And my other question is -- is -- are the provisions for ACA

taxes part of the administration fee, or should I just ask what's the approach to ACA taxes in the new solicitation?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Do you want --

ACTING COMMITTEE MEMBER LOFASO: Pay 'em if they're -- pay 'em if they're applicable, don't pay 'em if they're suspended for a year?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: The -- They're not -- the taxes in the current 2019 ACA fees are not -- not exist -- they do not exist, because they're not going to be charged. However, we do have provisions that should -- not necessarily these taxes, but future taxes come back, that we evaluate that as we would any other ACA provision in terms of how we incorporate it into our plan designs and our premiums.

ACTING COMMITTEE MEMBER LOFASO: And just for transparency sake, are those subcomponents of the administrative fee, or are these stand-alone components on the -- in the rate negotiation?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Let me see if Ben or David want to answer that. Come on up here, counselor.

ACTING COMMITTEE MEMBER LOFASO: And if that becomes a closed session question, I -- you can -- you can --

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: That's why I'm going to ask him to help me.

ACTING COMMITTEE MEMBER LOFASO: -- you can -- yeah.

SENIOR STAFF ATTORNEY VAN der GRIFF: We would probably recommend that we would take that question up in closed session --

ACTING COMMITTEE MEMBER LOFASO: Okay. Thank you.

SENIOR STAFF ATTORNEY VAN der GRIFF: -- since it does deal with financials.

CHAIRPERSON FECKNER: Please identify yourself.

SENIOR STAFF ATTORNEY VAN der GRIFF: Oh, I'm sorry. David Van der Griff, CalPERS legal counsel.

CHAIRPERSON FECKNER: Thank you.

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

CHAIRPERSON FECKNER: All right. Thank you. Seeing no other requests, that brings us to Agenda Item 10, Summary of Committee Direction.

Ms. Bailey-Crimmins.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Mr. Chair, I took two items. One is to invest -- investigate enhanced member capabilities to compare plan benefits. That was action item we took. And the other is to provide

the PHBC quarterly updates on the VBID implementation starting March of 2019, because it's actually getting implemented January of 2019. So March will mark the first quarterly update.

CHAIRPERSON FECKNER: Very good. Thank you.

Agenda Item 11, public comment. We have one request from the public. CT Weber, please come forward. Not here.

VICE CHAIRPERSON TAYLOR: No, there he is.

CHAIRPERSON FECKNER: Oh, there we go.

Thank you.

Please identify yourself for the record and you'll have three minutes for your presentation.

MR. WEBER: Yeah. My name is CT Weber. I'm a member of several of the organizations represented here today, but I'm speaking as an individual, because I wanted to speak on an issue that I just read in the paper yesterday. And that was I was sort of disappointed to read that the CalPERS Board has rejected the opportunity to divest from illegal arms dealers.

To me, I think that's sort of an assault. Right now with the assault weapons becoming more available, and faster the ability to kill and wound more people is increasing. And there's a movement growing to restrict this killing -- these killing machines.

I know you have a fiduciary responsibility, but I think you also have a moral responsibility. And I think that these two are in conflict. And sometimes I kind of wonder about the fiduciary responsibility of CalPERS anyway, because we're in a little bit of a financial crisis anyway.

So I just want to say that there is a thing out there called social investing. I'm sure you're well aware of it. I think sometimes it gets greater results, and some that I see we're getting today.

That's it. Thank you.

CHAIRPERSON FECKNER: Thank you.

Seeing no other requests to speak, we will adjourn the open session and we will go into closed session in 10 minutes.

Thank you. See you next month.

(Thereupon the California Public Employees' Retirement System, Board of Administration, Pension & Health Benefits Committee open session meeting adjourned at 11:57 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 26th day of March, 2018.

JAMES F. PETERS, CSR
Certified Shorthand Reporter
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