MEETING

STATE OF CALIFORNIA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

BOARD OF ADMINISTRATION

PENSION & HEALTH BENEFITS COMMITTEE

OPEN SESSION

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A P P E A R A N C E S

COMMITTEE MEMBERS:

Ms. 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

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STAFF:

Ms. Marcie Frost, Chief Executive Officer

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Ms. Liana Bailey-Crimmins, Chief Health Director

Mr. Matt Jacobs, General Counsel

Ms. Donna Lum, Deputy Executive Officer

Dr. Kathy Donneson, Chief, Health Plan Administration Division

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

STAFF:

Ms. Jennifer Jimenez, Committee Secretary

Dr. Melissa Mantong, CaPERS Pharmacist

Mr. Karen Páles, Assistant Chief, Heath Policy Research Division

ALSO PRESENT:

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

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 afternoon, everyone. We're going to call the Pension and Health Committee meeting to order.

The first order of business will be to call the roll, please.

COMMITTEE SECRETARY JIMENEZ: Rob Feckner?

CHAIRPERSON FECKNER: Good afternoon.

COMMITTEE SECRETARY JIMENEZ: Theresa Taylor?

VICE CHAIRPERSON TAYLOR: Here.

COMMITTEE SECRETARY JIMENEZ: Matthew Saha for John Chiang?

ACTING COMMITTEE MEMBER SAHA: Here.

COMMITTEE SECRETARY JIMENEZ: Richard Gillihan?

COMMITTEE MEMBER GILLIHAN: Here.

COMMITTEE SECRETARY JIMENEZ: Henry Jones?

COMMITTEE MEMBER JONES: Here.

COMMITTEE SECRETARY JIMENEZ: Priya Mathur?

COMMITTEE MEMBER MATHUR: Here.

COMMITTEE SECRETARY JIMENEZ: David Miller?

COMMITTEE MEMBER MILLER: Here.

COMMITTEE SECRETARY JIMENEZ: Bill Slaton?

COMMITTEE MEMBER SLATON: Here

COMMITTEE SECRETARY JIMENEZ: Alan Lofaso for Betty Yee?

ACTING COMMITTEE MEMBER LOFASO: Here.

CHAIRPERSON FECKNER: Thank you.

Next item is the Executive Report.

Ms. Bailey-Crimmins and Ms. Lum, please.

DEPUTY EXECUTIVE OFFICER LUM: Good afternoon, Mr. Chair. Donna Lum, CalPERS team member.

This morning in my executive report, I wanted to take the opportunity to share with you some highlights of some of the work that we've been doing with our employers. From month to month I tend to share a lot of information with you about what we're doing to service our members. However, our employers, as we also refer to as our business partners, are a real key part of the organization and the services that we provide. So in my report I want to share with you things that we've been doing to specifically increase our engagement with the employers, how we provide education, what we're doing to increase compliance to avoid audit findings, and ultimately a number of things that we're doing to enhance their experience with us.

So for some of you that have been with the Board for a while, you know that during a stakeholder survey that was done in 2012 we received a lot of feedback from the employer community, with specific information on how we could improve the services that we provide.

And the one thing that was very common in the feedback that we received is our employers wanted a specific individual that they could contact consistently whenever they had sensitive or urgent inquiries; someone that they knew would be able to follow the inquiry from end to end and provide a timely response. So we set out with criteria that was very different and why employers would call this group versus the contact center. And from that to experience -- came what we called the employer response team. We launched the employer response team in 2013; and since then, our response team has helped, you know, hundreds of employers very satisfactory in resolving their critical needs.

While we figured that that would be one good use of our resources, we also identified that we needed to do something that was more proactive, and we needed to find a way that we could reach out to the employer community to determine what else could we do; what were their pain points; and from a customer service perspective, where did we need to focus our time and attention. As a result of that, we then created what we called the employer response dialogues. And these dialogues are set up as very small venues where we could interface with our employer community on a small -- in a small scale, but on very, very important items.

We launched the employer response dialogues and we host them at all of our of regional offices and sometimes in remote locations where we know that we have employers that are interested in dialoguing with us but would have a longer commute to do that.

Over the past few years, again we have implemented several of the dialogues; and the survey responses that we get from these dialogues have been really good. They are exceeding 90 to 95 percent in the satisfaction.

But just to give you an idea some of the topics that we talked about: So in 2013, obviously PEPRA was the main issue and we were helping the employers kind of navigate through and understand what was being required of them.

From there, you know, we had a number of things with regards to what are the common audit findings; how can we help you with that; how can we help you with working-after-retirement issues, reciprocity issues; all the way through 2018 where we've had team members from our Actuary Office who have joined us at these ERDs and who are talking about things like the amortization policy as well as asset liability management.

So I think it's been a really important venue for us and mechanism for us to do face-to-face communication

with the employer community, and we know that they're very appreciative of that effort.

In addition to that, since we do have a small team that travels to host these response dialogues, we also do some research before we go out there to identify if there are other employers in the same general geographical area that have special needs. Either they have dialogued with us around some audit findings or some very complex issues that are -- we would need to discuss with them one-on-one as opposed to even in a smaller venue.

And I'm happy to say that as we have done this travel and have gone out to the ERDs, over the last year we've hosted more than 17 of those one-on-one meetings, and what we've been able to see is a really good response from the employers. They are able to address those complex issues. We're seeing audit findings that were aged, that were taking quite a long time, primarily because they didn't know the right questions to ask and they didn't know who to go to to get information; and we're seeing things like that being closed.

So those are just a couple of the things that we've been doing very proactively in going out and reaching and having these face-to-face dialogues. But we've also been marketing some of the other education

opportunities that we have. Our employers know that we have the Ed Forum. We also have on-line education that they can participate in; as well as whenever we receive interest from an employer who may be wanting to host, for example, a retirement fair, we do send team members on site to be able to help with that.

Specifically more recently we know that there are some schools that have had some special needs; they have large retirements that are taking place. And there again, we send our team on staff and on -- on a site and they're able to help with the retirement applications and help with doing counseling right there on site.

Another just example of where we're seeing benefits from this direct outreach that we've been doing. In past years we know -- we've had a number of issues with employers submitting payroll timely. And when CalPERS doesn't receive timely payroll, it impacts a number of things and that includes member benefits from being paid timely. I'm happy to say that with all their outreach we've been doing on payroll-specific items, as well as the increased capabilities that we've had with the my|CalPERS system, nearly 100 percent of the employers are submitting their payroll timely. This avoids things like fees, because we recently implemented legislation that would enable us to assess fees when timely -- when a payroll

isn't submitted timely. But I think more important, not only just getting this interaction and the payroll timely, it's the partnership that we are forging with our business partners, our employers, through all of these interactions.

So, again, I just wanted to take a little bit of time out of my executive report just to give you some insights to I think a lot of the great work that the team has been doing with our business partners.

That being said, I also wanted to share some information with you, as I always do each month, with regard to our latest CalPERS Benefit Education Event. On March 23rd and 24th we held the CalPERS Benefit Education Event in Redding, California, one of the most northern points of California that we go to with this event. This is considered to be one of our most remote locations because the nearest regional office is here in Sacramento, and it's about a two-and-a-half-hour drive. We served well over 750 members at this location. And again, it's always nice to have the team interact with members; and we snow that they really appreciate the work that has been done out there.

During our CBEEs we issue surveys, and we're also pleased at each of the sessions to review the surveys. They provide us with very constructive feedback on things

that we can do to improve sessions, but they also give us feedback on how well the session has been conducted.

So with that, I just wanted to read to you one of the statements that we got back on one of the surveys from an anonymous member. And it said: "I am amazed at the magnitude of this seminar. It's much more than I expected. And thank you."

And I think it's a real good sentiment of again the interaction, the work that the team is doing; and we know that the members appreciate these events. It does take a lot of -- throughout the enterprise, not just in the customer service teams, but we have many other groups that participate.

So, we did -- again, the team was very pleased to see Mr. Feckner there at the Redding event.

And just to remind you that our next event is going to be held on May 11th and 12th, and that's at the Olympic Valley in -- up here in California.

So, Mr. Chair, that completes my report. And I'm happy to take any questions that you may have.

CHAIRPERSON FECKNER: Thank you. And I do want to say that, when I went into the general session, it was nice to see that you had a trailer up there before -- on the screen before the session started, like trivia questions and things. Would have better, the Steamboat

Willie cartoons. But, you know --

(Laughter.)

CHAIRPERSON FECKNER: -- it was neat to see a lot of questions and answers coming up on the screen that would help educate the members before the session even started.

So pass that along please. I thought it went well.

DEPUTY EXECUTIVE OFFICER LUM: Thank you.

CHAIRPERSON FECKNER: All right. Seeing nothing else.

Ms. Bailey-Crimmins.

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

For my opening remarks I have three highlights that I'd like to provide to you.

The first is regarding an update related to the ongoing develop -- Dependent Eligibility Verification process.

The second is regarding Kaiser Permanente. Our members have been asking about Senior Advantage and when potentially they might be expanding. So I thought it would be nice to provide you just a quick little update on that.

And then last, just to share some highlights that you should be expecting from today's agenda.

So the first is the Dependent Eligibility and Verification Project. CalHR and the California State University, also known as CSU, contracts with CalPERS to notify members of the requirement to verify dependents that are utilizing health benefits. And we do this every three years.

The scope encompasses State and CSU active and retired members. It does not include public agencies and schools. And in February, CalPERS sent out 14,000 letters to subscribers that have an April birthdate. And this encompasses about 35,000 dependents.

Notices were sent out to subscribers at a 90-day, 60-day, and a 30-day interval. It instructed them to provide the necessary information to the State and CSU human resources offices as they work for to avoid any dependents from being removed from their health plans.

To date, CalHR and CSU have successfully verified that 75 percent of the dependents have been verified. There's still 25 percent that need to be verified between now and April 30th.

If a State or CSU member has not received a validation letter, I just want to remind everybody this is a three-year process. So once you've been validated, then

the clock starts ticking for another three years.

So if you just happen to wonder where's my birthday, my mailing schedule, you can find this information on the CalHR and the CSU website.

The prior validation project, maybe -- I don't know if you're aware -- was actually done by an external consulting firm. That has now transitioned to internal staff and is being done by CalPERS.

But CalPERS believes in continual improvement, so this first batch of 14,000 letters -- we heard from our stakeholders, and we will be making a few changes. The most prominent is to revise that third letter, that 30-day notice. We think that we need to clarity some due dates. And also to align with the prior tone of the prior two notices. So it enhances communication and hopefully prevents any confusion that might happen for the member that receives that.

And for retirees, we will be initiating the process later in the year. If they are interested in knowing more about that, that's available in the spring perspective that was just submitted -- published. And as the date approaches, I promise it will be giving you some more information as that approaches us.

Now, Kaiser Senior Advantage, our stakeholders have been asking when is CalPERS expanding that program?

We reached out to Kaiser, and they did tell us that they are strongly committed to the Medicare program and they definitely intend to expand in the future. But what we wanted to let everyone know is that per CMS rules, which is the Centers for Medicare and Medicaid services, based on regulations, Kaiser's not permitted to discuss their 2019 offerings until October of this year.

Once October hits, we'll then be able to let everyone know where those expansions are going to be occurring.

And then today for the Pension and Health Benefits Committee there are three agenda items that I'm going to first highlight.

The first is a second reading of the CalPERS Health Beliefs. Great work takes time, and February marked the one-year anniversary since we introduced the desire to establish a set of CalPERS health beliefs.

This was a very inclusive approach. We thought it was important that our stakeholders had an opportunity to, you know, have a voice in this process and that include members, employers, CalPERS team members, executives at the Board.

Second, CalPERS now believes it's time to expand our reference pricing model. It's been very successful, but we now think it's time to start looking at

pharmaceuticals by therapeutic class. And so today CalPERS will be discussing a pilot for three therapeutic classes. Dr. Kathy Donneson and her team have researched and worked hard to establish a pilot that:

1) Reduces the need for prior authorizations;

2) Ensures that it reduces the member out-of-pocket cost and is another step towards our goal of reducing the cost of pharmaceuticals in the future; and,

Lastly, for our preferred provider organizations, also kindly known as PPOs, the CalPERS team will be providing you an update on the 2000 benefits. The benefits that you had voted in last year just became effective in January, so we're going to give you a quick update on that, and highlight some recommended changes for 2019.

Please note that there are two new preventative care benefits that we will be recommending: Wisdom and Spine Care. What's unique about this is there is no effect on the 2018 premiums so we will actually be able to implement them the latter part of this year.

And for our members, good news, there will be no copay for the "are deemed preventative" services. And you're going to learn more about those programs when the agenda item is in front of you in just a few minutes.

Mr. Chair, that concludes my opening remarks.

And I'd be happy to answer any questions.

CHAIRPERSON FECKNER: Thank you. Seeing none.

Item 3 is an action consent item.

What's the pleasure of the Committee?

COMMITTEE MEMBER MATHUR: Move approval.

VICE CHAIRPERSON TAYLOR: Second.

CHAIRPERSON FECKNER: Moved by Mathur, seconded by Taylor.

Any discussion on the motion?

Seeing none.

All in favor say aye.

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no.

Motion carries.

Item 4 is the consent items.

Had no requests to move anything off of the consent.

Brings us to Item 5, Health Beliefs - Second Reading.

Ms. Páles.

(Thereupon an overhead presentation was Presented as follows.)

HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: Good morning, Mr. Chair, members of the Committee. Karen Páles, CalPERS team member.

Today I'm here to continue our conversation about the CalPERS health care beliefs by presenting Agenda Item Number 5, and that's called Health Care Beliefs - Second Reading. And this is an action item.

Today agenda is going to include

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HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: Today's agenda is going to include looking at our progress, discussing the beliefs updated with feedback, and looking at our next steps.

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HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: Taking a look at our timeline just as a quick refresher.

The health team began our work on the Health Beliefs a little over a year ago with our stakeholder outreach, and we also included some workshops with CalPERS Board members and our executives. And that ended last on the work we've done together over the last 14 months, which included the January off-site workshop. You provided valuable feedback to us and suggestions on the refined beliefs statements. We incorporated your feedback to land on the beliefs that you're going to see here today.

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HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: For our conversation today, I'm going to walk through each of the revised statements, providing some insight about any changes, and then we're going to discuss the options that we're putting forward today, and then open it up for some discussion, and then finally ask you to take action.

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HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: The framework on the beliefs is -- actually remained the same from January through today. Although the beliefs statements they've actually evolved over the course of our discussions and your feedback. And that makes sense. The theme areas have actually stayed the same, which also makes sense because they are a product of the stakeholder outreach and the Board and executive input that we received about the theme areas that are appropriate for health belief development.

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HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: The first theme area is health program sustainability. On this slide you can see both the January workshop draft and last month's first reading version. When we discussed the theme area last month the Committee was pretty comfortable with the overall March

version. The suggestion for improvement was to eliminate the words "long-term," because when we think about sustainability it's both the short-term and the long-term that are important to CalPERS. So we accepted that suggestion, and the revised version reads that 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 second theme area is high quality care. We have both the January workshop and the first reading version here. This theme actually had quite a bit of discussion in March at the meeting. Based on the conversation, we seemed a lot closer in our March -- in our January version than we were in our March version. So we actually revisited the January writing.

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HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: And then we had an improvement from your feedback to remove the word "must" and replace it with the word "should."

So that currently reads: "Health benefit plan designs should improve member health outcomes, maximize quality, and reduce unwarranted care."

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HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: Next up is affordability. As you can see here, the January and the March versions were pretty similar. The difference was to separate in the March version the affordability and the sustainability based on the stakeholder group. And similar to the high quality care, there was more preference for the January version. So we've actually reverted back to that, and it now says, "Health premiums and out-of-pocket costs must be affordable and sustainable for members and employers."

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HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: Our next area is comprehensive care. There was some really great conversation on this theme last month and the Committee seemed fairly comfortable with the overall theme. The suggestion with -- to improve it was to key in on evidence of evidence-based medicine or evidence-based health care. So that's something that we took back; and we realized that CalPERS advocates for that in our health plan, so it makes perfect sense to include it in our health care belief.

So the belief statement currently reads that "Health plans shall encourage healthy life choices and provide access to essential health care and evidence-based

health services."

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HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: For competitive plan choice, when you look at the January and the March versions, most of the conversation really focused around the different perspectives on the terminology competition.

When we started our conversation about health care beliefs, you may remember that we talked about lenses, and that the same issue looks very different depending on the lens that you use to look at it.

As a purchaser through that lens, CalPERS uses competition between our plans to help drive cost containment and innovation.

While at the same time with our member lens, we know that we need to have competitive options for our members in their care, which is something we heard very loud and clear from them in our outreach sessions last year.

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HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: So taking the Committee's suggestion, the revised version now reads that "CalPERS shall manage competition among health plans to help both drive cost containment and give members access to options among health plans,

benefits, and providers.

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HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: For the theme area Quality Program Administration, the Committee seemed pretty comfortable with the March version, so we're just going to move forward with that.

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HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: And it 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 of the seven theme areas that we have is Policy Leadership and Advocacy. This statement actually had quite a bit of conversation last month. And we took that feedback and went back and thought about it. And you may recall that at the July off-site we provided to the Board - what would I want to call them - ranked stakeholder themes in importance to our stakeholders. And you might also recall that when we looked at the top priorities for our stakeholders, this was not one of their top priorities. But it was a top priority for the Board, the executive team, the health team, because we recognized that it's a critical path to getting at those other theme

areas that percolated up through our outreach efforts.

So as the other theme areas were combined through our work and they boiled down to their current version, this one really stayed the same. And I think it's because it was a little bit different. And I think that that might be why it feels different, is that it was really a critical part of how we think about health and what we believe that we do, but it wasn't really in those top sort of one-off -- you know, affordability, quality. This was a much more strategic belief area.

So this leads to the two options that we're bringing forward today that --

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HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: There's two ways we can go. So we can keep the policy leadership and advocacy as a theme with its own belief statement, or we can move it to the introductory text that we have for our beliefs. That lays out the foundational principles that we operate under, sort of the bedrock for our beliefs statements.

And so you could leave it as it is and have a belief that reads: "As a leader of the CalPERS Health Program shall engage in activities that influence the state and federal policy landscape and align with other entities who share our values."

The other option would be to move it to the introduction area where we lay out CalPERS Core Value impact on our work, the approach that we take, and sort of our foundation for how we approach our work. And if we did that, then it would read: "CalPERS Core Values are engrained in the work that we do every day. These values drive us to be transparent, accountable, and ethical to achieve CalPERS goals. As a leader, the CalPERS Health Program shall engage in activities that influence the state and federal policy landscape and align with other entities who share our values." And then we would enumerate the other six values underneath -- the other six beliefs underneath.

So the two different options are laid out for you in option 1, which is on Attachment 1, and option 2 is on Attachment 2. We're actually recommending option 1, which is to have this statement as part of the introduction; and primarily that's because the policy leadership theme is a little bit different from other belief areas and the policy leadership theme seems a little more strategic in nature. So that's why we thought it would be, from our perspective anyways, a little bit more of a tool to achieve our other theme belief areas.

Does that make sense?

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HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: So at this point we've walked through each of the theme areas and the options that are available. And I would very much like to open it up for discussion, and then we'll move on to finalizing the beliefs. And after you make an approval of a set, we will work with Public Affairs to get those beliefs published. So if you have any feedback for us.

CHAIRPERSON FECKNER: Thank you.

Before I go to questions I do want to say I want to thank you and your staff for listening to the Committee last month and taking a lot of information back and coming back with I think was a very fine product. So thank everyone for a job well done.

HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: Thank you very much.

CHAIRPERSON FECKNER: Ms. Mathur.

COMMITTEE MEMBER MATHUR: Thank you.

Well, I agree. I think the process was very effective and got us to a place that I'm very comfortable with. So I am prepared to move option 1. I guess that is my motion.

COMMITTEE MEMBER SLATON: Second.

COMMITTEE MEMBER MATHUR: I just want to suggest that option 1, which incorporates the policy -- I'm sorry,

the seconder was I think Mr. Slaton -- that incorporates the legislative engagement is a departure from what we did on the Pension Beliefs. So we might want to revisit the Pension Beliefs at some point. I mean, I can't remember -- it's been a few years since we looked at them in any case. But at some point we might want to revisit them and just align them or...

But thanks.

CHAIRPERSON FECKNER: All right. We have a motion before us, moved by Mathur, seconded by Slaton.

We have a few other people who wish to speak.

I just want to make sure everybody's clearly understanding. You explained which the option 1 is as compared to this last item?

HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: Yes. Option 1 has the policy leadership in the introductory verbiage because it's a foundational bedrock piece of what we do to accomplish the other belief areas.

CHAIRPERSON FECKNER: Very good. Thank you.

Mr. Jones.

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

I can support option 1. But I do have one question on high quality care. The term "unwarranted care." We had a lengthy discussion at the off-site, and I

thought it was an agreement that we were removing that and replacing it with "unnecessary care." So when did it come back to unwarranted? I just remember a lengthy discussion on that.

HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: Actually part of the discussion last month was to have "unwarranted care." It's just a terminology that we typically use. When we're looking at care that is not nec -- we actually discussed inappropriate, unwanted, unnecessary. There were quite a few words that were thrown out for this particular belief. And last month it came back with some comments that we should go back to the maximizing high value and reducing unwarranted because we talk about that in so many other areas of our health program.

COMMITTEE MEMBER JONES: Okay. I just think "unwarranted" is not the -- because we all want health care.

HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: Well, it's not "unwanted," it's "unwarranted."

COMMITTEE MEMBER JONES: Warranted, okay.

CHAIRPERSON FECKNER: Thank you.

Ms. Taylor.

VICE CHAIRPERSON TAYLOR: Thank you very much.

I want to also thank your team for working so

hard on this. I know we were going back and forth for each session and making sure that we were understood, and you guys came back. And I just thought the process was really a great process. So I also would support option 1.

So thank you very much again.

HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Lofaso.

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

Just one minor comment. Ms. Páles, in your narrative on the competitive plan choice item, you referenced both cost containment and innovation, but there's no mention of innovation in the belief. Is that -- is that an intentional iteration in the process I missed or --

HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: No, its just my personal take on what that means to our program.

ACTING COMMITTEE MEMBER LOFASO: Okay. It was persuasive. I thought adding "innovation" might make sense, but I'll leave that to the Committee.

Thank you.

CHAIRPERSON FECKNER: Very good. Thank you.

Seeing no other requests.

We have a motion before us.

All in favor say aye.

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no.

Motion carries.

Thank you very much.

HEALTH POLICY RESEARCH DIVISION ASSISTANT CHIEF PÁLES: Thank you very much.

CHAIRPERSON FECKNER: Job well done.

Brings us to Item 6, Strategy for Reference Pricing Pharmaceuticals.

Ms. Donneson.

(Thereupon an overhead presentation was Presented as follows.)

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Good afternoon, Mr. Chair and members of the Committee. This is a presentation on a proposed pilot for 2019 to reference price pharmaceuticals by therapeutic class.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Today I'm going to talk to you -- provide you with a little bit of the background on the journey we've been through in order to come to our own proposed pilot.

Talk about pricing strategies that we have provided to you, and how this fits with those strategies. Talk about the analysis that we conducted and talk about what the member might experience in terms of an example, and then talk about next steps.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Reference pricing by therapeutic class offers pricing transparency as all -- in addition to a way for both the health plan, which is CalPERS, and the members to save money on some different pricing options.

At the January off-site, you heard from a panel that talked about reference pricing as part of the strategy. Between February and March, we went back and we looked at proposing some, not just reference pricing as a strategy, but a series of strategies for 2018 and '19.

And we're here today to talk about the results of the analysis that we have concluded so that we can recommend this pilot.

If we're successful, it will replace the Member Pays The Difference Program, and it may eliminate most utilization management processes such as prior authorization and step therapy.

It also -- reference pricing by therapeutic class also improves transparency to us as the plan and to our

members, and it provides options for members to have a lower cost drug when they choose a therapeutic alternative or equivalent.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: For this pilot we wanted to start with a few classes. Now, I know your agenda item talks about how others have done this and the numbers of classes. And we did do a lot of work to see other models. Although this is where we are in the development of our own.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: We looked at 16 different therapeutic classes. Some of them we were worried about offering as a pilot, such as diabetes drugs; we felt that would be complicated. We looked -- there are other mental health classes that we looked at and chose not to go into that area.

So we selected three classes of drugs. They're all naturally made in the body. And they also have sort of a -- they have many equivalents and alternatives, and we believe that the ones that we've whittled down to are appropriate for a pilot.

The ones we're recommending are the nasal corticosteroids which are used for things like allergic rhinitis, which is allergies with sneezing; thyroid

medications; and estrogens.

The reason we selected these three was low generic use, additional formulary options, and a low rebate impact.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I want to provide you with an example of how reference pricing by therapeutic class works. We're using a drug that was available in 2017. And by the way, all of our analysis was based on 2017 claims data.

The non-preferred brand is Nasonex, and its cost in 2017 was $123.70 per month. The member would pay a $50 copay, and CalPERS would pay the remaining $73.70.

Mometasone is a tier 1 generic that is available for $97.41. The member would pay $10 and CalPERS would pay 87.41.

Fluticasone is a therapeutic class alternative that costs $3.65. It is the generic alternative to Nasonex, and at $3.65 the member would pay that amount and CalPERS would pay zero.

If we had reference priced in 2017 and the member taking Nasonex switched to fluticasone, the member would pay $3.65 and CalPERS would save the $73.70.

So that's an example of how reference pricing would work.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Now, the member retains the same options that they had with Member Pays The Difference. They can ask the doctor to switch them to the therapeutic class alternative or equivalent to lower their prescription drug costs. They also could ask for a medical necessity determination, which is associated with all of our programs. Or they can continue to use the medication and pay the cost difference.

Now, based on another program that implemented a similar program, about 85 percent of patients offered the therapeutic class alternative made the switch; another 1 to 3 percent asked for an exemption through medical necessity; and 12 percent continued to want to pay the retail price.

So there's still choice for our members in terms of how they wish to spend their dollars for their pharmaceuticals.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Reference pricing optimizes cost alternatives across the therapeutic classes when clinically appropriate.

Far our next steps, we will come back with

further analysis in terms of this is a recommended pilot for 2019. If approved by the Board, which could either be in May or June, we would provide extensive pharmacy and provider outreach, and then we would again come back in 2020 and -- or 2019 at a later date and provide further updates.

That concludes my presentation, and I'm happy to answer questions.

CHAIRPERSON FECKNER: Thank you.

And I hope as part of our process, that we're not just expecting the members to ask their doctor to go to a lower priced drug; that we're going to actually educate the providers as well, so that the doctors can start recommending a safe alternative that's a lower cost.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: That's correct. And also that brings us to our other pilot, the academic detailing pilot, which is kicking off this year, in which we will be really addressing the physician's side of prescribing in terms of our formulary. This is a possibility. I did get a feedback from one of our physicians who said this is used in Germany. It makes sense to a physician. They don't have to worry about a formulary if they know that they can pick from a therapeutic class.

CHAIRPERSON FECKNER: Great. Thank you.

Mr. Miller.

COMMITTEE MEMBER MILLER: Yeah, two things. One thing, I just -- with this particular example, it kind of looks like it would cost CalPERS more for the person to choose that -- a generic, the mometasone, and -- but to go to the therapeutic equivalent, the member would drop from $10 to about $4. And I'm not sure how compelling that would be to them, versus, you know, if there was more of an incentive there, like zero maybe for that alternative.

But my real question is, you mentioned that there was a few percent that asked for a necessity exemption. Do you know what percentage of those were actually approved, of those 2 or 3 percent that asked for it? Or was that what was approved? I'm interested in that -- the success ratio for folks that ask for that, what's their experience, how many times do they have to ask, how many of them actually get it, versus what percentage are ultimately denied and, you know, how -- how that works?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: This -- these statistics were taken from another program. We do though run our own medical necessity determinations through our appeals process under Dr. Sun. We'll go back and find out, you know, a little more detail around the one -- the 3 percent.

But in general, we ourselves, once they've had a determination made by the health plan, the member can continue to appeal all the way to us. And under Dr. Sun we manage that appeal. And they can appeal actually all the way to the Board.

COMMITTEE MEMBER MILLER: Great. Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Lofaso.

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

I wanted to get a bit of a handle on therapeutic equivalents and alternative as we're going forward. I did a -- some -- I won't call it sophisticated research. So what I learned was there are two kinds of corticosteroids, gluco and mineral. I'm not sure if those apply to nasal. I know that's a narrower zone.

I looked up something in the range of 25 to 50 estrogen drugs. The vast majority were under the same generic name, but they came in -- some were gels, some were injections, some were I think maybe ingestible.

Throwing those examples out, can you give me a sense of what therapeutic alternatives really are? I mean, do they -- is it not a therapeutic alternative if the means of administration are different? Are there chemical subsets that make things equivalent or

non-equivalent or, you know, sort of on the margin?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Well -- and I'm probably going to have my pharmacist come up and help with some of those questions. But the therapeutic equivalents have the same equivalent ingredients. So they are equivalent ingredients. They may differ in terms of maybe some additional additives.

The alternatives are an alt -- they're not equivalent but they are an acceptable evidence-based alternative. And they can both be within a therapeutic class.

And now, if Melissa could come up and help answer that question.

DR. MANTONG: Thank you. Melissa Mantong, CalPERS team member.

You're correct, there are different type of corticosteroids. And the one that we're recommending is specifically to the inhaled corticosteroids that are used through internasal for other -- rhinitis.

And in regards to your question about the different estrogens, you're absolutely right. There are a lot of different subclasses. And we do need to flesh out the subclasses under estrogen because there are some oral product, there's vaginal, there's topical. So the next step in the further analysis is to further narrow down the

subtherapeutic classes for estrogens.

ACTING COMMITTEE MEMBER LOFASO: Okay. Appreciate the perspective on the steps going forward.

Just one more follow-up on Mr. Miller's question. Is the medical necessity process in this going to look a lot like the medical necessity process for our other reference pricing programs for the non-prescription drug? And can you elaborate if so.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yes. The answer is yes. We do manage the appeal process. If it gets turned town through the PBM, it comes to us to further adjudicate in terms of the member, and we collect medical records and we in some instances contact the physician.

So, yes, the medical necessity determination is a pretty standardized process in terms of how we manage our appeals.

ACTING COMMITTEE MEMBER LOFASO: I guess bottom line question is, if a regular PBM prior authorization process largely relies on the judgment of the physician and this relies on the judgment of physician, what fundamentally is the difference between those two processes?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I don't believe there are.

Go ahead, Melissa.

DR. MANTONG: I believe it is the same process that currently is in place for other formulary requests. If a member needs a medication and does not meet the utilization criteria, it's the same process.

The physician need to provide medical justification why the member may not use or cannot use a formulary alternatives. And a decision is rendered based on that information.

If the decision is a denial and the member and the prescriber feel that -- or it does not agree with the physician, then they can have the appeal rights consistent with the plans and the CalPERS. That is external review, as afforded by the Affordable Care Act; and then, in addition, is the CalPERS administrative review rights.

ACTING COMMITTEE MEMBER LOFASO: Appreciate that. But I think the essence of your answer is it's in the utilization criteria. And in your response to my prior question, we're still working on exactly how that works. So I appreciate all the answers. Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Slaton.

COMMITTEE MEMBER SLATON: Thank you, Mr. Chair.

So on the third -- the flutic -- how do you pronounce it?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Fluticasone.

COMMITTEE MEMBER SLATON: Fluticasone. That's Flonase as an over-the-counter, right? That's what we're talking about as one of the brands that's out there?

DR. MANTONG: Yes.

COMMITTEE MEMBER SLATON: It is over the counter?

DR. MANTONG: That's one of the brand names for fluticasone.

COMMITTEE MEMBER SLATON: So my question as we go into this, what do you -- do you have an estimate for what you expect to see in savings from this on our side and on the member side? A projection?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Part of the analysis is going to be looking at the subclasses. We have done some high-level analysis of savings. But we need to look at -- fleshed out a little bit more in terms of the subclasses and those that we would actually recommend within the therapeutic class for the reference price. So we're still working on many of those things.

COMMITTEE MEMBER SLATON: But you're not making your decision subject to some determination of a number? In other words, you plan on going forward with this as a reference pilot; is that --

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Mr. Slaton, this is an information item, and so the goal is to get your dia -- have a dialogue about it. And then what we'll be doing is bringing it back for a decision in front of this committee as part of a benefit design. And then we'll have the savings and a lot of that detailed analysis that you're looking for.

COMMITTEE MEMBER SLATON: I see. But it will still be in the framework of a pilot?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Correct.

COMMITTEE MEMBER SLATON: Okay. Thank you.

CHAIRPERSON FECKNER: All right. Thank you.

Seeing no other requests.

We do have one request from the public.

Neal Johnson, please come down to your right, my left. The microphone will be on for you. Please state your name for the record. And you'll have up to three minutes please.

MR. JOHNSON: Neal Johnson, SEIU 1000.

While we're supportive of the concept -- and reference pricing has been around in a variety of forms for years. Your hip-and-knee-replacement procedures is -- it's an example of that. But one of the things - and Mr. Slaton sort of touched on this in his question of -- we get -- and this I think has been done a number of

times -- we have these pilot projects but we don't really what the objective is, we don't have a hypothesis that we can test. Maybe there is one but it's -- it's, you know not brought before you as part of that decision process. And, you know, I would hope that at some point we start actually looking at: How do we evaluate the pilot? What are we really looking for? Do -- you know, cost impact, is it better outcomes? Whatever. And have that paradigm set up before we actually launch into the pilot.

With that, I thank you very much.

CHAIRPERSON FECKNER: Thank you.

Brings us to Agenda Item 7, Preferred Provider Organization (PPO) 2018 Design.

Ms. Donneson.

(Thereupon an overhead presentation was Presented as follows.)

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Mr. Chair, members of the Committee. Kathy Donneson, CalPERS team member.

Today I'm going to update you on benefit designs that we launched in 2018. It's still early in 2018, so these are preliminary. And I won't focus on every item that's in the agenda because we need to collect more claims information. But we -- our intent is to come back and periodically update you on how we're doing.

I'll begin with the benefit design changes that became effective this year, which is covered in your agenda.

I then want to cover two new programs that we want to elaborate a little more. Ms. Bailey-Crimmins talked about them in her opening remarks, but I'd like to give you a little more detail on those too.

And then I'll discuss any benefit designs that we might be coming back to ask for approval in 2019.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: First I want to talk about the many benefit designs that we offered. I, as I said, don't have information on all of these to date, but I do have -- I want to update you on three: Ambulatory Surgery Center reference pricing, the Castlight pilot, and SilverSneakers.

And I would like to address a little bit of Mr. Johnson's comments in terms of evaluation. Absolutely when we do these pilots, we do have an evaluation period; and many of the reference pricing efforts that we did for hips and knees and for the three ambulatory surgery center pilots were done -- rigorously done by both internal staff and the University of California at Berkeley.

And the conclusion that Dr. Robinson, who did the

evaluation, came to, the reason we reference price is that there's a lot of variation in pricing across different procedures and of course, as I illustrated, across different therapeutic classes and tiers.

And so we absolutely agree that pilots should be evaluated and the merits presented, not just to the Board but to the public at large.

And so really reference pricing is a market approach to decrease the amount of variation in any procedure or any drugs.

So I just wanted to let you know that's why we felt it's not only important to expand in the ambulatory surgery centers space, but also to look at reference pricing by therapeutic class as well.

Now, to the ambulatory surgery centers, we proposed 12 in 2017, which went into effect in 2018. We added in addition to the three in place, so we have three classes -- or 15 procedures in ambulatory surgery centers that are underway.

We also have been careful in terms of how we look at what to reference price. They have to be safe, that is, low risk. And sometimes you have to wait for technology to catch up in order to be able to say it can safely be done in an ambulatory surgery center. So it really has been several years since we've had this

conversation.

But as we expected in the ambulatory surgery results that only encompass the first two months, our highest variable and potentially -- potential for standardizing price is in the upper GI endoscopies with biopsy, without biopsy, and laparoscopic gallbladder surgeries.

For those of you who are new to this Committee, we have studied our population health for several years, and our number 4 high cost set of conditions is in the GI tract. So we kind of expected that we would see those would start to rise to the top.

And even within two months for just three of those 12 classes introduced we've now saved about $420,000.

So you can see that the -- it's not just -- it's safety, it's evidence, it's quality, but it's also trying to drive down the variation in pricing that occurs within our markets.

Now, I'd like to move on to Castlight. We've been disappointed in Castlight. You approved it for 2018. You heard presentations throughout 2017 on what benefits was being derived by our membership. We've had two or three years to try to get the Castlight tool to be increased in use. It is based -- what we pay is based on

households. And yet only about 22 percent of our households today continue to use the Castlight tool.

I did want to let you know that on page 3 of your written agenda item, the savings was identified as 270,000. That is simply a -- that's not an annual -- that's a year-to-date expense. The expense that we will be avoiding if we ask -- if you agree to terminate the Castlight contract would be $1.8 million in 2019.

We are working with Anthem to try to find a replacement transparency tool.

And then, finally, SilverSneakers, an update. We don't yet have enough claims to be able to look at savings from the program. But I will tell you that we had 7,000 members enroll in January. That's 5 percent of the Medicare PPO population, and nearly 25 percent of those members are over the age of 80.

And again, this is -- this is a -- SilverSneakers promotes an exercise strength training and flexibility program which is important to our members as they age, especially as they get to the more frail age groups.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I'd now like to talk to you about SpineZone and Wisdom that was -- that was mentioned by Liana. This is -- this -- these two programs are meant to really look

at overuse, underuse, and misuse of services, especially as they pertain to the back. And the back in this instance is not just the low back; it's the mid back and the neck. So this is an evidence-based program that is preventative, so there's no -- there's no copay. There's also no increase in administrative expenses.

And it is -- the intent is to reduce back surgeries by offering non-surgical control of back and neck pain.

These program -- this program is designed to empower the patient to engage with their physician and with the physician staff that are part of this SpineZone team. It uses a coaching system. There's an on-line program and then there's an in-clinic program.

So right now, the clinics are down south, but they're moving north. And then we expect to see a SpineZone clinic up here in the later part of 2018.

But really the whole point of SpineZone is to look at the entire musculoskeletal frame. There are support muscles and then there are non -- there are muscles that support us and then there are muscles used to do things like lift and bend. And sometimes the non-support muscles get used and then you have an acute -- you may have an acute back pain occur.

So it looks -- there's a -- it looks at the whole

back, and it tests the musculature of the neck that supports the head, the mid back and the low back. And through that personalized analysis, a member can then be -- have a tailored back program.

Now backs -- backs and back injury can be acute or it can be chronic or it can come as a result of the aging process, just the body getting tired.

So the individual diagnosis is done and then the resistance training, coaching, and exercises are prescribed. And it is managed by spine surgeons, physician assistants, physical therapists, and other assistants and kinesiologists that are part of the program.

Sharp Health Plan has rolled this out. And they feel that it is very promising, and we do as well.

And all PPO members can participate.

The other program is a study, and it is called Wisdom. And it's a new approach to breast cancer screening. It looks at a personalized set of diagnostic tests in terms of high risk versus low risk. And if a patient is determined to be high risk, then recommended additional resources and potentially additional tests are prescribed. It doesn't replace any of the current programs we have. It is a study and it is voluntary.

And we'll continue to work with Anthem to let you

know how these programs are going once we roll them out.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Next I'd like to talk about the benefit proposals for 2019. We are going to come back and ask for two. The first would be a copay change for urgent care and specialty care. And the second would be to add a reference price to three therapeutic classes.

I'd like to talk about the copay change from 20 to 35 dollars, and let you know that we have not changed the copays for PERSCare and PERS Choice for several years, over 13 years in fact.

But our market has changed. And it's changed in an interesting way. And, that is, we offer the urgent care copay at $20, the same as a primary care physician copay. And that copay has existed in a market that has now grown to have many urgent care centers available. And we do like having urgent care centers available as an alternative to the more expensive emergency rooms, but the market itself has also changed in terms of how primary care is being delivered. They're being delivered in clinics within pharmacies, they're being delivered in clinics within retail stores. And we do start to see a fragmentation in terms of how our members may be using those types of setting versus the primary care setting.

So I just wanted you to think about that as you deliberate about the change in the copay.

Also, these are higher -- both in urgent care and specialty care it's higher levels of care. And we believe that some additional copay for that level of care is warranted.

And we are not recommending at this time any change to the coinsurance or the deductibles.

And the second one is reference pricing, which I've already discussed with you.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: That then takes us to our next steps, where we will continue to track our benefit design changes and the value that is accruing that we implemented in 2018. We will come back in May or June for some decisions about 2019.

We will embed some of these savings, especially with the ambulatory surgery centers, into projected expense of premiums for 2019. So we do want to look at including those savings as part of premium reduction.

And then we will continue to monitor and implement our programs for their effectiveness.

And that concludes my presentation.

CHAIRPERSON FECKNER: Thank you.

We have a number of requests.

Ms. Mathur.

COMMITTEE MEMBER MATHUR: Thank you.

Well, I think one of the things that this presentation highlights is that when we do establish a pilot program, we do monitor it. And then if it's successful, we continue it; and if it's not successful, we close it down.

And I think that is the case with the Castlight product. It just did not work for our members. For some -- whatever reason, our members did not utilize it and it was not worth the investment that we were making in it.

So I thank you for bringing it back to us for reconsideration, and I think it's an important part of the pilot assessment process and in determining whether these things should be embedded over the long term in how we approach health care. So that's really important.

I did have a question about the ambulatory surgery centers piece. You said that there were $420,000 of savings. Do you know -- and 1,759 procedures since the beginning of the year. Do you know what that number of ambulatory surgery center procedures was last year, what the comparison is? It's hard to know how big or small that number is out of context.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Thank you.

We did not reference price last year, so --

COMMITTEE MEMBER MATHUR: Right.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: But we do have data that supported what we expected to save. And for all 12 we expected to save a little over $3 million.

So this is three, but it is the big three. But we expect we're on track for those savings and quite possibly it could go above that.

The 1700 figure also includes the numbers that we have for arthroscopy, colonoscopy, and retinal surgery. So that is -- 1700 is for the full set of 15.

COMMITTEE MEMBER MATHUR: That's for the -- 1700 is for the full set of 15?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yeah. If you expect -- if you would like, we can continue to let time go by and continue to collect this data and bring it back.

COMMITTEE MEMBER MATHUR: I guess what I'm wondering is, have we seen an uptick? I mean is the 1759 an uptick over before we reference priced? Are we seeing more people using ambulatory surgery centers? I guess we must if we're seeing some savings. That's the -- I guess

that's the number I'm trying to get at. And maybe we're not --

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Right. We're not there yet. We will be. If you'll remember, when we did the three, arthroscopy, colonoscopy, and cataract surgery, we saw a movement out of the outpatient hospitals of up to about 90 percent.

So, again we have demonstrated savings in terms of the original three, and that's well documented.

So we can go back and continue to look.

COMMITTEE MEMBER MATHUR: Thank you.

I want to raise one other thing, and that is with respect to the copay changes. We had a public comment this morning in Finance Committee questioning the rationale for increasing copays at a time when we are -- we have excess reserves in the PPO plans. And I was wondering if you had an answer to that question.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: We are going to be looking at a reserving policy. We -- Mr. McCollum and myself will be working with external actuaries to try to find the source of why excess reserves could be building up. So that is another piece of work that we are undertaking that looks at that side, the reserves.

My rationale for asking for a $20 to $35 copay

increase is really more so to reflect the market costs and some of the market behaviors that are happening in terms of our members using more fragmented care in some of these retail and pharmacy centers versus seeing their primary care physician.

COMMITTEE MEMBER MATHUR: So you're really trying to drive a change in behavior, you're trying to drive people to the primary -- is it really that or -- maybe you can expand on that a little bit.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: It's partly to contin -- it's partly to continue to look at does a $20 copay at an urgent care as -- which is the same as the primary care, move members into different sites of care that may be more costly. Urgent care centers are more costly. Retail clinics are probably less costly, but -- and I say that because, you know, they're using nurse practitioners and physician assistants under the rubric of the medical ownership. But in a way that may be fragmenting care away from primary care.

So part of it is it's an economic reality that those are more -- higher cost sites of care. But, secondly, by keeping them equivalent as these new sites of care come up, it may be driving members away from the primary care physician.

COMMITTEE MEMBER MATHUR: And you think this is the best way to modify behavior, changing the copay from 20 to 35? You think that's the most effective strategy approach.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Just as a reminder, the number that Mr. McCollum had given was an aggregate across all. And we have numerous subaccounts.

And so when it's talking about that, the 120 million, it's in the scheme of a $9 billion fund. And if you saw the charts, there are certain plans that have a lot more reserves and then other plans that are less reserves. Our job is to ensure from an administration what is that -- the typical reserve. And then what we're going to be coming back in June is - Dr. Donneson was talking about - is talking about what is too much and what is too little, and then having a policy that the Board can say, "Do we" -- "do we have a premium holiday? What could we actually do with those extra reserves?" And that will be coming to this Committee in June.

COMMITTEE MEMBER MATHUR: So then that would be a policy that would cov -- that we would review periodically -- establish a process by which we review the excess reserves or the status of the reserves?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Correct. And just, also, it was a December 2017 date. If there has

been any reserve changes, it's not reflective necessarily for 2018. So it was a point in time. So just letting people know that that was last year's; there may have been changes that have already occurred there.

COMMITTEE MEMBER MATHUR: Okay. Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Miller.

COMMITTEE MEMBER MILLER: Yeah, thank you for the very informative presentation, and all the staff work I'm sure that's behind it and has gone in.

I have two areas I want to kind of revisit and touch on. One is the Castlight example and then the other is also this increase in copays.

So one of the things that struck me with one of Mr. Slaton's questions and Mr. Johnson's comments was -- and having not been here for the run-up to these pilots, is, it will be really helpful for me to understand as we go forward to see that when we design the pilots, from the get-go we're talking about what does success look like on a pilot? And not just purely the financials, because I'm sure we've got, you know, objectives, goals, targets, projections of what success means there. But also in terms of what are the other things we've got to look at for that pilot to be a success, whether it's patient experience, numbers of people choosing something,

satisfaction, dissatisfaction - perhaps not as far as engagement measures. But to have it designed in up front, knowing that, you know, here's how often we're going to check in, or this variance from what we're projecting will cause us to say, "Woe, do we need to take an action? Do we need to modify? Do we need to terminate?" And have that designed into the pilot in a very transparent way up front, so we don't get two or three years down the line and say, well, kind of looks like this didn't work.

So if we had the crystal ball, if we had that set up, if we brought Castlight's performance to date back in time and said, "Here's what you're going to be looking at, you know, in two years or three years. Do you want to do this?"; we shouldn't be figuring that out, you know, down the line much further.

So -- and whether that's incremental or a go/no-go point or a, you know, percent variance from plan, I don't know. But something to really think about design phase up front.

And when it comes to the increases in the copays, I understand the desire to try to get a handle on what degree of, you know, financial pain will cost someone to make a different choice, particularly if those -- that person is in financially rough straits, which many people that -- higher acuity, fixed income, you know, a retiree

or a meagerly paid public employee. And so I wonder whether figuring that out by making just a 75 percent increase - well, why not go to a hundred, why not go 50? Without giving us some alternatives of what is the value of trying to get that information figured out versus the impact on our members and how many iterations of trial and error do we do before we say, "Oh, that's what worked best," I'm not sure I'm sold on that approach for getting that information.

So...

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Thank you.

I think -- I think you spoke very well in terms of actually understanding our goals for our program. We have set a goal of patient -- of affordability and sustainability. So we really try to look at our strategic plan as guiding our efforts.

And in terms of some of the market changes, maybe we better go back and take another look at, and update ourselves, in terms of what is actually happening. We've got consolidation going on out in our market. You could have -- we -- the reason we've got members moving to ambulatory surgery centers is that evidence shows they're actually as safe or even better safety and quality. But a hospital system's response to that could be, "Well, let's

just buy the surgery centers." And that's what we're thinking -- that's we're seeing too. We've got market consolidation going on with the PBMs and the health plans.

So we -- yes, we're down a little bit in the weeds on some of this, but it's within the context of how markets are changing.

And as you're well aware, we have not changed our copays on our pharmaceutical in -- I think the last time was 2005 too. So we're very careful about looking at trying to balance copay changes versus trying to encourage the best programs for our members to engage in evidence-based medicine.

So that -- that is our guiding principle, which is part of the principles that you just approved.

But we do need to watch our market and we do need to -- whether it's a copay increase or not, we've got to pay attention to what's happening in our market, what changes are going to be threats to affordability and sustainability.

In terms of our pharmacy programs, one of the reasons that I've offered reference pricing by therapeutic class as an alternative, it's an alternative to more tiers in our formulary. It actually is in many respects a better approach than managing high cost generics, which are inflating, as a tier 2 versus a tier 1, or specialty

drugs as a tier 4 or a tier 5.

So we do try to look at the context in which we are presenting our design changes and our pilots. And should you decide that the copay should stay the same, or go up, and ask us to go back and do more work, we'll be happy to do that.

But we will not be coming back for a decision until May or June. So --

COMMITTEE MEMBER MILLER: Yeah, thank you.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: -- you don't have to decide today.

COMMITTEE MEMBER MILLER: And again I just -- you know, I appreciate where our focus is, and -- but I think we need to, at least for me -- I try to, you know, see a little bit more rather than kind of these unitary -- these one-dimensional kind of measures of success. I think we need to, you know, go a little beyond that, at least in terms of explaining it to me, that I can see that, yeah, we can save some money here. But I also want to see, yeah, we're improving the patient experience, we're improving outcomes, our members are happier, they're more satisfied, they're more engaged with us as a result of what we've done in this pilot. Or at least we didn't hurt that in generating some savings.

CHAIRPERSON FECKNER: Thank you.

Mr. Gillihan.

COMMITTEE MEMBER GILLIHAN: Thank you, Mr. Chair.

So on to one of my favorite subjects, SilverSneakers, as you -- some of you may recall I was a bit skeptical of this when we adopted it last year, I guess. So it doesn't look like it's off to a strong start, at least based on the numbers here. I realize it's early, but it would seem like if there was pent-up demand for something like this, the initial sign-ups would be more reflective of the demand than what we're seeing here.

So my questions are: How much -- remind me of how much we're paying to make this service available, because I know it's at no charge to the participants.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Each visit is $4.25 up to a maximum of $5.14.

The $5.14 is set as a ceiling just in case every PPO Medicare member decided to engage in terms of -- in terms of taking advantage of it.

So far right now we're in the numerical range of $4.25 per visit.

So it's not our expectation that everyone is going to either want to or be able to participate, but that's currently where we are.

COMMITTEE MEMBER GILLIHAN: And I assume we're locked into this for 2019 unless the Board makes some

decision. But presumably we're still early into this experience that it's probably a decision point for the 2020; is that correct?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Correct.

COMMITTEE MEMBER GILLIHAN: And so it would be about this time next year when we'd revisit this?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Correct. But in that time, we will be collecting data in terms of the benefits of SilverSneakers as well as connecting, as we wanted to, to any reduction in pharmacy or medical costs.

COMMITTEE MEMBER GILLIHAN: Assuming there's any benefit. But -- and I recall at the time we did it the Chair at the time gave staff direction to bring that analysis back. And so we're still on track to do that?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Well, I just want to also, for your -- you're not locked in. If -- I mean obviously we've only had two months of claims, so it's too earl -- I mean it's early. But May is when we make the decision on benefit designs for 2019. We would recommend from a staff recommendation that we give ourselves a full year of experience before we make any decisions.

COMMITTEE MEMBER GILLIHAN: By locked in I meant

I think it's too early to make a decision. If the decision's made to try it, we need to at least give it a shot. And so that was I guess the point of my "locked in" comment.

Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Lofaso.

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

I don't want to let go by uncommented upon, Dr. Donneson. I know how much effort you put in to find cost-effective ways of improving spinal health. But since it's not controversial, I won't comment on it anymore.

And I think you well got through the pilot issue with Mr. Miller. I guess I appreciate what you said about the sort of the big strategic issues about the way the marketplace is reacting in an investor sense to all the things we're doing.

I don't know what to add in terms, but I -- what Mr. Miller said about trying to zero it down to the consumer experience really resonates. And I know we talk about it. For example, you alluded to what you presented to us last year when we were expanding the reference pricing, which was related improvement in quality with the expertise associated with the surgery centers. So I guess

at some point it's a presentation issue.

Moving along, on the Castlight issue, we're still -- of course another pilot we're talking about. Can you elaborate on what we think we've learned from Castlight. And you mentioned working with Anthem. And I'll be honest with you, I was a little -- I asked myself questions after the January off-site about our focus on a relationship with one health plan in terms of our approach to technology tools. What I'm really trying to ask is, what did we learn and what are we thinking in the future in terms of technology tools that we're -- where we're trying to get to in terms of technology tools for our members?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I'll start with the evaluation of Castlight, which is -- this is a continuation really of that discussion that started with a professor who evaluated Castlight with Dr. David Cowling of our branch who is a scientist -- a research scientist and manager.

I was disappointed when the evaluation came out. I was disappointed that the promise of Castlight, which was a transparency tool to allow, say, a new mom looking for doctors in the area to select from. And it was for the PPO, and it was for the PPO basic members only, looking for a doctor to select from from which they could

see quality scores, they could look to see distance from home. And I really thought this was a good transparency tool, which we introduced I believe in 2012 or so.

And so, you know, that was its intent, to allow -- as we did reference pricing, to allow our members to have one place to go to understand the reference price, to see the effect of the reference price in terms of what they would pay through their benefit design.

Some of the members -- some of the households did use that tool, some used it really to search doctors in the local area.

To me, the unfortunate thing about Castlight had to do with the fact that it's based on households. And it -- when you have a pilot such as this, there has to be energy kind of put into the pilot. Castlight was a new company at the time. It was a promising company. We engaged Castlight through Anthem. And the 22 percent who are using it must have value. We just wished that it had been more and we wished that the evaluation study had turned out differently.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS:

Mr. Lofaso, I'm just going to expand on that. What we have learned, what you're going to see in this agenda item that maybe you haven't seen in prior years, is that you will -- Ms. Don -- Kathy Donneson actually showed

you what -- the benefits from the prior year. Typically at this time of year we're only talking about net new. We're not actually saying what were the results of the prior year. And so if we are in a pilot, we should be bringing back -- as we've talked about SilverSneakers. If we're in a pilot stage, every year we should be talking about, are we on mark, are we not, and at any point in time do we continue or do we stop?

And Castlight obviously has been here in -- it actually went from pilot to program. So it had been a program for a while. And what we believe we owe to you is -- for the April agenda item is not only net new but tell you about what you approved last year and where we stand in relation to those benefit designs. I think that helps you continue to have a pulse on what's going on and do we want to continue.

ACTING COMMITTEE MEMBER LOFASO: But if I understand correctly, the essential thing behind Castlight is assisting members in their provider choices. Are we sure that, A, that's what members want in terms of a technology tool or, B, maybe that's what we want because we see that as a cost driver. But are there other things that maybe consumers want that if they had that, then they might be attracted to this thing that maybe -- I don't know. I actually don't know if members are -- I mean, I

know members want the best doctor. But of course they want convenience, they want -- they don't want to get out of network. They want to know who's -- there's lots of things they want that don't have a direct relationship to what we want, which is, you know, cost-effective provider choices.

Anyway, I -- I'm throwing a bunch of things out there. But I guess the question is, are we attracting them with what they want to get them to do what we want?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: We will be working with Anthem -- well, one, we need to evaluate where we are with Castlight once it's done. So we've done an evaluation. It was done by an academic. It was done under the auspices of our Center for Innovation at the time.

So we need to really look at where -- at the end of the year where we got to.

The other is, we do want to take those lessons learned and use it to work with Anthem to look at a potentially new transparency tool and...

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: And also you're talking not just only looking in the rearview mirror. You're talking about looking forward. So when it comes to technology, being a prior CO for many, many years, you have to be at the pulse of what your members

want. Our retirees have talked about, if we're getting rid of paper, can we do more app-type devices on our smartphones? So you talk about the user experience and you get a pulse of what your members, both active and retirees, want. You see if there's technology out there that meets the needs. You figure out if you do it through a third-party administrator.

So there will be more of that to come. That's kind of my strength, is understanding how to implement technologies that matter to members. Castlight was not one. They thought the behavior members would shop; and there was a thought that that was going to happen, and that did not happen. Should we have pulled the trigger sooner? Hindsight's always 20/20. But I'm glad that this Board and this group that we did make the right decision today not to move forward with that.

ACTING COMMITTEE MEMBER LOFASO: Appreciate that. Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Jones.

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

The first question I had is also what Ms. Mathur was referring to and earlier today in the Finance Committee about the proper level of the reserves. So I'll

hold my question until June when you bring that report back.

The other question I have is the estimated savings of 11.8 million. And is that savings coming from the two changes of the urgent care copay and the specialty copay?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yes, that's correct.

COMMITTEE MEMBER JONES: So we're just shifting then? Because if I'm a member and you raise my copay, and now you reduce my per-month-per-member cost, right, and if looking at this is 50 bucks maybe for the PERS Choice, so that -- you're just changing where you're getting the money from; is that correct? Because you said I'm going to increase your copay from 20 to 35, and then you're going to decrease my per-month-per-member charge of $4.70.

So why are we just switching like that? Why --

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: It's premium savings. So the savings that we reflected in the agenda item lowered the premiums.

COMMITTEE MEMBER JONES: The premiums for the member?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So it's -- obviously it's too early to be talk -- I mean from a premium perspective that will come in preliminary May.

But any savings that CalPERS gets in relation to the system drives down premiums. We're not allowed to have a huge number of reserves. So that's one of the things we're going to be doing is bringing back in June as a reserve policy.

But the reason that we've talked about the copay going up is in -- basically in 13 years the cost of care has gone up for specialty care, and the copays stayed $20. It's reflective of the market increase, and that's what the $15 increase is.

A specialty care should cost more than a primary care physician.

The same thing with urgent care. That also has gone up.

Emergency room services, obviously that's coinsurance, so that's a very different situation.

But it's not a cost shift. It's care has gone up in the last 13 years, and the copay should reflect the increase in cost.

COMMITTEE MEMBER JONES: But the overall premium for medical care has gone up anyway.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Correct.

COMMITTEE MEMBER JONES: How long you say, 13 years? The cost has already gone up, and so we've already increased the cost to pay for that increased cost. So why

do we need to raise the cost for the member to...

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So, the premiums are based on the last year and a half of experience. And so we set a premium, and people's copays are the out-of-pocket cost and what they're --

COMMITTEE MEMBER JONES: That's the part I'm --

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Right.

So maybe you can explain, Kathy, of --

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Right. If you reduce the premium, it's a savings to both the member as well as to the plan. And it's the PPO and we are the plan. So it's not that the member doesn't save. The member does save.

We can bring back those figures and show them to you in May.

COMMITTEE MEMBER JONES: Okay. I'd like to, along with that reserve question too, because it has an impact.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: And I think it's confusing because we're talking about reserves, premiums, deductibles, and copays. This specifically is just a copay. But we'd be happy to bring back something that shows how those all intertwine.

COMMITTEE MEMBER JONES: Okay. I've gotcha.

But when I look at this chart, the 11.8 million

is the savings as a result of the copays?

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

COMMITTEE MEMBER JONES: Okay.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Correct.

CHAIRPERSON FECKNER: Thank you.

Mr. Miller.

COMMITTEE MEMBER MILLER: I'll try to be really quick with this.

Kind of Henry's point. One of the things that strikes me is, when costs go up and we adjust our premiums, we're distributing those costs and we're sharing those increases between the individuals, the employer, across all individuals regardless of their individual needs or usage patterns. When we, you know, make a 75 or 100 percent increase to copays, it very specifically hits the people who are higher acuity or have the needs for those services, with the assumption that somehow we'll change some behavior that people may or may not have needed to access those. But it's not distributed, and it just seems like there's a real philosophical question there about do we want to impose -- differentially impose those higher burdens on the people who most need those types of health care services, versus distributing those costs and trying to address it in our -- you know, in all

the other ways we're trying to address costs?

So that's kind of my comment; not so much a question but a concern.

CHAIRPERSON FECKNER: Mr. Slaton.

BOARD MEMBER SLATON: So I'll take the -- kind of the opposite view, which is, you know, the premium is spreading the cost over the entire base. And so to the extent that people see a specialist versus their primary care doc, that is now subsidized -- if the price stays the same, subsidized by everybody in the plan.

So, you know, it is a philosophical question of how much do you want people to bear the cost or some of the cost of their decision versus have that cost be subsidized by the entire plan participants?

So, you know, it's never easy to make an adjustment in price. But I think what we're -- what I sense is going on is we're trying to encourage people to use the skill sets of their primary care physician in all cases where they can - some cases they won't be able to - and to the extent they do, then they don't incur an additional cost. So that would be my view of it. So I'm less concerned.

CHAIRPERSON FECKNER: Mr. Jones, did you want something else?

COMMITTEE MEMBER JONES: Yeah, just another

question just triggered based on Mr. Slaton's comment.

The urgent care copay, that's when someone has an immediate urgency and they go into some facility and that's why the copay.

But on the specialty copay, doesn't a primary physician refer the patients to this benefit?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: In the PPO program for Care and Choice, they can go direct to the specialist without primary care.

COMMITTEE MEMBER JONES: Okay.

CHAIRPERSON FECKNER: All right. Seeing no other questions.

That brings us to Agenda Item 8.

Thank you, Ms. Donneson.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Thank you.

CHAIRPERSON FECKNER: Brings us to Agenda Item 8, Summary of Committee Direction.

Ms. -- Oh, pardon me. There's a request to speak from Mr. Larry Woodson.

And, Mr. Woodson, after you speak, just stay there because you'll be back up shortly.

MR. WOODSON: Well, I'll try to make this brief because I'm late for my SilverSneakers class.

(Laughter.)

CHAIRPERSON FECKNER: Take Mr. Gillihan with you.

(Laughter.)

MR. WOODSON: Larry Woodson, California State Retirees. Thank you for the opportunity to comment.

I'd like to inform Board members, as I did at stakeholders with the staff on Thursday, about recent attention focused on major shortcomings in the quality of care nationwide at ambulatory surgical centers.

CSR supported CalPERS VBID proposal for adding 12 additional procedures to be done at ASCs instead of outpatient hospital facilities, and we still do with qualification.

We asked staff at the time it was proposed if the quality of care and medical outcomes were equivalent to hospital surgeries, and they assured us they were. And that's probably what the research data shows to date.

Staff reports that for the first two months of 2018, there have been 1759 claims. There's been cost savings. But there's no medical outcome information collected or reported.

Kaiser Health News published a well-researched article in March titled "As Surgery Centers Boom, Patients are Paying with Their Lives." I provided copies to staff last Thursday, after stakeholders, after discussing it there. I encouraged them to share it with you.

It describes the proliferation of ASCs over the last 10 years. And there's something like 5700 certified by Medicare throughout the United States, many more than there are hospitals, and certainly less regulated and less monitored than hospitals.

The article documents ASCs that are poorly staffed; not well-equipped with emergency equipment; poorly trained staff in ER procedures; long distances from hospitals and ER rooms, specially in rural areas. And they found that -- they identified 260 patients that had died in the last four years after in-and-out procedures at ASCs across the country.

Dozens died after routine procedures such as colonoscopies and tonsillectomies, which by the way are procedures included in the 12 added design procedures.

After reading the article, a couple weeks later I had a personal experience with an 87-year-old man who I know well, was a CalPERS plan retiree, covered, who had a very dangerous experience during the recovery at an ACS -- ASC in the Sacramento area, fairly remote from the hospital. And there were no doctors remaining on site after the surgery during -- he was finally stabilized. But it drove home some of the point in the article.

And certainly the majority of centers are well staffed and equipped. But the report shows -- or the

article shows greater vigilance is needed.

In conclusion, that we ask -- we did ask staff how ASCs they are utilizing are certified and who regulates them in California. And they agreed to provide that, and we're looking forward to that. But relying solely on physician's judgment to determine where to perform these procedures is clearly not enough as demonstrated in this article.

So in conclusion, we think it's important that CalPERS evaluate and report on quality of care where members are having these procedures done, in addition to reporting the number of claims processed at ASCs.

Thank you very much.

CHAIRPERSON FECKNER: Thank you.

Brings us to Agenda Item 8, Summary of Committee Direction.

Ms. Bailey-Crimmins.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Mr. Chair, the one item that I have for action is to bring back statistics specific to CalPERS regarding therapeutic classes in PBMs and specifically medical necessities. We will be bringing that back.

I didn't take it as a Board directive, but I did want to at least acknowledge that we will be potentially reviewing Pension-beliefs and then also the additional

analysis that had been requested to a relation to the benefits design copays and how they relate to premiums, I think more from an education perspective. But we need to understand that as we're making these decisions.

Thank you, Mr. Chair.

CHAIRPERSON FECKNER: Very good. Thank you.

Mr. Jones, did you have something else?

COMMITTEE MEMBER JONES: Yes, I did. The request that -- he mentioned that you had agreed to provide some information on this subject matter that he just talked about. And I would just, say Mr. Chair -- Mr. Chairman, when that's done if we could also get that information.

CHAIRPERSON FECKNER: The Committee -- the full Board will get a copy of whatever they turn in.

COMMITTEE MEMBER JONES: Okay.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: That is correct.

CHAIRPERSON FECKNER: All right. Seeing nothing else.

Agenda Item 9, Public Comment.

Mr. Woodson.

MR. WOODSON: All right. Thank you, Mr. Chair, again. I think I'll just start off by saying that CSR does oppose the increase to $35 for copay. And I understand the logic and I'm not sure it will really serve

as a disincentive -- or as an incentive for seeing -- people seeing their primary care physician. If you have 104 temperature on a weekend, you don't have access to your primary care provider.

So -- and keep in mind too the $30,000 a year median pensioner. This is a -- I can afford $35, but some people it's a bigger hit.

Okay. We are concerned about potential increases to costs for some of our members in the health plans, especially the PPO plans, and especially because CalPERS decided to abandon the practice of risk adjustment in setting premium rates.

It's been an applied practice for five years, and each year staff has characterized it as a positive exercise in maintaining parity among the cost of plans and making the highest cost plans more affordable to members. And part of the rationale has been that higher cost plans usually reflect different member demographics, namely older and sicker members.

So we're especially concerned this impact may have on over 37 -- or 30,000 PERSCare members since PERSCare has one of the higher rates if not risk adjusted. And there's a strong likelihood that without risk adjustment, monthly premium contribution limits will fall well short of the unadjusted premium.

There are several other plans where this will likely affect members as well.

In discussing this with staff and stakeholders last week, the rationale we were given was that by not doing risk adjustment, about 79 percent of covered members would see their premiums go down while only a small percentage would have theirs increase. So for the overall good, this is good idea.

And that argument that more members would benefit is sort of misleading for especially fully vested retirees since the vast majority of the low cost plans even adjusted -- risk adjusted are fully covered by the contribution levels of CalPERS.

So in conclusion, although PERSCare Basic is the most expensive of the three self-funded plans, it's sometimes misrepresented as being a Cadillac plan. And that really isn't the case when you consider that members have to pay 10 percent of all non-preventative care in addition to the 500 or a thousand dollar deductible for a family. And there are 18 counties where HMOs are not available so people are forced to take these plans.

Even where HMOs are available sometimes members join a PPO to retain the providers that they already had.

So I thank you for your time.

CHAIRPERSON FECKNER: Thank you. Thank you for

your comments.

Though seeing nothing else on our agenda, this open session is adjourned. We will go into closed session at 2:15.

See you all next month.

(Thereupon the California Public Employees' Retirement System, Board of Administration, Pension & Health Benefits Committee open session meeting adjourned at 2:07 P.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 23rd day of April, 2018.

JAMES F. PETERS, CSR
Certified Shorthand Reporter
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