MEETING

STATE OF CALIFORNIA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

BOARD OF ADMINISTRATION

PENSION & HEALTH BENEFITS COMMITTEE

OPEN SESSION

ROBERT F. CARLSON AUDITORIUM

LINCOLN PLAZA NORTH

400 P STREET

SACRAMENTO, CALIFORNIA

TUESDAY, SEPTEMBER 25, 2018

2:23 P.M.

JAMES F. PETERS, CSR
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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 Ms. Ruth Holton-Hodson

Ms. Adria Jenkins-Jones, represented by Mr. Ralph Cobb

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

STAFF:

Ms. Marcie Frost, Chief Executive Officer

Ms. Liana Bailey-Crimmins, Chief Health Director

Mr. Matt Jacobs, General Counsel

Ms. Donna Lum, Deputy Executive Officer

Dr. Kathy Donneson, Chief, Health Plan Administration Division

Mr. Rob Jarzombek, Chief, Health Account Management Division

Ms. Jennifer Jimenez, Committee Secretary

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

STAFF:

Ms. Shari Little, Chief, Health Policy Research Division

Dr. Richard Sun, Medical Consultant II

Mr. Tim Taylor, Chief, Information Technology Services Branch

Ms. Emily Zhong, Health Actuary

ALSO PRESENT:

Mr. Al Darby, Retired Public Employees Association

Mr. David Henka, ActiveRADAR

Ms. Stephanie Hueg, California State Retirees

Mr. Harvey Robinson, Retired Public Employees Association

Mr. Larry Woodson, California State Retirees

I N D E X

P R O C E E D I N G S

CHAIRPERSON FECKNER: What we're going to do is first of all we're going to call the meeting to order.

And the first order of business will be to call the roll

COMMITTEE SECRETARY JIMENEZ: Rob Feckner?

CHAIRPERSON FECKNER: Good afternoon.

COMMITTEE SECRETARY JIMENEZ: Theresa Taylor?

VICE CHAIRPERSON TAYLOR: Good afternoon.

COMMITTEE SECRETARY JIMENEZ: Ruth Holton-Hodson for John Chiang?

ACTING COMMITTEE MEMBER HOLTON-HODSON: Here.

COMMITTEE SECRETARY JIMENEZ: Ralph Cobb for Adria Jenkins-Jones.

ACTING COMMITTEE MEMBER COBB: 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.

The next order of business is approval of the 20 -- of today's timed agenda. Who wants to make the motion?

VICE CHAIRPERSON TAYLOR: Move approval.

COMMITTEE MEMBER MATHUR: Second.

CHAIRPERSON FECKNER: Moved by Taylor, seconded by Mathur?

Any discussion on the motion?

You have to raise your hands today folks.

Seeing none.

All in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries.

Executive reports. Ms. Bailey-Crimmins, Ms. Lum.

DEPUTY EXECUTIVE OFFICER LUM: Good afternoon, Mr. Chair, members of the committee. Donna Lum, CalPERS staff.

Today, I have four brief updates to share with you. The first is an update on what's happening with open enrollment within the contact center. Secondly, I'll give you a report on the final two CBEEs that we had in August. And then I'm happy to share some new information about a

new surveying methodology and tool that we've been using recently at the CalPERS Benefit Education Events. And then lastly, I'll give you an update on what's happened with some adjustments that we've made with the East San Gabriel retirees.

So regarding open enrollment, you're going to have a more comprehensive update on the overall open enrollment and what's happening with the health plan changes soon. But what I wanted to share with you is that obviously this is a very, very busy time for the CalPERS contact center.

We have had approximately an 18 percent increase in the number of calls that we received this year over the number of calls that we received last year. Now, that's not surprising to the team with the various health plan changes that took place. We anticipated that we would likely have more calls in the first two weeks.

That being said, however, I will say that the team has done an excellent job in terms of fielding the number of calls that we've received. On day one, we had approximately 6,400 calls offered into the contact center, and well over 80 percent of them were answered and not abandoned by the caller.

Our average call wait time over the past two weeks has just been slightly over five minutes. And we

will continue to see that number drop as we're into week three and then obviously at the last week of open enrollment.

We are seeing that the calls are taking slightly longer to respond to or to answer the questions. But certainly what we are seeing as well is that our members are calling with a lot of information, and have done a lot of research independently on their own. And so we're happy to say that as we are providing the assistance that's needed, we know that we're ensuring that we're also giving them the information that they need to make an informed decision.

And then lastly, with regards to open enrollment, I had an opportunity to go over to the contact center last week. And I sat down with one of our agents and listened in to the calls. And it's really insightful when we get to do that, because we're able to see -- you know, to understand better what the calls are about. But what I experienced in the calls that I sat on was a great amount of gratitude that our members are expressing with regards to the information that they've either received in the mail, or that they've researched on the website, or that they have gotten from our call center agents.

So again, we're heading towards the end. Open enrollment closes on October 5th. And again, I believe

that our contact center agents are continuing to be energized and our members are in good hands when they contact us.

Secondly, the CalPERS Benefit Education Events. In August, we successfully completed the remaining two CBEEs for the calendar year. We hosted a CBEE in San Diego on August 10th and 11th. And we had over 1,200 attendees, which again surpassed the previous record that we had in this area of about a thousand attendees.

Ms. Frost conducted her town hall both days at the CBEE. And on Friday, she did another one of the Facebook Live events. And I'm certain that she'll give you an additional update on how those events went.

Our last CBEE for this calendar year was at Garden Grove, and that was hosted on August 24th and 25th. We had about 1,200 attendees and which was previ -- which was slightly higher than the previous attendance that we'd seen in that location.

And thereto, Ms. Frost conducted another town hall on Friday, and we were able to stream live that on live Face -- on Facebook.

We did get a lot of compliments from the members that have been attending. These talks that Marcie has been giving at the CBEEs, members are commenting on how important it is to hear from our CEO, and how grateful

that they have been for the opportunity to be present in these.

And so as we move forward into the next calendar year, we continue to have plans to use the CBEEs as an opportunity to continue to reach out to our members and to share the important information that Mrs. Frost has.

I just wanted to take a moment to thank all the Board members that attended these two CBEEs, as well as those of you that have attended the CBEEs throughout the career.

As you know, our team is very honored to have you present at the CBEEs. But more importantly, we know that our members that are attending the CBEEs also take note, and know that you're there. And I know that you also appreciate the interaction that you're able to have with them.

Our next CBEE is scheduled for January 10th and 11th agencies at Seaside, California. All of the CBEEs that are scheduled for next calendar year are posted on the CalPERS online website. And so for our members that are watching this webcast, you can find the dates at www.calpers.ca.gov.

Also related to the CBEEs, in June, I shared with you that we were going to be launching a new survey initiative. And this gave our team members the

opportunity with tablets to survey those members that -- survey a sampling of the members that attended the CBEEs. And it's a great opportunity because we're able to get firsthand experience and information interacting with the members and gathering information on the interaction that they've had with our team.

This was just another method of us for being able to get a better understanding of our customer satisfaction with the services that they're receiving. Between June and September, we surveyed over 200 of our members at the CBEEs, and the overall results were very positive. Ninety-six percent of those that were surveyed indicated that they were very happy with their experience. Ninety-two percent indicated that their issue was resolved in a timely manner. And 98 percent responded "yes", when we asked if we made them feel like a valued customer.

Members consistently provided feedback on the contact center as well as the regional office team members. And as they were commenting, they indicated that they greatly appreciated the thoroughness of the information that they received, and the professional manner in which our team members are conducting their customer service.

In addition to that, we were pleasantly surprised as many members also expressed that they have been using

online resources to answer their own questions. And this is a testament to CalPERS' ability to provide the information members are looking for through the CalPERS website, as well as the my|CalPERS system.

And then lastly, I wanted to give you a brief update on some adjustments that were recently made for the East San Gabriel Valley Human Services Consortium retirees. As you know, these retirees, 74 retirees, experienced a reduction in their retirement warrant. I just wanted to share with you that the 74 ESG retirees had their retirement benefits adjusted, and will be receiving a subsequent increase to their retirement allowance.

Now, this increase is due to a decrease in the terminated agency's liabilities. The benefit increase was effective for the September retirement period and will be reflected on their October 1st retirement check. All of the 74 retirees were notified of this increase by certified mail last week. And they would have received the certification letter no late -- or the certified mail no later than Saturday, this past Saturday.

Just to give you some insight in terms of what the adjustments look like. About 47 percent, so 35 of the retirees, are receiving an adjustment of under $25. Twenty-seven percent are receiving an adjustment between 50 and 25 dollars. Sixteen percent are receiving an

adjustment of 50 to 100 dollars. And then we had eight percent that are receiving an adjustment between 1 and 200 dollars. There's one retiree that is receiving an adjustment of slightly over $400.

So with that, Mr. Chair, that completes the updated. And I'm happy to take any questions that you may have.

CHAIRPERSON FECKNER: Thank you.

Any questions or comments?

Seeing none. Thank you.

Before you start, Ms. Bailey-Crimmins, I want to note for the record that Ms. -- Board Member Brown has joined the Committee today. Please note that.

Ms. Bailey-Crimmins.

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

For my opening remarks, I have four highlights for you today. The first is to provide an update on the CalPERS health plan open enrollment efforts; second is to share some exciting news in regard to employer outreach and retention; third is to announce the launch of our PPO third-party administrator solicitation; and then lastly provide you executive highlights on what to expect from the Pension and Health Benefits Committee agenda items

today.

So as Ms. Lum had mentioned, open enrollment is underway. It began on September 10th and will end October 5th. Since the Pension and Health Benefits Committee met in June, CalPERS has taken numerous steps to ensure that the 2019 health plan changes were effectively communicated to our members and employers. For example, we mined the data, and anyone who is going to be impacted by an increase in premiums, changes in copayments, service area or significant network changes, receive additional targeted communication from the CalPERS team.

Even though overall communication improvements have been made this last year, I want to personally acknowledge that our third-party vendor did erroneously send out a set of letters to PERSCare members. They indicated that there was an enclosure. So at the bottom of your letter, you know, you see -- you always see that there's an enclosure, the vendor failed to include attachments.

We were alerted of this from a member. The vendor took immediate responsibility and corrected the error, and new member health statements were distributed through the Postal Service to all impacted parties, including an apology letter. And it was received and delivered prior to the September 10th open enrollment

date.

The second item is employer outreach. In addition to the State of California, CalPERS Health Program contracts with approximately 1,200 public agencies and schools. We believe engagement is key. Therefore, we hold quarterly meetings with our employers. And at our recent August meeting, we covered the 2019 open enrollment updates, including HMO and PPO and the recently approved VBID for the PERS Select plan.

Employers have commented that they found -- find this tremendous value because they get to have face-to-face interaction with CalPERS. The team is currently expecting to plan another employer outreach event in early December.

As you're aware, contracting agencies and schools have a 60-day window each year after open enrollment, or after each -- the premiums get set in June, sorry, to submit a termination resolution. That termination resolution window ended on August 20th. And based on the preliminary data, we're on target to achieve the highest retention rate with our employers in five years. I want to personally thank the Health Policy and Research Division and the CalPERS health marketing team who do an amazing job going out an meeting with the employers, and making sure that they have the vital information necessary

to share that with their employees and our members.

The third item is PPO solicitation. The Health Plan Administration Division is soliciting proposals for a third-party administrator for the CalPERS portfolio of PPO health plans.

The solicitation will result in a new five year agreement from January 1st 2020 through December 31st, 2024. As a reminder to any potential bidders that are watching, CalPERS is in a no contact period. If firms or other parties are interested in receiving information in regarding to the solicitation, they can check out our website or they can email us at ossd_contractsadmin@calpers.ca.gov.

Today, the Pension and Health Benefits Committee will cover four key topics. The first is the Health Care Reserve Policy. Today, we will be requesting your approval to mature our prior Health Care Fund reserve practices into a policy.

The second is an update on the reference pricing pharmaceutical pilot. CalPERS State staff and UC Berkeley have come up with the three therapeutic classes. We also had an opportunity to work with RXTE, which also now known as ActiveRADAR. Those gentleman are actually in the audience. They shared a wealth of experience and knowledge with us, which allowed us during the research

phase to help this Board make a final decision to proceed with the pilot.

And third, with -- we wanted to share our progress on the health care regions. This will be the third of the five sessions that we will be having with you on this. And we're specifically sharing today our stakeholder outreach efforts.

And lastly, we will be sharing a demo of our new health plan open enrollment app where we demonstrate how State IT staff rose to the challenge and worked collaboratively with the program to deliver results. And just a fun fact, our first retiree made a health plan change on the open enrollment app from Hayward, California at 4:30 a.m. on the first day of open enrollment. Hats off to the retirees.

CalPERS continues to bring the very best experience to our members and look towards technology advancements to help that member experience.

And, Mr. Chair, I would like the Committee's permission for a moment of privilege.

CHAIRPERSON FECKNER: Certainly.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: I want to personally thank Dr. Richard Sun for his years of service. He is leaving the State of California to go join the private sector. I don't how I feel about that, but his

last day will be September 28th. He has worked here at CalPERS since 2008, has been our Chief over the Clinical Programs and Appeals Section. He started his State career in 1992 at the California Department of Health Services. He oversaw their Medi-Cal program plans.

And something I didn't know about him, that he actually was involved in the CDC bioterrorism cooperative agreement. I want to personally thank him for being a strong advocate on behalf of our members. He implemented the Diabetes Prevention Program that is required across all of our plans, that wonderful population health dashboard that we hold each plan accountable for health outcomes. And he established regulations for post-ACA, and many, many more.

So with that, I'd like to turn around and thank Mr. -- Dr. Richard Sun for all his service.

(Applause.)

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Mr. Chair, that concludes my opening remarks. I'm available for questions.

CHAIRPERSON FECKNER: Thank you. And on behalf of the Committee, Dr. Sun, we want to wish you well on your new adventure. Wish you weren't leaving us. You brought a lot of insight and great business acumen to this organization. And we certainly appreciate all the help

that you've given us over the years. You've taught us all a lot and your shoes will be big -- hard to fill. So thank you and good luck.

Anybody else have any questions or comments on this item?

Seeing none.

Moving to Item 4, the action consent item. We have one item. That's the approval of the minutes. What's the pleasure of the Committee?

COMMITTEE MEMBER JONES: Move approval.

VICE CHAIRPERSON TAYLOR: Second.

CHAIRPERSON FECKNER: Moved by Jones. Seconded by --

VICE CHAIRPERSON TAYLOR: Taylor.

CHAIRPERSON FECKNER: -- Taylor.

Any discussion on the motion?

Seeing none. All in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries.

Item 5 is the information consent items.

I have had no requests to move anything off of those.

That will take us to Action Item 6, Health Care Fund Reserve Policy. Ms. Bailey-Crimmins.

(Thereupon an overhead presentation was presented as follows.)

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So I'm going to go ahead and turn this over the Kathy Donneson. As we've discussed prior, that we have had a historical practice. And recently we have used reserve monies to buy down the PPO CalPERS Care and the Medicare. And so what we're asking today is to mature that practice into a policy which I believe provides additional transparency that our members and our stakeholders are looking for. So with that, I'll turn it over to Kathy.

CHAIRPERSON FECKNER: Very well. Thank you.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Mr. Feckner -- Chairman Feckner, members of the Committee, good afternoon. Kathy Donneson and Emily Zhong, CalPERS team. We are presenting Agenda Item 6a, which is the Health Care Fund Reserve Policy.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: In 1997, a reserving practice establish -- was established based on four months of premium for the PERS Choice and PERSCare plans, both basic and Medicare.

In 2004, CalPERS adopted the National Association of Insurance Commissioners guidelines for using risk-based capital approach to reserving for our PPOs.

In 2014, CalPERS flex-funded its HMO plans, which included Anthem HMO, Blue Shield Access+, NetValue, Sharp Health Plan, UnitedHealthcare, and Western Health Advantage. And we established fund accounts within the Health Care Fund to support the flex-funded plans. Those accounts were meant to pay for any fee-for-service claims, third-party administrator fees, and other fees as required. We've been administering these flex-funded plans since 2014.

Today, we are bringing before you a proposed Reserve Policy that memorializes the reserving practice within the PPO fund accounts. This policy will also address any distribution of flect-funded -- flex-funded surpluses that accumulate in the HMO fund accounts.

Ms. Emily Zhong will now discuss the previous use of the PPO sur -- surpluses, and then we will go back and talk about the HMOs.

HEALTH ACTUARY ZHONG: Thanks you Kathy.

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HEALTH ACTUARY ZHONG: Good afternoon, Mr. Chair and members of the Committee. Emily Zhong, CalPERS team member.

The PPO reserves are calculated and set aside for each PPO basic and Medicare fund account and during the plan year, which is calendar year. The Health Care Fund

receive premium and investment income and pays out claims and expenses from each firm account. In some years, the incoming fund exceed the claim and the expenses paid out creating a surplus.

Surpluses occurred mostly due to the conservative cost trend assumption that bear into the premium, and those surplus amounts has been accumulated over the past several years. Currently, there is no formal procedure in place to review and take action to handle this excess money.

However, CalPERS has used this excess funds in the past. And based on Board approval, those include a premium holiday in 2009 in the amount of 260 million, which pay for two months of premium for each PPO plan, CalPERS administrative costs for fiscal year '17-'18 in the amount of 40 million, a premium buydown for PERSCare and Medicare PPO for calendar year 2019.

Next slide, please.

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HEALTH ACTUARY ZHONG: This slide shows the changes within the proposed PPO Reserve Policy, which includes the update to the current reserve level or risk-based capital or the RBC level, and our recommendation handling of surpluses or deficits on PPO plan fund account. And both item are both reflected in

the proposed policy, which is in attachment 1.

Over the past decade, as CalPERS Health Program evolved and the PPO calculation has increased, we observe less overall claim volatility and smaller yearly premium increases in recent years.

In other words, health care costs for CalPERS members are more predictable than in the past. So as a result, the team suggests a lowering of the RBC reserve from the current 300 level, which is approximately two months of claims to the 250 level, which is approximately one and a half months of claim.

Included in the policy also is the proposed methodology of handling potential surpluses or deficits that may occurred in the PPO plan fund account that include trigger threshold for potential action in the timing for review.

During the annual rate development process, the team will review the Health Care Fund reserve and compare those to the required reserve amount. There will be three scenarios. If the plan reserve fund at the end of the year is within 10 -- within plus or minus 10 percent of the required reserve, no action will be taken. If the plan reserve fund exceeds 110 percent of the required amount, a premium reduction will be considered to lower the reserve level back to the 100 percent of the required.

Conversely, if the plan reserve fund falls below 90 percent of the required reserve amount, an additional surcharge may be considered to be included in the future premium. And this process will be performed on the individual plan level.

Now, let me give you an example. Given the required reserve for a particular plan is 100 million, if the amount of the total reserve fund at the end of the year is anywhere between 90 to 110 million, then no action will be taken. If the total reserve fund let's say now is 112 million, which is above 110 percent threshold of the required reserve, this will trigger the consideration of using the 12 million surplus to lowering the future premium.

Now, on the opposite scenario, if the total reserve fund falls to -- let's say it's now 85 million, which is below 90 percent threshold of the required reserve, the team will then consider including surcharges into the future premium to make up the 15 million deficits and bring the reserve back to the required level of the 100 million.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Thank you Emily. And now I'd like to discuss how we're going to handle the flex-funded portion of the

Reserve Policy.

For the flex-funded HMO plans, at the end of each calendar year, any surpluses that have accumulated during that year will be reviewed during the rate development process.

The team will review each flex-funded plan's financial performance, including capitation, third-party administration invoices paid, fee-for-service medical claims processed, and fee-for-service claims run-out, and any other expenses to determine whether there is a surplus in any of the flex-funded accounts. These amounts should be minimal and will roll-over to the next year within that five-year period of the contract.

At the end of the five-year contract, for example, the end of the 2014 to 2018 contract, CalPERS will review each flex-funded HMO plan account, analyzing the revenues and expenditures claims run-out and contractually required reconciliations to determine whether there is a surplus as we close the five-year contract.

For the flex-funded HMO plans, with which CalPERS has entered a new contract, for example, the 2019 to '23 contract, the objective will be to use the 2014 to '18 surplus, if any, toward the same plan.

Where CalPERS has not entered into a new contract

with an individual flex-funded HMO plan, the goal will be to use the surplus towards the employees and employers from which the surplus was generated. In some instances, such as plan termination, this may entail using the surplus towards a comparable plan. At the end of 2018 contract on December 31st, 2018, the CalPERS team will execute procedures to close the 2014 to '18 flex-funded HMO contracts, and on January 1, 2019 execute the 2019 to '23 contracts.

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HEALTH ACTUARY ZHONG: In summary, the CalPERS team is recommending this Reserve Policy for the PPO self-funded health plan to memorialize consistent and transparent approach for detecting and reporting surpluses or deficits within the PPO account in the Health Care Fund. It also outlines a methodology for handling annual surplus within the flex-funded HMO account. This policy also documents the requirement for reporting and monitoring in detail.

CalPERS team will assess PPO program reserves and will report any changes to the Pension and Health Benefits Committee during the annual rate development process.

As we have done in the past, the team will continue to provide semiannual reports to the Committee, regarding changes to the total assets reserve and any

surplus or deficits for both PPO and flex-funded HMO programs.

This policy is a dynamic document that may require revision from time to time, based on the changes of the CalPERS Health Program. CalPERS team will perform evaluation to the policy at least once every four year, and we will report back to you.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: This slide provides -- this slide provides our next steps once the Board approves and sets the provisions for the Health Care Fund reserve review, the semiannual financial reporting for all plans, and the four-year policy review.

Chairman Feckner, members of the Committee, at this time, we invite questions from the Committee. And at the conclusion, we ask that you accept our recommendation to adopt the Reserve Policy and that concludes our presentation.

Thank you.

CHAIRPERSON FECKNER: Thank you.

Anybody have questions or comments.

Turn on Ms. Holton-Hodson's microphone, please.

You're on.

ACTING COMMITTEE MEMBER HOLTON-HODSON: Okay. So

I just wanted to say thank you. I think it is high time we had such a policy. So I'm really glad that we've moved toward, because I know when the question of excess reserves has come up, we're all like so do we have a policy? And then you explain sort of what we did the last time. And I think, you know, it's also confusing for our members to know, well, if there is reserves why aren't you giving us a holiday. And we're not in this plan, so why don't we get anything. So the clearer we can make the process, and the clearer that we can make sort of what triggers what actions the better, so we appreciate this and we're in full support.

CHAIRPERSON FECKNER: Thank you.

Mr. Lofaso.

There you go.

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

I ditto Ms. Holton-Hodson on the value of the policy. Just can -- I came in trying to understand exactly what the Board role versus the staff role was, and how it's going to be implemented. And I'm under the impression that you all make lots of tiny adjustments that maybe we don't see. And I -- maybe you can't answer my question in open session. But are you able to basically tell me, when we see numbers during the rate development

process, where is the -- where are -- where is the source of funds that fill the reserves? Is it part of the premium? Is it part of the administrative fees? Where are we going to look for it when you're reporting to us?

HEALTH ACTUARY ZHONG: I'm going to take this question, Mr. Lofaso. During the rate development process, we're trying to be really transparent. So in our rate development process, we're trying to look for the fund balance for each account, which is like -- well, we recommend it on the process. We will compare the -- what's the calculated -- the required reserve and what the individual account whether they have money in their account. So as what we described it's over 110 percent. So in the example, the $12 million, we will be really open and report to you.

So how we're going to use the $12 million applied to the premium adjustment in the rates? So we're trying to be really transparent.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Mr. Lofaso, this is Liana Bailey-Crimmins. Just to remind the Board is that the Finance and Admin Committee is where we would actually see the -- we -- bi-annually the actuary gives the -- what the subaccount balance are and also reports on where the reserve dollar amounts sit. And then that number would then go into the rate development

process, as we start to establish the premiums. So I just wanted to make sure that I reminded the board where that is discussed.

ACTING COMMITTEE MEMBER LOFASO: Appreciate that. My question is really focused on the retail experience not the wholesale account management, but I appreciate the answer.

One more question. So if there's a shortfall in the current year, and there's a need for more revenues to restore the reserve in the current year, can you walk us through how that process works?

HEALTH ACTUARY ZHONG: I think, as -- I kind of mentioned it in the example, like in the current year -- there's a shortfall currently at this point. And we still have several months of unknown experience to go. If, at the end of year, we still see a shortfall, let's say it's below 90 percent of the required reserve, and then we will try to incorporate some surcharge into the premium and trying to bring the reserve back to the required level.

But also one thing we need to keep in mind, which is our goal is to minimize the volatility year over year on the premium volatility. So this is not a very hard formula that let's say we have 12 million. We have to use entire 12 million to put into the premium for next year, or we have 15 million deficits that we have to make

surcharge toward -- toward the next year the premium to make up the entire amount. So we have to keep in mind that we have to minimize the volatility. So this is another item we have to think about.

ACTING COMMITTEE MEMBER LOFASO: Appreciate it. And I understand there are controls to make a current year adjustment an extremely repair event. So thank you. Thank you, Mr. Chair.

CHAIRPERSON FECKNER: Thank you.

Ms. Mathur.

COMMITTEE MEMBER MATHUR: Thank you, Mr. Chair.

I agree this is a very sensible, well thought through policy. With respect to the adjustments or the surcharges, if we needed to make up a shortfall, that would be in the following year, correct? So we would experience a shortfall in a given -- let's say it's 2018, then in 2019, we would -- well, it would be for the -- or would it be for the year later? It would for the next rate -- so it would be in 2020 that we would actually experience the surcharge, correct?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: That is correct.

COMMITTEE MEMBER MATHUR: Okay.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: PEMHCA does allow us to make a change, but our practice has not

been that. We very --

COMMITTEE MEMBER MATHUR: It's very hard midstream to make a change for members. So as a practical matter it would -- it would be in the rate development process that begins in 2019 but then that would actually be effective for 2020.

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

COMMITTEE MEMBER MATHUR: Okay. That's helpful clarification. Thank you. Well with that, I'm happy to move adoption of this policy.

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.

Thank you.

That brings us to Agenda Item 7a, reference pricing prescription drugs by therapeutic class.

Before we get into that discussion, let me ask -- just a question. Since you guys have been delving into

this for quite some time now, do you have enough data or is enough data out there to not go into a pilot program but actually go out to bid on an item and forget the pilot side, and maybe reevaluate it in a year, or two, or three?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: That's an excellent question. So historically, we all understand that premiums matter to our employers and members. And when we establish a premium it's medical, and it's also pharmacy. And so -- when we've affected a lot of innovation when it comes to medical, and we've done a lot -- numerous pilots, such as hip and knee, we start out small, we build upon the success, and now we've just -- last year, we added another 12 procedures to medical.

The same falls to suit to the -- the pharmacy side. We have to balance savings plus member's experience. If I focus purely on savings and we don't take a methodical step in to making sure that the member's experience at a fixed price for pharmaceutical isn't highly accepted by our membership, that may alter what we end up doing. So we start small and build upon our successes. So that's been our historical practice.

I think we have enough data to end up doing the three therapeutic classes. But I think if we jumped to something bigger, we could potentially end up in a situation where our members' satisfaction could be

negatively impacted.

CHAIRPERSON FECKNER: But according to you, we could start with just the three therapeutic classes and not have to go through the pilot?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Well, we're calling the three therapeutic classes a pilot because it's -- we're not expecting to have a huge number of savings. It really allows us to test what the members' experience will be with those three therapeutic drug classes. So I think at this point, we're recommending about -- I think, it's about 2.5 million in savings, which is not huge.

If we expanded it more in the future, it would be a lot more savings, but we want to make sure that we get our feet underneath us, and that we have the procedures with our call centers, prior authorizations, all the things that are necessary before we would expand it even further. So we believe that the therapeutic drug class with the three is a pilot before we actually do a full solicitation beyond that.

CHAIRPERSON FECKNER: Okay. Ms. Donneson.

(Thereupon an overhead presentation was presented as follows.)

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

Committee. Kathy Donneson and Dr. Richard Sun, CalPERS team members.

This is Agenda Item 7a, an information update on reference pricing prescription drugs by therapeutic class.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: This is a program that we have done extensive research by our team, as well as three presentations that -- to you that discussed ways to lower and stabilize CalPERS over $2 billion in prescription drug costs. And you'll also note that you have an information consent item that discusses the annual spend that we are presenting. And it shows that in Agenda Item 5c in 2017, total drug costs paid under the pharmacy benefits program was 1.25 billion, a $223 million increase from 2013.

I want to just remind the Committee about how we came to these therapeutic classes, because we have spent really over four years looking at this as an option, and even worked with CVS to see if we couldn't implement when they held our contract. And while the classes and the savings are important, there also patient safety considerations.

And then as Dr. -- as Mr. Lofaso pointed out in one of our Committee meetings, it's not just the therapeutic class, it's also the subclasses which describe

how a drug is going to be administered.

For example, while corticosteroids showed up as one of the top 10 classes. Corticosteroids are quite a -- a number of different types of drugs, delivery systems, creams, patches, injections. And so it's really the subclasses that we have presented to you as part of this pilot. The nasal corticosteroids, the oral estrogens, as examples.

And so while we talk about the therapeutic classes, those are really a higher level of classification. What we are presenting are the subclasses.

The other part of running a reference pricing program that showed up as part of our research is patient safety, that is we can say that this is a good drug to maybe reference price. But if it's in the class of antipsychotics, it might not be good. And so we could save quite a bit of money if we wanted to reference price the antipsychotics. We could save a lot of money if we wanted to reference price all diabetic drugs, regardless of whether the pancreas is producing insulin or not, whether or -- whether a member was insulin dependent and would die without it.

So there's -- there's a lot to consider when looking at reference pricing drugs by therapeutic class

that do involve the PBM's pharmacy and therapeutics committee. And so I just -- those are things I don't think we spelled out in our discussions with you that I want you to consider. We did look at 70 classes with UC Berkeley. And we could save $34 million, but that's -- that's sort of a wholesale approach to really savings versus value. Savings, safety, quality, evidence.

So with that, I will just remind the Committee about the -- what we have done to date, and then I'm going to turn it over to Dr. Sun.

So our program does begin, and we called it a pilot. It's -- for lack of a better descriptive term. And it is the three therapeutic drug classes that we presented to you. And it is in -- those classes are administered through our claims system by our PB -- pharmacy benefit management company. And we've designed this so that it's more transparent to you what you're actually spending money on, because if you just say generic preferred brand, not preferred planned, there's not a lot of transparency around what you're paying for.

In June, you did direct us to include another vendor, but it was really primarily for the customer service portion as we interpreted our directions. It was more for a customer service outreach, including provider education. And that is an area of focus for us this year

is not just provider education on our formulary, or our reference pricing program, but on opiates as well. So we are -- we are launched in 2019 beginning now of a really strong approach to outreach to our prescribing physicians.

So those are some of the considerations that I want you to think about in terms of the customer facing focus for this second vendor that we were directed to look at.

And with that, I'm going to turn it over to Dr. Sun and have him continue the presentation.

--o0o--

DR. SUN: Richard Sun, CalPERS Medical Consultant for a few more days.

(Laughter.)

DR. SUN: To implement the Committee's direction, team members first noted that the participation of the PBM is critical. In general, in collaboration with CalPERS, a PBM's tasks in reference pricing would include establishing the therapeutic drug lists. And as stated in previous agenda items, we've already decided on the initial three therapeutic classes, programming the claims processing adjudication system, developing marketing and communication materials for members, providers, and pharmacies, and finally implementing and managing the program.

For example, the PBM, with assistance from its pharmacy and therapeutics committee, is expected to monitor the therapeutic drug calls lists on a regular basis.

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DR. SUN: However, involving a third-party vendor required a division of labor among the PBM, the vendor, and CalPERS. The current concept is that the vendor would be assisting with certain aspects of the program, marketing, member support, clinical support, and ongoing program evaluation, and quality assurance. Please see attachment 2 for details.

Next slide.

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DR. SUN: Member communication and customer service are very important to the administration of the program. Customer facing support, which will involve the PBM, the vendor, and CalPERS will include interacting with members, pharmacies, and prescribers face-to-face, online, and via phone.

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DR. SUN: To get to this point, the CalPERS team analyzed four different approaches to administering the

program, whose advantages and disadvantage are summarized on page three of the memo.

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DR. SUN: Number one, administration by the PBM only; number two, by the PBM and the non-profit governmental entity; three, by the PBM and a for-profit entity; and finally, to hold a solicitation that would lead to a direct contract between CalPERS and a vendor.

As we balance the considerations and consider the Committee direction, we decided to go forward with option two. The PBM recommended that the reference pricing program involved the University of Massachusetts, a non-profit governmental entity, and CalPERS accepted the recommendation.

As noted in the agenda item memo, this option allows launching of the program in 2019. Other options would have delayed the program. A solicitation would potentially divert team resources away from the current PPO solicitation.

And now, Dr. Donneson will summarize the next steps.

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

I wanted to point out that's the University of

Massachusetts School of Medicine, who has an independent arm that manages programs for customer outreach such as this.

It is our plan to move forward with implementing the reference pricing program for pharmaceuticals using the option of another vendor -- another vendor being the University of Massachusetts School of Medicine. We will work closely with the PBM and this entity to deliver comprehensive engagement and communication activities to deliver superior services to our members, doctors, and pharmacies.

We will update you on the progress of the program in 2019, and we will continue researching additional solutions to stay ahead of increasing drug pricing.

Thank you. That concludes our presentation, and we're available to take questions.

CHAIRPERSON FECKNER: Thank you.

We do have one request from the public to speak, but is there any questions on the Board?

Ms. Mathur, please.

COMMITTEE MEMBER MATHUR: Yeah. I just have -- forgive me for if I've -- you've shared this and I am not remembering. But could you remind me, so how -- so if we do a pilot with these three therapeutic subclasses, as you've identified, how long will the duration of the pilot

be and what's the process for evaluating, and then either expanding the on -- you know, either solidifying the program as a program and no longer a pilot, or expanding it to other therapeutic subclasses?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: One of the questions that has been asked of us many times when we bring forward innovations is how are going -- what is your measure of success?

COMMITTEE MEMBER MATHUR: Yep.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: How will you evaluate it? How do you declare success?

And I thank -- I thank many of the Committee members who continually ask us these questions. So we do have a research arm of our branch under Dr. David Cowling. He has research scientists. He's worked directly with University of California, other academic institutions, and he is working directly with Berkeley on this. And so he has already thought about how to evaluate this pilot.

One of the reasons we want to start small is we -- is disruption. We just want to be very careful in terms of our membership. And that's -- that's really why we were beefing up more of the customer service end of this pilot.

So we do have ways in which we plan to evaluate

this pilot. We would report back to you in a year our progress. And then at that point, he could -- we could make a report on where we are in terms of reference pricing. So that's kind of our plan. Give a year, see how it works, let us work out the kinks with our members, because our members -- these are very -- pharmaceuticals are very important to our members. We want to work out those kinks.

We do want to see if it will eliminate member pays the difference. We do want to see if it reduces high performance generic step therapy or eliminates it. We do want to see if utilization management can be streamlined. Those are sort of the goals of the pilot.

As we -- as Liana pointed out, it's not so much to save money. Although, we don't want to not have some savings. It's really about can we do this on a small scale before scaling it up to a large class -- set of classifications of therapeutic classes. When we looked at even the top 10, the diabetes drugs are showing up. We didn't -- the antipsychotics, which are -- treat bipolar disorder, which treat schizophrenia, which treat depression. We just have to be, in my opinion for safety reasons, very careful with not just classes of drugs, but what subclasses. There are some on this list of 70 we may never want from a patient safety perspective to reference

price.

So that's kind of our time frame. We would report back in a year. If we felt that it was successful -- even though hips and knees took like five years before we reported back on its success, we probably could come back with a fairly -- with an idea of how much it would work and perhaps then start carefully adding more classes.

COMMITTEE MEMBER MATHUR: Okay. Thank you very much.

CHAIRPERSON FECKNER: Ms. Holton-Hodson.

ACTING COMMITTEE MEMBER HOLTON-HODSON: Thank you.

CHAIRPERSON FECKNER: You're on.

ACTING COMMITTEE MEMBER HOLTON-HODSON: I think we are excited to see how this turns out. Certainly big supporters of member pays the difference.

I guess a couple of questions. One is, you know, what is UMass's experience with reference pricing, particularly when it comes to sort of customer service, and serving a population like ours. I know there's sort of a limited pool of experts in this area. I -- and also if you could speak to sort of Optum's experience in this area, and how have they done reference pricing. Do they do it themselves? Have they partnered? Who have they

partnered with? So if you could just sort of go into those two issues, I'd appreciate it.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I'm going to answer the second question first and then have Dr. Sun address the first question second.

ACTING COMMITTEE MEMBER HOLTON-HODSON: Okay.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yes. OptumRx has reference priced -- has done reference pricing for other clients. And so they it's -- it operates very much the way EnvisionRx, which is now out of business. They sold to Rite Aid. It's very much structured the way Envision did it as well, and that is they come up with the reference -- the list for the reference prices, sometimes themselves are in concert with a second -- a second part -- a second party. So sometimes the second party who's contracted say with a health plan recommends the list, then it goes over to the PBM, who then has to take that list and run it through its pharmacy and therapeutics committee, again looking for safety, looking for -- sometimes -- sometimes the classes of drugs are small. You may not get as much return or maybe it's just not a good class to reference price.

So even though you can have a PBM plus the second party working together, the PBM's today are moving in this direction. And not only the value-based purchasing -- or

reference pricing pharmaceuticals by therapeutic class is moving forward, it's moving forward with the other two PBMs, sometimes with a second party, sometimes they're thinking of it on their own.

I will tell you that specialty drugs and reference pricing specialty drugs is the next frontier for -- for the pharmacy industry admini -- as the PBMs administer specialty drugs.

So it is a -- it is a movement that is -- that all PBMs are doing now, but there's probably going to be -- you'll probably see within the next two or three years that it's expanded, not just to the non-specialty drugs, but to the specialty drugs as well.

ACTING COMMITTEE MEMBER HOLTON-HODSON: And so could I just add on to that, is there a reason we just didn't ask Optum to go through its usual process with its usual second party to do this, instead of choosing UMass? And again speak to the experience of UMass.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Well, Optum could do the whole -- as any PBM in this day and age can do, they can do it themselves. But we were looking at more of the customer focus, because that's where we get so much friction. But that doesn't mean that we can't continue to explore other relationships or other activities that make it more efficient.

ACTING COMMITTEE MEMBER HOLTON-HODSON: Thank you.

DR. SUN: To our knowledge in previous efforts in reference pricing, OptumRx has not had a direct contract with a subcontractor for reference pricing work. Now, about the division of labor. In attachment 2, CalPERS and OptumRx went back and forth about which tasks the vendor would be able to do, the vendor being University of Massachusetts. UMass has not participated in a reference pricing program previously. Yet, they have numerous projects in the pharmacy space. And so they are able to do the -- they're able to help with marketing members, pharmacies, physician, member service support, clinical, financial, and analysis support and so forth.

ACTING COMMITTEE MEMBER HOLTON-HODSON: So if they haven't done this previously, why are we picking them versus vendors that are more experienced in doing it.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So part of it is it's broken up. So there are analytic -- there are third-party analytics that actually run your data through their tool. And then when they mine their tool, they will tell you what your subclasses of information and your savings and how to administer it. So there's that piece of it. There's the PBM that does the claims and the adjudication.

And in this case, what we were looking at is we'd already worked with the University of Berkeley who had had all of our subset, and we came up with the three drug classes working with them.

And then as such, all we've asked of OptumRx and then University of Massachusetts is to basically work together to ensure that our members experience the prior authorization, the things that are on the list of -- what attachment is that -- attachment 2, is outlined. And those were the requirements that we have made of OptumRx.

They proposed who they wanted to sub with, and contractually we have the authority to approve or deny, but we do not have the authority to tell OptumRx who to subject contract with.

ACTING COMMITTEE MEMBER HOLTON-HODSON: Thank you.

CHAIRPERSON FECKNER: Mr. Jones.

COMMITTEE MEMBER JONES: Thank you.

CHAIRPERSON FECKNER: Just a second, Henry. Push your button. There you go

COMMITTEE MEMBER JONES: It's pushed.

Okay. Thank you. Thank you, Mr. Chair.

Yeah, two questions. One is did you go through an outreach program with the stakeholders and retirees about this program coming forward when you first presented

it several months ago, I guess, we first -- that's the first question.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yes. We've done many outreaches with the stakeholders on this topic.

COMMITTEE MEMBER JONES: Okay. And then the second question is that I appreciate the toolset where you talked about evaluating the program, and reporting back, and getting information on the progress. But I think also many times a sample size could -- in terms of a pilot could be small. Then when you get ready to roll it out, and there's a large group implicate -- implications, it doesn't seem sometime to work out the way. So I would suggest you also -- when you roll out a new program like that, based on a small sample size of a pilot, there be an exit strategy included in your implementation program, okay?

Yeah, because we've had programs before that when we implemented them, they didn't work out as we planned, and then we were scurrying around trying to find out how to get out of it. So I would suggest we do that as part of the plan.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I think that is an excellent idea, and that would be part, I think, of the evaluation study that --

with the evaluation study, we'll set the parameters up front, launch the pilot. The upfront parameters would also include what worked -- if it worked or didn't work, and then the exit strategy.

CHAIRPERSON FECKNER: Ms. Taylor.

VICE CHAIRPERSON TAYLOR: Yes. Thank you, Mr. Chair. So what are the other two PBMs that you were talking about?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Express Scripts and CVS. Okay. And as I understand, CVS hasn't started this. They're going to, but they have not.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: There is -- is that correct, Richard? They've actually announced publicly.

DR. SUN: Yes.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Okay.

VICE CHAIRPERSON TAYLOR: So -- and then -- and then you guys talked about UC Berkeley and Optum working together to do what exactly for this?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So what -- originally, what we did is we worked with UC Berkeley. We provided them a copy of all of our claims data. They mined it, they worked with to do the research,

and they helped us come up with what three therapeutic subclasses we should be looking at.

The State staff, Melissa Mantong and Dr. Sun were the ones that mainly file -- made that recommendation. Based on that, working with Optum, we want them to implement this from a PBM perspective because the medical claims and adjudication, you cannot do this without the PBM. It's very clear.

And then what we asked, based on Board direction, is even though Optum said they could do it, Board direction as of June said please consider including another vendor. And so what we wanted to make sure is that the University of Massachusetts has done pharmacy type plans with -- maybe Dr. Sun, you can explain, because I know you have the requirements. But they've actually done a lot with other states regarding working with PBM's.

DR. SUN: Yes, that's correct.

VICE CHAIRPERSON TAYLOR: Okay. So Optum actually didn't bring this to you. You went to UC Berkeley to talk to them about it. Am I --

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So we actually -- when we were with CVS Caremark, we've actually been thinking of this for a while. 2015 when we worked with OptumRx, there actually is a line item in our contract in order to implement this. So it was actually

built into the contract with that in mind.

VICE CHAIRPERSON TAYLOR: But they didn't -- they didn't go out and, you know, look at this themselves and bring it back to us. We had to bring it to them.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: We brought it to the team. Kathy and the team have been pushing to move this innovation forward. But they were not the ones that established the subclass. That was our work with UC Berkeley, and Mr. Jamie Robinson.

VICE CHAIRPERSON TAYLOR: And then we brought -- so when we asked for more vendors, then you brought in UMass. But they haven't ever done reference pricing, just other stuff with pharmacies, correct?

DR. SUN: That's correct.

CHAIRPERSON FECKNER: Okay. So do they have a population similar to our population that they've done -- I mean, we've got what 1.4, 1.6 million people?

DR. SUN: I do not recall the number of lives that they have worked with, but it's substantial. It -- I do not know the -- if we added up the number. I don't know the sum.

VICE CHAIRPERSON TAYLOR: We probably should get that, because it would seem to me that if they're the ones that are going to be working with us, and we have another vendor that we've talked about before that has worked with

several hundred thousand up to almost a million members already, and they've done reference pricing, and this -- I'm just concerned now -- I didn't hear this before, that UMass had not done reference pricing. I was led to believe they had done reference pricing. So I'm a little concerned now that we're at this point of consideration, but UMass hasn't done that.

So it is in my opinion that we don't do this right now, until we have more information.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I would like to provide some information as you requested. University Massachusetts School of Medicine consults with 28 states in the United States, and they do a variety of different services in the pharmacy space. They also do consulting in the medical space, but this is about pharmacy.

They do utilization management reviews. They do client advisory outreach to providers, to physicians, to prescribers. We did not -- I mean, we have seen the extensive list of services that they offer. Reference pricing is a very narrow part of pharmacy benefits management. It really -- what it does is it says here's your -- here's your brand price, here's your generic price, here's your lowest cost alternative within a class. If the member selects the lowest cost alternative, even if

it's below the copay, they get the lowest cost alternative for that price. So that is really the crux of reference pricing. It has to be done through a claims adjudication system.

You can bring in secondary vendors that say okay we took your data -- and we have to give them the data. We took your data, we ran it through, and these are the classes we recommend.

Unfortunately, formularies change, and so you're doing that -- you could be doing it every day, but we don't choose to, but you could do it every quarter. So periodically, we have to provide to a secondary vendor our data, so that they can make recommendations on the classes and make recommendations on the savings. It is a guide for a purchaser. And we appreciate that.

VICE CHAIRPERSON TAYLOR: So does Optum --

CHAIRPERSON FECKNER: Ms. Taylor's microphone, please.

VICE CHAIRPERSON TAYLOR: Oh, I'm sorry. I thought Pam did it.

CHAIRPERSON FECKNER: There you go.

VICE CHAIRPERSON TAYLOR: Does Optum have that ability to do that, run it through the pharmacy?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yes, they do. And they have clients -- other

clients that they're reference pricing for.

VICE CHAIRPERSON TAYLOR: Okay. So they do?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: OptumRx does, yes.

VICE CHAIRPERSON TAYLOR: OptumRx is already doing referencing pricing?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yes.

VICE CHAIRPERSON TAYLOR: Okay. And they do the adjudication --

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yes.

VICE CHAIRPERSON TAYLOR: -- themselves already?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yes.

VICE CHAIRPERSON TAYLOR: So what's the -- and UMass does it too? I'm confused.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: UMass does not reference price, but they provide sort of a holistic shell around reference pricing. They outreach the utilization management reviews, the academic detailing to the physicians, the outreach to the pharmacy, they run a -- they actually run customer call centers, but we -- and so we looked at train -- you know, sort of a -- because we were looking at front-end customer

service, we were really looking at them for synergies around more customer outreach, so that our members get a higher touch in terms of the pharmacy benefits program.

VICE CHAIRPERSON TAYLOR: I'm just a little confused.

DR. SUN: If you look at attachment 2 under claims system set-up, the vendor column is blank.

VICE CHAIRPERSON TAYLOR: I'm looking at it right now.

DR. SUN: And that's because we do not foresee the vendor having any role in claims adjudication.

VICE CHAIRPERSON TAYLOR: Okay. So what is the -- what is the purpose of UMass? I'm confused. So they don't do reference pricing, and they're not going to. It's going to be -- or OptumRx.

DR. SUN: The purpose is UMass is to respond to the Committee's direction.

VICE CHAIRPERSON TAYLOR: Pardon me? Okay. I'm lost.

CHAIRPERSON FECKNER: Anybody else from the Board before we go to the audience.

ACTING COMMITTEE MEMBER LOFASO: Mr. Chairman.

CHAIRPERSON FECKNER: Mr. Lofaso, please.

ACTING COMMITTEE MEMBER LOFASO: Thank you, Mr. Chairman. Just to circle back, if I understand correctly,

when we're talking about reference pricing, the key issue was what the reference is. And in the medical procedure context that's very different than the pharmacy context.

What I'm understanding you saying is that the role of UMass is to provide the pharmacy expertise, so that the references and the reference pricing in this pharmacy context are appropriate to a pharmacy context. The focus is on pharmacy more on reference pricing, am I correct?

DR. SUN: That's correct.

ACTING COMMITTEE MEMBER LOFASO: Thank you.

CHAIRPERSON FECKNER: Ms. Mathur, please.

VICE CHAIRPERSON TAYLOR: You're on.

COMMITTEE MEMBER MATHUR: I'm sorry. I thought the -- now, I'm -- I thought that the purpose of having a vendor was really to -- us -- another form of assurance that the experience that's being reported -- you know, just to give us more confidence in the data and the analysis of the data that we are receiving from the PBM?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So that's correct. So referring back to attachment 2, they will be providing the clinical and financials analysis support, so you'll see where the check marks is where they are responsible. Obviously, CalPERS is not giving up its responsibility. But they are supposed to be adding a

value for their participation.

COMMITTEE MEMBER MATHUR: Yeah.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: The piece was is we've already established a therapeutic class. The PBM is the back -- the engine that runs all the claim information.

COMMITTEE MEMBER MATHUR: Of course.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: It's also. We want to make sure that for these three drug classes our members don't have a different member experience or customer service number that they have to call. It needs to run through the same process that they're used to with the PBM. It should all be very transparency to them.

But one of the things that the -- UMass is going to provide the value at of is basically, you know, in developing draft candidate, drug classes for inclusion and program, they will be doing therapeutic committee essential drug class review, I mean, there's reporting, there's things that are actually -- that sit on top of the PBM.

COMMITTEE MEMBER MATHUR: Right.

CHIEF MEDICAL DIRECTOR BAILEY-CRIMMINS: So they are kind of like - I think Kathy was saying - the shell that kind of pulls it all together. If we were

establishing from the very beginning the therapeutic drug classes, we would need a very different vendor. But since we've already established that and spent this last year --

COMMITTEE MEMBER MATHUR: Right.

CHIEF MEDICAL DIRECTOR BAILEY-CRIMMINS: -- with Jamie Robinson, we're already -- we're already there. We just need someone to take --

COMMITTEE MEMBER MATHUR: We just need to select the therapeutic classes.

CHIEF MEDICAL DIRECTOR BAILEY-CRIMMINS: Exactly.

COMMITTEE MEMBER MATHUR: We don't actually need such expertise in how reference pricing works in the pharmaceutical context.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Correct. But when we're ready to expand, let's just say -- let's just say we're successful, we will need a third-party to look at everything and decide what's the next course, which is potentially where a lot more savings will happen. But we'll have the member experience behind us in order to make that decision.

COMMITTEE MEMBER MATHUR: Right. Thank you. That's helpful.

CHAIRPERSON FECKNER: Any other questions from the Committee?

Seeing none.

Mr. Henka please come down. You'll have up to three minutes. Please identify yourself for the record.

It's on.

MR. HENKA: Mr. Chair and members of the Committee. David Henka. I'm the President and CEO of ActiveRADAR, which is an analytics and technology company that specializes in reference pricing. We have a technology platform that works. We've worked out the kinks. We're a member and customer communications expert.

In our experience, a pilot is really not necessary for this type of program. The data, in many respects, speaks for itself. We would recommend working with staff and select a number of therapeutic categories, whether that be three, six, nine to identify where the cost savings is.

Our platform is able to identify down to the belly button level how many people are impacted and what the expected cost savings will be for CalPERS. We also have built into our platform the analytics and reporting capabilities to share with staff, and with the Committee, and with the Board on a regular basis what the impact to members is, and what the cost savings is. And we could set up the metrics on that on a monthly, quarterly or biannual basis.

Our recommendations would be to start off with a

select number of therapeutic categories, review it, not an annual basis, but on a much frequent basis to determine what the member experience is and what the member impact is.

Our platform and our experience in this field is over eight years. We are the leading experts in this area, and have worked very closely with the University of California at Berkeley. Our work was featured in their research that was published in the New England Journal of Medicine this past year.

So I believe that we have the expertise and the experience. In addition to that, our platform has been integrated with OptumRx on numerous occasions. We're a California based company, and we have hundreds of thousands of members already on the platform with Optum as a PBM in California.

Our program includes pharmacy, provider, and member outreach as part of our package. That's already built in. It's been tested. It's been vetted. The devil is in the details with any type of technology platform. And our platform has been a proven success in this marketplace.

CHAIRPERSON FECKNER: Thank you.

MR. HENKA: Thank you.

CHAIRPERSON FECKNER: Any other questions or

comments from the Committee?

Ms. Mathur.

COMMITTEE MEMBER MATHUR: Thank you, Mr. Chair. You know, you started out this item asking the question as to whether this needed to be a pilot or whether a full solicitation really is appropriate. And I -- I'm still left with that question and not feeling fully satisfied on that question. And so I'm wondering if it would be appropriate to ask staff to -- I know this is -- we've been -- we've -- we've brought this item back a few times. But to ask staff to come back to review -- review that a little bit more fully of what -- what would a full solici -- solicitation look like. Because I think is being called pilot, but usually a pilot is really around having a smaller population testing an idea. This is really having our entire population and just first rolling it out to three therapeutic subclasses with the possibility of rolling it out to further therapeutic subclasses, again for the entire population.

So I'm -- the word -- the use of the word "pilot" I'm not sure it's really -- it's really sort of our first step into this -- into this world of reference pricing and pharmaceuticals. And I share your question as to whether it needs to be called a pilot or whether it just -- launching it and doing a full solicitation with some

options for expansion further out might be more appropriate or exits.

CHAIRPERSON FECKNER: Great. Thank you. Ms. Bailey-Crimmins.

Good luck.

(Laughter.)

CHAIRPERSON FECKNER: There you go.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Oh, there we go. I would just like to point out to the Board we're in the middle of a PPO solicitation. So if there was a solicitation, it would not be until after rates, which we would be bringing that back to April. So we would not see a full solicitation actually hit the street till June or July of next year. And it would delay potentially any savings for a year to potentially a year and a half. Just wanted to make sure you're aware of that.

CHAIRPERSON FECKNER: But you could also take the information that I brought forward and Ms. Mathur did and come back in November and give us a better idea of where we can go from there, correct?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS:

Absolutely. Yes, sir.

CHAIRPERSON FECKNER: Okay. That will be the direction then.

All right. Oh, Mr. Miller, sorry.

Hold it second. There you go.

COMMITTEE MEMBER MILLER: I just want to make sure I understand. So if I understood correctly, CalPERS didn't choose UMass, Optum chose them, and we basically assented to their choosing UMass for that kind of overlay of what they're doing?

But if CalPERS had had the option, we might have chosen someone different, say Berkeley or someone?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So in June when we gave the recommendation, it was Optum and then based on Board direction we were told to bring on another vendor. But Kathy pointed out at that time, that PBM is the workhorse. It is the engine that requires us.

And so the only way we could this is actually through a subcontracting relationship with our current prime PBM. And so what we did is we explained to OptumRx what our requirements were. We had already established the therapeutic drug class.

So we needed was a complement to Optum in order to make the pilot successful. And as such way our contracting rules are is that we cannot tell our prime who to subcontract with, because I'm holding that prime accountable for contractual performance measures, so I don't want to get between them and their contractor relationship. And so what they did was based on our

requirements they gave us a presentation, and we have the authority to approve or deny anyone they bring in front of us. We just can't tell them who to work with.

And so when we got -- when we received the presentation from the University of Massachusetts, it seemed like they were able to add the complement of expertise that we felt like we needed in order to proceed.

COMMITTEE MEMBER MILLER: Thank you.

CHAIRPERSON FECKNER: All right. Thank you. Seeing nothing else on this item.

7b, evaluation of health regions for public agencies and schools. Ms. Little

(Thereupon an overhead presentation was presented as follows.)

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: Good afternoon, Mr. Chairman.

CHAIRPERSON FECKNER: Not yet.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: That one.

Let's try this again.

CHAIRPERSON FECKNER: There you go.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: Good afternoon, Mr. Chair and members.

CHAIRPERSON FECKNER: Good afternoon.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

Shari Little, CalPERS team member. Today, we're here to talk about Agenda Item 7b and to continue our discussion around health care regions for public agencies. I know that CalPERS -- and as you well remember, CalPERS regions were first were created in 2004 as a result to maintain and retain our contracting member agencies.

We risk losing some employers and the Board decided to create some regions so that we could be competitive and go out and retain what we had currently in place and gain more public agencies and schools, as they represent currently 41 percent of our total book or around 600,000 total covered lives.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

Today's presentation is an information item. So I'd like to begin by sharing the results of our employer survey and some of our outreach activities with our stakeholders. I'll also talk to you a little bit about the methodology in preparing the analytic -- analytics, and will show you the first subset of the data that shows the relative costs of health care by county for public agencies and schools as it compares to the statewide average.

And finally, I will preview for you what we are planning to do in November and December at our Board

meetings.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

This is the third presentation in our series. At the July offsite, if you'll recall, we talked about the history, the background, and some of the challenges that we faced. Milliman also talked about their methodology using the CalPERS data and how regions were first established in 2004, and provided a market analysis and scan.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

The slide you see before you right now was also presented by Milliman at the July offsite. We thought it would be a helpful reminder to visually show you the concentration of agency and school membership right now. The left-hand side represents the employers, and the right-hand side represents the employees by county.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

So when we were looking at this, we wanted to think about the best way to take a comprehensive approach so we could get to the right decision. So we incorporated both qualitative and quantitative approach in gathering data and information.

The processes include working with employers and our stakeholder groups, and getting their feedback and their concerns and insights into the process. The team also signifi -- completed a significant amount of work to date. And I want to remind you we're still going through all of the data that we have. It's been quite while since we revisited it. But we want to make sure that we bring you the appropriate -- answer the right decisions -- bring you the appropriate data, give you the right decisions to make, some decisions around regions, the regional factors, the nomenclature, and all of that moving forward for the 2020 year.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: We also wanted to make sure that both employers and stakeholders had a voice in the discussion, and were able to share their insights, and their ideas. So to that end, we conducted a survey with our health contracting employers. We also had an educational webinar called your guide to health regions. It was the first one for me. I think it was the first one for a lot of people on our team. And we covered the history and addressed primary questions that we had been hearing from our employers.

If you haven't had a chance, I'd encourage you to take a look on the CalPERS YouTube channel. And we were

able to get some really positive feedback from our stakeholder groups. I think CSAC said it was the best webinar they'd ever seen, which was kind of nice, refreshing to have nice feedback.

We also had three additional focus groups. We met with our retirees, the labor folks, as well as the employer associations. So I'd like to just take a minute to walk through some of the highlights of that feedback.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

Between July 29th and June -- June 29th - excuse me - and July 20th, we survey our CalPERS health employees. We received about 260 responses across al of our different regions. And just to give you some of the general observations, over half the employers that we talked to said that our premiums were moderately competitive in the marketplace. And over a third said that we were extremely competitive in the marketplace.

That data point indicates that how competitive our rates are in the market, which is important as we continue to try to attack -- attract more public agencies, but also retain the ones that we existed -- we have existing.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

There were a few consistent themes we also heard in our outreach. We heard concerns from the Bay Area and other Northern California region employers about premium costs, as well as the naming conventions. Very simply, employers don't quite understand why they're called the Bay Area if they're not geographically located in the Bay Area.

We had consensus from all the stakeholders that, at a minimum, regardless of what we do moving forward, we may want to reconsider that factor, and maybe think about renaming to something like zones, or colors, or shapes. We heard all kinds of things around that.

And during the focus groups, when we asked stakeholders if they were open to the concept of splitting up counties into zip codes, they liked that approach. They wanted to take a look and see where that led. So we've been collecting some three digit zip codes that we'll be bringing back to you in November.

And beyond that feedback, we heard about a lot of other things that we're rot region fact -- regionally related, but we received feedback as we always would with stakeholders.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: So moving to the analytics, I just wanted to go over a couple

of things first. I wanted to talk a little bit about the methodology that Milliman and the team used, and the information used as the basis for the analysis. For the methodology, the team used millions of health care claims records for a five-year period, between 2013 and 2017 from the CalPERS data warehouse.

That data was summarized and grouped by plan for the differences in payment structure, in benefit design, and in the networks. Our methodology combined both PPO and non-Kaiser HMO to calculate the relative costs of care over the five-year period. Kaiser HMO was not factored into this and will be considered separately when we meet with you in November because, as you know, it's a two region model, north and south.

For the basis of the analysis, I wanted to refer you to attachment three. It's called cost relativities by current region and county. And I think it gives a good snapshot. It's a table that shows the relativity for each county ranked by the cost. The relativity was calculated based on each county's health care costs and adjusted for health status.

To account for the outliers, such as high cost claims, or counties that had low membership, we excluded them at this pass. Those counties are Modoc, Sierra, Alpine, Mariposa, and Kings. In using this methodology,

the county with the highest cost you'll see is Siskiyou with a relative cost of 1.41, and the lowest is San Bernardino with 0.77.

So basically what that means is Siskiyou is paying 41 percent higher rate than the state average. And San Bernardino is paying a 23 percent lower rate than the statewide average.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: In moving to attachment one of your agenda, this is a visual representation of the data that you just saw in the table. You'll see the counties higher than the statewide average illustrated in variations of red and blue. The red are higher obviously and the blue are lower. And you'll also notice some gray counties. And those were the ones that had low membership and had insufficient data to calculate a credible cost.

This is one way of looking at the data. But it's -- I'd really like to caution that we can't just use the red and blue to carve out regions. Our analysis between now and November will take into consideration this, along with the three digit zip codes, and the Kaiser HMO, and overall impact to employers and employees.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: So

to summarize the region analytics, I want to call your attention now to attachment four. This is a scatter plot view that shows the relative costs of care for each county within the CalPERS regions.

Please note that this ones is revised. I think you were just -- I hope you just received a handout. It's a new revised scatter plot. And there are also additional copies in the back of the room for everyone in the audience.

Because of the scatter -- the way scatter plots are developed, the first version didn't quite capture. It was hard to see some of the counties, so we revised it and wanted to give you a more clearly defined one.

As expected, you'll see a variation across statewide. And not surprisingly, you'll see that the high cost areas are spread from Northern California to Central California.

I also want to note that there's a slight update to this slide that's supported by the data. There are 40 counties above the state average, and roughly -- that roughly represent about 53 percent of our total covered lives and 13 below the average that represent about 47 percent of our total covered lives.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: So

moving forward as we analyze the data, we will develop and assess scenarios based on some fundamental principles, which we discussed with the stakeholders as well.

One, and the most obvious, is that we want to remain competitive in the health care market. This is really the impetus for creating regions in the first place and it still holds true. Being competitive allows us to win and retain what we have currently in place and to grow our total covered lives that gives us better leverage.

It's also important that regions provide the greatest benefit for the greatest number of people, that's the theme that not only we believe, but was echoed repeatedly by our stakeholders. And, of course, we must be PEMHCA compliant, since that's the law that governs our program.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

Looking ahead between now and November, the team is going to use the relative costs of health, and the stakeholder feedback we've received, to shape and bring you scenarios. And with each scenario we present, we're going to show you how the shape -- how that would have impacted the 2019 premiums to give you a good idea of how employers and members would have been effected by each scenario, and take that as it's compared to the market.

All this will be done, and we will continue to do some stakeholder outreach at Ed Forum.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: And the culmination of all of these presentations and that data is really intended to provide you the best information you need to make a couple of decisions.

Those two decisions will be about regions, regional or zone boundaries, how we draw them. And the subset of that being the nomenclature, how we name them. And the second will be regional factors for HMOs, which we'll ask for direction on how to be determined.

We have -- we could keep them as they are currently, we can also develop a range that's acceptable, or CalPERS can just set regional factors.

In November, you'll see the full set of data and the scenarios for your consideration. And it should give you a little bit of time to ask questions and contemplate that. And then in the December meeting, we're going to ask for a recommendation and see what your thoughts are about that for the 2020 health plan year.

And with that, I will conclude my report and offer an opportunity to ask questions.

CHAIRPERSON FECKNER: Thank you.

Anybody have any questions or comments at this

time?

Ms. Mathur.

COMMITTEE MEMBER MATHUR: Thank you.

I just want to say that I think this is a really good start to this -- to this work. It's important that we're doing this work now. I think we've heard, as you've heard from many employers, I think that's a good sign that more than a quarter of the employers actually responded, that -- I think that's excellent, and I really appreciate the direction that we're going in to be very thoughtful and evidence-base -- databased around -- around how to advance or continue with the region. So I want to thank you all for the work that you've put in so far and look forward to seeing your first cut in November.

Thanks.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: Thank you.

CHAIRPERSON FECKNER: Thank you.

Anyone else?

Mr. Lofaso.

ACTING COMMITTEE MEMBER LOFASO: Thank you, Mr. Chair. I think the stakeholder process here is looking really good. Just -- so it's pretty obvious that the data is pretty instructive in terms of saying that while north and south are pretty clearly differential, maybe urban

rural aren't so clearly differential. Given how challenging it is to do these regions, I'm wondering does staff think that the relationships and the table that you put in our packet, the one that shows that Siskiyou is the highest and Inyo is the highest, that that is fluid over time, or do we think these relationships, in terms of this county versus that county are generally fixed over time.

The point of the question is are you looking to design a system that allows to account for changes in the cost relationships over time, or do you have to go to a whole new process every time you want to adjust the geographic areas based on changes over time.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So I believe that they are fixed for a period of time. But what I would say is what we recommended is at least every five years to bring back an analysis to the Committee. Our stakeholders -- actually, employers are recommending every three years, but it's a pretty heavy lift to bring this much data to all of you to consider redrawing any lines that often.

But I would say as hospitals and providers grow, as more Northern California moves away from fee-for-service, if I have my wish list I'd move towards capitation, you might have better contracts. It might actually reduce the overall costs.

I think they're fixed for a period of time, but hopefully the market starts to drive where they are becoming more competitive, and the cost may vary. So I wouldn't want to say that this is the way it would be -- look like in the next, you know, 10 years, I would say. We would -- we owe it to you to bring that thoughtful -- the data, like Ms. Mathur had mentioned. We owe that to you to see, at any point in time, do we need to make a change.

ACTING COMMITTEE MEMBER LOFASO: Appreciate it. Thank you.

CHAIRPERSON FECKNER: All right. Thank. You seeing no other requests. Thank you.

We'll see you in November.

On to Item 7c, open enrollment app.

(Thereupon an overhead presentation was presented as follows.)

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: When we talk about live demo, it's live. It's actually connected to the phone.

CHAIRPERSON FECKNER: I see that.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: All right. Good afternoon, Committee Chair, members of the Committee, and other Board members. Rob Jarzombek, CaPERS team member. Presenting with me today

is CalPERS team member Tim Taylor.

As Liana mentioned earlier, this year we developed a new mobile app for open enrollment which debuted on August 27th. The goal was to enhance access to health plan information and provide it in a way that members have requested. So to do this, we reached out to IT to see if they could assist.

This turned out to be a great partnership, and I'd like to publicly recognize key contributors who rose to the challenge to create a unique mobile experience for our members. They are David Krasniy, Paul Makhnovskiy, Mike Moltzen, and Marilyn Clark.

I'll turn it over to Tim to explain what his team did.

INFORMATION TECHNOLOGY SERVICES BRANCH CHIEF TAYLOR: Good afternoon, Tim Taylor, CalPERS team member.

I just want to echo Rob's sentiments in regards to the project. Great partnership between program and IT. I have to commend Rob's team, as well as Office of Public Affairs, who contributed greatly in this very quick activity that we were tasked to do, but successful.

I just wanted to point out that it is our first foray into mobile application development for CalPERS. It was a, I would say, mildly unanticipated request, but a great opportunity. And we seized the opportunity to rise

to the challenge.

We leveraged the existing my|CalPERS system and the development of the system. So it's really important to note that the primary system was leveraged. We're using a lot of those components. And we're just able to build complementary mobile application that interfaces with it, and that allows members the convenience of either interacting with the system from their desktop computer or from their mobile and having a seamless transition between those two.

So again, a big thanks to our partners. We really appreciate the opportunity. It was fun.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: All right. Thank you, Tim.

The mobile experience can be accessed by members watching at home or here in the auditorium by going to mobile.my.calpers.ca.gov on their smartphone or tablet. The app allows members to use their mobile devices to access their my|CalPERS account where they can search and compare medical plans, view any custom messages they may have, and retirees can make a health plan change and also add or move a dependent.

So first and foremost, the mobile experience is secure. The OE app integrates with the existing my|CalPERS Identity management solution to keep our

standard for security and reliability. Members who don't already have a my|CalPERS account can register through the app or reset their password if they've forgotten it. So let's take a look at the app.

So for this demo, we're in a test environment using a fictitious member. Jane Doe is a State retiree currently enrolled in the PERS Choice basic plan. After a member logs in, they're taken to this home page, where they can view messages just for them, look at information about their current medical plan, see information on the -- about the subscriber, as well as any dependents, and also view any future transactions.

So first, let's look at the message in their account. So I'll select -- you have one message. And this is one of the custom messages we have this year. So for this member who's enrolled in the PERS Choice basic plan, we want to inform that group that their copays are changing for 2019. This is just one of over 20 specialized custom messages we've created to help inform members about key changes that are happening to their health plans, should they decide to remain with that health plan in the next plan year.

Going back to the home page, the next feature to check out is the compare tool, or explore plan options. So because we're in a -- the members are logged into their

own account, the search criteria pre-populates with their information, so information such as their eligibility zip code, we know what member type they are, whether they're State, CSU, or public agency, or school, and we also know what coverage type they're in, whether it's basic, combo, or Medicare.

A member can modify this information or proceed with the comparison. So based on the information we've entered, here is what the results show. So their current health plan shows first. So this shows the member share, what the member would pay out of pocket, the employer share, as well as the total premium.

So for this member, she has nine other health plan available to her. So for this comparison, let's compare the PPOs. So we'll compare PERS Choice and then scroll down to find PERS Select, as well as PERSCare, and selected compare. So by doing this you see the out-of-pocket member cost up at the top, as well as a variety of other information, such as the calendar year deductible, the maximum calendar copay and coinsurance, and a variety of other information.

So the members can then scroll from left to right to look at all the different plans that they've selected to compare. Members can also save this comparison by selecting save, and it's saved to their account. So they

can view any saved comparisons without having to walk through these steps by selecting the saved button, and they can also pick up where they left off, if they choose to log in back at home on their computers, because it's all in the same my|CalPERS account.

So now after we've compared the plans, let's make a plan change. So to do that, we would select change down at the bottom, and it gives a list of the things that we would like -- its -- we're able to do via the app.

So first, we'll change. So it asks about association information which will continue. To do this, it -- we really want to make sure the members are really informed and using the correct information. So although it pre-populates, we want them to acknowledge this. So we'll continue with this. It gives them information about their current plan and what would happen if they choose to stay with that plan for the next plan year. We're going to explore plan options, which is the exact same thing that we just did when we did the compare feature.

And so we'll be selecting PERS Select, because that has a zero out-of-pocket cost for the member. Select continue. It will ask you to confirm that. And then are you sure? Yes, we're sure. And the medical plan has been updated.

So it's that easy and simple for a member -- or

retiree -- a retired member to make that change via their smart phone or tablet.

Lastly, let's look at adding a dependent. So we'll go back to the home screen. And so for this demo, the -- Jane is going to add her spouse John to this -- to her health plan. So we've already added John's information and that appears here.

So to move ahead, I want to take advantage -- I want to show how the -- this app can take advantage of the abilities the phone has. So when you're adding a dependent, you need to provide certain documentation. So for a spouse, it's a marriage certificate. So it calls that on out here. So it says the documents that we need, and then it takes it -- it takes advantage of the camera feature on your phone to quickly and easily take a picture of the marriage certificate, use the photo, and then submit it to CalPERS.

So this is a very easy and convenient and secure way to get that document to us in a matter of seconds. This saves the member time from having to upload that marriage certificate to their home computer and then upload it to their account in my|CalPERS, also having to make a copy of it, and mail it in. It goes through the mail, then the mailroom, then finally makes its way to a CalPERS team member to process.

So this brings it to the CalPERS team member in a matter of seconds so that they can process it more timely. So this mobile experience will be available through the end of open enrollment, which is October 57th. So far, we're happy to report that over 10,000 unique members have logged onto the app to access their information. Forty-four percent of that population has been retirees. And that falls right in line with our general member -- our general subscriber population.

We've also had nearly 150 plan changes made via the app alone and two retirees have either added or removed a dependent.

To gauge customer satisfaction, each week we are emailing a survey to members who have used the app. It's a quick survey which aims to gain feedback on the ease of navigation, the information available, and their overall satisfaction with the mobile experience.

As of mid-September, we have an 88 percent overall satisfaction rating with the app. We're always looking for ways to improve our communications and the customer experience, so the feedback will be helpful in identifying those opportunities, as well as helping inform us on where we go next with our mobile experience.

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

CHAIRPERSON FECKNER: Very well. Thank you. Nice presentation.

Any questions?

Ms. Holton-Hodson, please.

ACTING COMMITTEE MEMBER HOLTON-HODSON: Thank you so much. I -- this is -- this is terrific. One question for you. Do you have any advice, or I didn't see any messages about, you know, being able to check if your doctor is in another plan, because I know for many people that's obviously of concern. So this is switching your plan, but do you advise, you know -- how do you even find out about is your doctor in the plan, sort of basic questions that you should ask yourself before you actually want to switch plans.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: Yeah. So this -- the app does not currently provide that information. So to know if your doctor is in a different plan, members do need to go to look at all the different plan providers so see if there is overlap. But that is definitely something we have heard from our members and are working towards to have in future iterations for open enrollment, and actually not just for open enrollment, but all the time where members can really shop around but keep the same doctor, but pay probably the lower price, if possible.

ACTING COMMITTEE MEMBER HOLTON-HODSON: Could you -- would you possibly think about adding sort of questions you should think about as you determine whether you want to switch plans, or does that end up driving people in ways that you don't want to be responsible for?

I mean, you know, for example if you -- if you're switching a plan, you need to think about your doctor, the hospital, whatever it is.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: So there are disclaimers throughout. Maybe not as easily displayed on the app, but are online. With the comparison tool, it provides a variety of information of all the different factors on what it is different between the different plans. But ultimately it is -- the members does need to be informed. But we can definitely look to see if there's anyway we can improve that to make sure they are making an informed decision.

ACTING COMMITTEE MEMBER HOLTON-HODSON: I appreciate that. I mean, I just think it's -- it's helpful. And I haven't been on the site because I haven't changed my plan in a decade. You know here are the questions you need to ask as you think about whether you want to -- whether or not you want to make a plan change.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: Okay.

CHAIRPERSON FECKNER: Any other questions or comments?

Mr. Jones.

COMMITTEE MEMBER JONES: Thank you. Just outstanding.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: Thank you. Thank you, Tim.

CHAIRPERSON FECKNER: Very good.

Thank you very much. Appreciate it.

Brings us to Item 7d, summary of Committee direction. Ms. Bailey-Crimmins.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Mr. Feckner, I took one action item. So in November, we will bring back to the Board, based on the reference pricing by pharmacy therapeutic class to bring back details regarding pilot versus full solicitation.

CHAIRPERSON FECKNER: Very good. Thank you.

Now, we're at 7e, public comment. I have four requests to speak from the public. We'll start with Harvey Robinson and Stephanie Hueg, please.

Please come down here. You'll have up to three minutes.

You're mic is on.

MR. ROBINSON: Good afternoon.

CHAIRPERSON FECKNER: Good afternoon.

MR. ROBINSON: My name is Harvey Robinson. And I thought I'd re-introduce myself to you or in introduce myself to you for the first time. I'm currently the RPEA director of health benefits recently elected.

For purposes of past background, I'm two term President of RPEA, one term director of health benefits. I also ran unsuccessfully to the CalPERS Board. When I retired in 2001, I had 29 years of service with CalPERS with the last six years of the Office of Long-Term Care.

When I entered the CalPERS Long-Term Care Program at age 51 in 1995, I elected the comprehensive lifetime plan with inflation at a premium of $77 per month. I now have a 10-year comprehensive plan at $275.86 per month.

As you are aware, a partial settlement for the class action suit has occurred with the plan actuary, where members receive some $64.49. Should the class action suit be successful against CalPERS, the sum 126,000 plan members would not be pleased if this resulted in increased premiums.

Thank you.

CHAIRPERSON FECKNER: Thank you.

MS. HUEG: Welcome back, Harvey.

I'm Stephanie Hueg, California State Retirees executive vice president speaking for Tim Behrens today.

I want to commend -- where did he go -- Robert

for the mobile app. Tim put the challenge out there on the cable and they picked it up and ran with it. And it's so far very good. I did like your comments though regarding questions you should ask, because they are very important questions.

Members are experiencing numerous problems with this open enrollment period. And Larry will talk to you when he gets up here about all of those problems. CSR gave public comment in two prior meetings before the Committee expressing our surprise and concerns regarding the CalPERS abandonment of risk adjustment. It was rather sudden and not very well explained to us.

You employed it for five years. You evaluated it annually, and you deemed it a successful tool in preventing carriers from cherry picking low-risk members for coverage, and then you abandoned it.

CSR, along with other retiree groups, objected to this matter in the manner in which it was canceled, in a vote in a closed session at the pub -- Pension and Health Benefits Committee in December 17; then not including it as a topic in the open session that followed; and then the cancellation was ultimately approved the following day by the Board of Administration.

Again, without having it anywhere on the agenda, but rather included in the Chairwoman's Committee report,

where it was briefly described as approved in closed session, moved, and approved without any member questions or discussion, let alone allowing public comment.

In April, when we learned of this action and complained, Mr. Jones did state in the June Pension and Health Benefits Committee, that CalPERS should make an effort to be more transparent in the future. We still don't have risk adjustment. We still don't know why it was taken away.

This action -- I'm sorry. Glasses. I forgot.

(Laughter.)

MS. HUEG: This action has resulted in much higher premiums for thousands of members and beneficiaries, even though low cost plans would see decreases. Lowering the premiums for lower and mid-cost plans did not help most retirees, since their premiums were already covered by CalPERS or the State.

Overall, CalPERS saves health plan fund monies by shifting costs to the members who must pay more out of pocket now and change -- and change to inferior plans in many cases. Paying more out of pocket is really difficult for people on a fixed income. And what we are meaning is when you go to see a doctor or a specialist, you're going to be paying extra due to these changes.

Overall -- oh, I already said that. Never mind.

Besides higher costs, thousands of members face other negative consequences, including plans leaving geographic areas or provider networks. Currently, this is going through a Northern California issue where Anthem is not reached an agreement with the providers and the hospitals. And the members have until, what, October 5th to make their final choice about where they're going to -- which plan they're going to choose and Anthem is they don't know. So we don't know if that's a viable option or not.

We've been assured --

CHAIRPERSON FECKNER: Your time has expired, Ms. Hueg.

MS. HUEG: I'm sorry?

CHAIRPERSON FECKNER: Your time has expired.

MS. HUEG: Oh, sorry. Okay. Thank you.

CHAIRPERSON FECKNER: Thank you. Thank you.

The next two are Al Darby Larry Woodson.

MR. WOODSON: Okay. Okay. Good afternoon. And Chairman, before we -- before you start timing me if I could ask a question. I did ask for a -- I'm not sure if read it on my card.

CHAIRPERSON FECKNER: I did.

MR. WOODSON: But I asked for five minutes, if I could, because I'm going to tell some stories.

CHAIRPERSON FECKNER: I did read it. You can just start and we'll see where we end up.

MR. WOODSON: Okay. Thank you.

Larry Woodson, California State Retirees. Chairman Feckner, members of the Board, thank you for the opportunity to comment.

As Ms. Hueg stated, I have received a number of complaints and questions from our retired members. CalPERS Health Benefits staff implemented an aggressive communications strategy to inform those who will be negatively impacted by the cancellation of risk adjustment, as well as other changes in 2019. And unfortunately, I'm finding that that isn't enough in all cases.

There is confusion and frustration, in some cases anger, among affected members, including active members that has come -- been drawn to my attention. It was reported in the Sacramento Bee that over 134,000 members received -- were sent letters informing them of negative impacts due to health plan changes in 2019. Fourteen thousand members in the Bay Area are losing their Blue Shield Access+ plans. And the Bee article also stated that a Blue Shield spokesman attributed that decision directly to CalPERS abandonment of risk-adjustment.

Now, although some retirees are affected, the

vast majority of those 14,000 are active employees, which begs the question, were Board members who represent those actives fully aware that thousands of their members would lose their plans when they voted to cancel risk adjustment? Some portion of the 14,000 will also lose their doctors if other affordable plans have different or more narrow provider networks.

CalPERS rate charts show PERSCare will increase by an average of 19.8 percent, but that's average. One active member is outraged that hid family PERSCare plan will increase 250 percent. If he twitch -- switches to PERS Choice, he would still have to pay much more than he currently pays.

I recently spoke to retirees actually last week at our CSR chapter in Stockton, regarding health benefits for 2019, and there are options. And one retiree and family on Anthem traditional HMO was having difficulty in interpreting the CalPERS material. Even though I understand it, some people don't.

And the rate charts are very -- there's a lot of date there. She was happy with her HMO traditional plan through Anthem, and was inclined to keep it and pay a little more until I pointed out the little more she would have to pay amounted to $901 a month more out of pocket. That is even factoring in the monthly contribution.

She doesn't like her alternative options as they have high deductibles and coinsurance. And some other basic plan members there were unhappy with their choices.

Two days earlier I spoke to our CSR chapter in Chico and found even more confusion. First, some combo members had switched to the Anthem traditional for 2018, which is being made available to them for the first time, which was great. And they were really happy to have it, because it didn't have co-insurance and deductibles.

Some received notices then of the huge premium increases. And after switching plans and doctors, just one year later, they're now forced to do the same thing again or pay $225 more a month out of pocket.

In another shock just that week, their local TV news reported that Enloe Hospital, Chico's only hospital, had given notice to Anthem that it was terminating its contract effective November 1st 2018. Members were afraid they're were going to lose coverage. This was not communicated elsewhere.

The next day at stakeholders, I shared this information, and Anthem's account executive confirmed to the staff and stakeholders that indeed they had received an intent to terminate, that it included all Anthem basic plans, including the PPOs. But he stated he was optimistic that an agreement will be reached. If not,

arrangements for coverage will be made in an alternate manner. We're not sure what that means.

I've communicated that to Chico retirees, but things like this should not be occurring in the middle of open enrollment, and without better communication than local TV news.

In conclusion, CSR strongly objects to the cancellation of risk adjustment and requests reconsideration during the next year. We would like to meet with Health Benefits management team to discuss this matter.

And finally, we urge CalPERS to evaluate the early timing of its open enrollment and consider making it consistent with most all other open enrollments a month or two later to avoid unresolved contract disputes.

Thank you very much for the time, Mr. Chairman.

CHAIRPERSON FECKNER: You're welcome. Thank you.

Mr. Darby.

MR. DARBY: Mr. Chair -- excuse me, Mr. Chair members and Committee members, Al Darby -- Al Darby, President Retired Public Employees Association.

I just wanted to thank the Committee and the actuarial team for the recalculation of the East San Gabriel JPA termination fee that gave the retirees a 10 percent increase in their very impaired pension. So their

haircut is not quite as short as it used to be.

These folks are very grateful to CalPERS for revisiting this unfortunate situation. So thank you again for that consideration.

CHAIRPERSON FECKNER: Thank you for your comments.

Seeing no other requests to speak, this meeting is adjourned.

(Thereupon the California Public Employees' Retirement System, Board of Administration, Pension & Health Benefits Committee closed session meeting adjourned at 4:20 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 1st day of October, 2018.

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