MEETING

STATE OF CALIFORNIA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

BOARD OF ADMINISTRATION

PENSION & HEALTH BENEFITS COMMITTEE

ROBERT F. CARLSON AUDITORIUM

LINCOLN PLAZA NORTH

400 P STREET

SACRAMENTO, CALIFORNIA

WEDNESDAY, NOVEMBER 14, 2018

10:00 A.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:

Mr. Ramon Rubalcava

STAFF:

Ms. Marcie Frost, Chief Executive Officer

Mr. Matt Jacobs, General Counsel

Dr. Kathy Donneson, Chief, Health Plan Administration Division

Ms. Jennifer Jimenez, Committee Secretary

Ms. Shari Little, Chief, Health Policy Research Division

Dr. Melissa Mantong, CalPERS Pharmacist

Mr. Gary McCollum, Retired Health Actuary

Ms. Renee Ostrander, Chief, Employer Account Management Division

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

ALSO PRESENT:

Mr. Tim Behrens, California State Retirees

Mr. Marc Fox, Solano County

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

Mr. Larry Woodson, California State Retirees

I N D E X

P R O C E E D I N G S

CHAIRPERSON FECKNER: Good morning. We'd like to call the Pension and Health Benefits Committee meeting to order. Good morning, everyone.

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

COMMITTEE SECRETARY JIMENEZ: Rob Feckner?

CHAIRPERSON FECKNER: Good morning.

COMMITTEE SECRETARY JIMENEZ: Theresa Taylor?

VICE CHAIRPERSON TAYLOR: Here.

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.

Please also show for the record that Mr. Rubalcava has joined the Committee today.

Next order of business will be the approval of the November 14th Committee timed agenda.

VICE CHAIRPERSON TAYLOR: Move approval.

CHAIRPERSON FECKNER: It's been moved by Taylor.

ACTING COMMITTEE MEMBER HOLTON-HODSON: Second.

CHAIRPERSON FECKNER: Seconded by Holton-Hodson.

Any discussion on the motion?

Seeing none.

All in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries.

Item 3, Executive Report. Ms. Ostrander and Ms. Donneson, please.

EMPLOYER ACCOUNT MANAGEMENT DIVISION CHIEF OSTRANDER: Good morning, Mr. Chairman --

CHAIRPERSON FECKNER: Good morning.

EMPLOYER ACCOUNT MANAGEMENT DIVISION CHIEF OSTRANDER: -- and members of the Committee. Renee Ostrander, CalPERS team member.

On behalf of Donna Lum, I wanted to highlight three items for you in this month's update. First, unique education efforts that took place at our employer educational forum. Secondly, our collaborative interactions with our reciprocal system partners. And finally, our efforts to connect with our members located in the fire-devastated regions of California.

So first, some representatives from our Benefit Services Division attended the Employer Educational Forum with the purpose of providing counseling to employers on the CalPERS special power of attorney and beneficiary designation forms at the exhibit booth.

After speaking with us, many attendees completed power of attorney forms and beneficiary designation forms on the sport for processing. The team also handed out hundreds of publications and forms to their employers for them to take back to their agency. Through this effort, employers were able to gain a better understanding of the importance of having these documents on file, and the value of including the documents in their onboarding process.

And for any of our members in the audience, or are watching online, and would like to do the same, you can find the power of attorney and beni designation forms online at CalPERS.CA.gov.

A few months ago, our team began meeting with LACERA. Our initial meeting has led to multiple conference calls to collaborate on different pieces of the reciprocal process where our teams interact. Both of our teams have been reporting positive experiences from this. In the same vein, we recently had an initial meeting with CalSTRS, the reciprocal partner we partner with most, and it's already providing some good potential.

So now we've initiated efforts to connect with many of our other reciprocal partners to see what improvements we can make with each relationship. While we understand the constraints of having to abide by the statutes and regulations that govern each of our systems, we have a desire to improve service to our shared members by doing this.

And finally, it's unfortunate to once again report on more fire devastation in California. Our team has identified the zip codes impacted by the multiple fires that are currently burning, and has begun making contact with impacted retirees that receive their retirement check in paper form.

Our goal is to ensure their December 1st retirement check is readily available to them.

That's it for my updates. I can answer any questions you have.

CHAIRPERSON FECKNER: Great. Thank you.

Seeing none.

Ms. Donneson.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Good morning, Mr. Chair and members of the Committee. Kathy Donneson speaking or Liana Bailey-Crimmins.

I want to start out talking about the fires as Renee left off, because it's -- we're saddened, deeply saddened about the terrible and tragic losses that are occurring in our state. We have learned from prior experience that when something like this happens, we develop frequently asked questions now. We reach out to our health plans. We have a standard format. And so now, as fires unfold in the future, we have a protocol by which we reach out to all of our health plans. We find out what are the impacted areas, what is the access, what facilities are closed, where are the providers. And we put out a fact sheet.

And then throughout the disaster, we continually update the frequently asked questions, so that our members are aware of how they can reach out to their health plans for things like where do I go when I don't have my provider available? What do I do when I don't have an identification card? And so, we -- we now do that routinely, put the fact sheet out, we update our website. And that will be really our direction going forward to make sure that members affected by these terrible disasters are supported.

I'd like to turn now to open enrollment. As you know, there were several health plan changes this year. We reached out to the members, and we did a lot more reach out to the members this year. But in addition, we also reached out to providers. As members, we're looking at what health plans to go to during open enrollment, and whether or not their personal doctors were available for those plan changes.

We think that is a good success for us to -- in support of our members, and that's a lesson learned for us going forward.

We also tested the new open enrollment application for members to compare their plans and view their health plan statements. We had over 13,000 unique users log in and 100 retirees change their plan using the app.

The survey of member experience showed that 87 percent were satisfied. And then we saw, as a result of this year's open enrollment, over 24 percent increase in open enrollment changes.

We had a successful Education Forum, and we had a very productive experience for our health plans and for our members. The health plan was represented by six exhibits. We made four presentations, and we had nearly 20 health plan representatives. All of our health plans supported the wellness centers. And I hope that Board members, as well as the employers, got the opportunity to experience the wellness center. And this was the biggest Ed Forum with over 900 employers.

And then finally, I just want to call out in the agenda item the Health Benefits Annual Report for plan year 2017. That will be on a consent item and not discussed. But it's important to understand some of the unique changes we've made in terms of that report. While it does talk about plan year 2017, we've had feedback, and we've taken that feedback to include look-aheads for 2019. And in those look-aheads, we've included some of the strategic policy and innovations you've approved.

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

CHAIRPERSON FECKNER: Very good. Thank you, both.

Seeing no comments.

We'll move on to Item 4, the Action Consent Item. 4a, what's the --

VICE CHAIRPERSON TAYLOR: Move approval.

CHAIRPERSON FECKNER: Moved by Taylor.

COMMITTEE MEMBER MATHUR: Second.

CHAIRPERSON FECKNER: Seconded by Mathur.

All in favor of the motion say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries.

Item 5, Information Consent items. Having heard no requests to remove anything, we'll move on to item 6.

6a is the Revised Proposed Regulation for Definition of Full-Time Employment.

Ms. Ostrander.

EMPLOYER ACCOUNT MANAGEMENT DIVISION CHIEF OSTRANDER: Thank you.

Before you today is Agenda Item 6, the Revised Posed Regulations for the Definition of Full-Time Employment, which defines full-time employment for purposes of determining CalPERS' membership eligibility, reporting overtime positions, and determining compensation earnable and pensionable compensation.

For purposes -- our purpose for pursuing these regulations are to, first, further solidify the Board's current resolution as a regulation, a step in strengthening the position already established; continue the practice of the individual employer defining what is full time; and finally, removing the maximum cap to provide flexibility for our employers.

Since we brought the regulations to you in June, they were reviewed by the Office of Administrative Law. OAL had some questions related to the equivalent of 34 hours per calendar week, and for the criteria related to exemption approval. Both issues have been addressed in the revised proposed regulation before you today.

However, while reviewing the proposed text for resubmission to OAL, we also believed we could provide further clarifications and language. The language changes are to affirm the original intent, including ensuring that both classic and PEPRA members are treated similar in terms of defining and reporting full time.

With the Board's approval, CalPERS team members will commence with an additional 15-day comment period. If no responses are received, we'll return the regulation package to the Office of Administrative Law for final review and adoption.

However, if any responses are received during that public comment period, we'll return the package back to you for review and approval prior to that final submission.

This completes my presentation, and I'm happy to answer any questions you have.

CHAIRPERSON FECKNER: Thank you.

I have a question. And it's -- it has to do with the school members.

EMPLOYER ACCOUNT MANAGEMENT DIVISION CHIEF OSTRANDER: Okay.

CHAIRPERSON FECKNER: Now, we've been at this for awhile. We tried it last year. Now, we're back trying to --

EMPLOYER ACCOUNT MANAGEMENT DIVISION CHIEF OSTRANDER: Right.

CHAIRPERSON FECKNER: -- get things a little more fine-tuned. I just want to make it sure that we're perfectly clear in the language and it's easy to locate that it spells out that only the equivalent of 40 hours is full-time for classified school employees. If it's not clear and easy to find, I'm afraid that we'll be back down this road again. So if you can just assure me that that's taken place, then I'm fine with it.

EMPLOYER ACCOUNT MANAGEMENT DIVISION CHIEF OSTRANDER: That's correct. In subsection (c) that's where it talks about -- specifically about the classified members. So you have (b), and it tells you right there. It says, "Except for as set forth in subsection (c) for purposes of your employers", this is what you do. So obviously, that carves out anyone that's in (c). So when you look to subsection (c), that talks about the reporting for classified members. And when you read through that, it discusses both compensation earnable and pensionable compensation. And so those are the two terms related to the pay reported for classic and for PEPRA respectively.

CHAIRPERSON FECKNER: Okay. All right.

EMPLOYER ACCOUNT MANAGEMENT DIVISION CHIEF OSTRANDER: Yes.

CHAIRPERSON FECKNER: Thank you.

Seeing no other requests, what's the pleasure of the Committee?

COMMITTEE MEMBER JONES: Move approval

COMMITTEE MEMBER MATHUR: Second.

CHAIRPERSON FECKNER: Moved by Jones, seconded by Mathur.

Any discussion on the motion?

Seeing none.

All in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries.

Thank you. I'm now onto information agenda items.

Item 7a, Regional Factors.

Ms. Little and Mr. McCollum from the retiree seat.

(Thereupon an overhead presentation was Presented as follows.)

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

CHAIRPERSON FECKNER: Good morning.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: -- and members of the Committee. Shari Little, CalPERS team member.

This is Agenda Item 7a, a continuation of our discussion about public agency and school health regions. We're looking forward today to presenting scenarios and regional factors. It's the culmination of months of work by the team and reviewing the data and analytics in conducting much stakeholder outreach.

Joining me today is our esteem -- as you mentioned, Mr. Chair, our esteemed Retired Health Actuary, Gary McCollum. Before I get started though, I just wanted to call out that we have revised attachments 2 and 3. The legend was mislabeled in Scenario C. So I believe you have them before you in a blue folder. And for the audience members, we have hard copies at the back of the room.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: So

I'll begin with a little bit of background for context before Gary walks you through the methodology, the five scenarios in assessing the regional factors.

As you're aware, we received a lot of valuable input from our stakeholders and employer groups through the assessment. And today, we'd like your direction and your input. In December, we'll be coming back to you based on that with a recommendation. And any change that you make, will be effective for the 2020 health plan year.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: We've been on quite a journey since January. I can't believe it's 11 months already. By way of background for the newer Board members, in January, we started out by providing some history and context about why regions were first established. In July, our outside actuary, Milliman, came in and talked a little bit about -- and provided a little bit of market perspective and a market scan to give you a little bit more history. And we shared the results from an employer survey.

Over the last couple of months, the team has been reviewing data starting with the analytics around cost relatively by county. And today, we're presenting to you five scenarios and options for calculating the HMO regional factors.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: So guiding us in this process were three fundamental principles. They set the stage for how we looked at the data, how we considered potential scenarios, and how we'd consider redrawing the regions.

We started with the understanding that we must remain competitive in the health care market. We do really well right now, but we have increasing competition in order to gain new agencies and retain the ones that we have. So any regions or regional changes that we make must remain competitive.

Furthermore, we need to make sure that we do the greatest number of -- the greatest good for the greatest number of people. That's sort of the driving principle in all things we do in health.

And last of all, we must be PEMHCA compliant. You hear that at every meeting we have.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: We heard time and time again from our stakeholder groups that the nomenclature was a point of frustration. It was a little bit of a pain point. I talked about this a little bit at our September meeting, and employers, just very simply, they don't want to be called the Bay Area, if they're not in the Bay Area. It causes a lot of confusion with their members.

So today, we're moving away from that as we present the scenarios to you. We'll be referring to them, for instance, as Scenario A rating region 1 and 2.

So with that, I will turnover to Gary to kind of walk you through methodology that we used in establishing the scenarios.

RETIRED HEALTH ACTUARY McCOLLUM: Good morning, Mr. Chair --

CHAIRPERSON FECKNER: Good morning.

RETIRED HEALTH ACTUARY McCOLLUM: -- members of the Committee. Gary McCollum, as she had retired, but CalPERS team member nonetheless.

(Laughter.)

RETIRED HEALTH ACTUARY McCOLLUM: I'll briefly describe the methodology that we used for this study. If you'll remember in September, the team presented county cost relativities, which was a measure of the cost of care in one county relative to the average cost of care throughout the state.

Now, county relative costs were calculated from each county's health care costs, adjusted for risk or health status of the individuals to reflect the actual cost of health care. This adjustment maintains the relative cost patterns that exist due to geographic differences and service delivery differences, while it factors out the cost of differences that are due to health risk.

So since September, we calculated cost relativities for three digit zip codes within the counties. And that gave us 157 unique county and zip code combinations. This allowed us to group and analyze the data in regions that related to zip codes, in addition to just counties.

We also assessed the impact to members' 2019 premiums. A negative impact means that member premiums would increase more than three percent. A positive impact means that premiums would decrease by more than three percent.

Now, we looked at thresholds other than three percent, but ultimately chose that number because we feel it's most reflective of market inflation over the past 10 years. And then we also evaluated how premiums aligned with the cost of care, which we refer to as marketability, or our ability to compete in an area. And we'll go into that definition in that figure a little bit more.

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RETIRED HEALTH ACTUARY McCOLLUM: So about the data and scenarios. So we built -- we built out a model, we analyzed the data, and we saw a few overarching themes.

First, when we looked at the zip code and the county data, we found that L.A. County was the only county that we felt warranted a split by zip code. Now, the guiding principles that Ms. Little referred to in slide four, they were very important as we went through our communications with stakeholders and we considered different scenarios.

Now, one of the scenarios you noticed grouped counties strictly by cost, regardless of where that county is. We found that that did not produce significantly different results from the others. And then finally, all employers have at least one employee that falls into each of the results buckets, or put another way, no employer would have 100 percent of their employees that are positively or negatively impacted.

Okay. Now, that finishes the appetizers. We're going to move on to the main course now.

(Laughter.)

RETIRED HEALTH ACTUARY McCOLLUM: So if you'll turn your attention to attachment 2, we'll take a look at the scenarios. And before we -- before we go into the scenarios that are there, just let me remind you that the current situation that we have is always a possibility or an option for you to consider and choose, if you so desire.

Okay. So Scenario A, two rating regions. This first one is the simple one. We all know that Northern California is more expense than Southern California in health care. So we split the state into two pieces, a northern piece and a southern piece. The northern region combines the current three regions that we have, Bay Area, Sacramento, and other northern. And the southern region combines the two current regions, Los Angeles and other southern.

After you turn to the next page, the metrics are shown on the second page. At the bottom of the page, you'll find the counties that are listed in each of the scenar -- or, excuse me, in each of the regions.

So let me walk you through the tables that are on this page. Now, each of the scenarios has the same table, so I'm going to talk in detail on this first one to make sure that you all understand what's there.

So the top table shows the estimated impact in total on 2019 premiums. Out of the 468,000 total covered lives -- and remember, these are basic members only, not Medicare, and these are public agency members - public agency and schools, I might say -- we see that 154,000 would be negatively impacted in this scenario, which means they would receive an increase greater than three percent.

Now, that's one-third of the total. Of the remaining two-thirds of the total, we have 41 percent that would be positively impacted, which means they'd receive a decrease greater than three percent. And we have 26 percent that would receive a change in their premium that was within that three percent threshold.

Now, if you move to the table below toward the lower part of the page, that shows the estimated premium impact by region. So for Region 1, which is the southern region. Now, the cost relatively is 0.854, or that southern region costs about 85 percent of the average cost for the whole state.

Now, in this scenario, the current Los Angeles region does not fair very well. As you can see, 81 percent of the members would experience an increase greater than three percent. Six percent would receive a decrease, and 12 percent would be within that three percent range.

And you can also see, if you look at the next line, that the scenario is more favorable to the current southern -- current other southern region. It shows that zero percent would receive an increase, while 46 percent would receive a decrease, and 54 percent would be within the range.

So now if you take a look at the northern region,

Region 2, here the cost relativity is 1.166. And again, that means that this region is approximately 16 and a half percent more expensive than the statewide average. So here, the members in the Bay Area -- the current members in the current Bay Area, and in the other northern region would be the benefactors of this option, each with only three percent in the increase column, and much larger percentages in the decrease, and no change or within threshold columns.

Meanwhile, the Sacramento region, if you see or notice, that it has 83 percent of its members showing an increase greater than three percent.

So is that clear to everyone? Is there any questions on the tables before we move on?

CHAIRPERSON FECKNER: We do have a few questions. Well, let's see if it's on this issue or not, but -- Ms. Holton-Hodson.

ACTING COMMITTEE MEMBER HOLTON-HODSON: It is on this issue. Thank you.

As we discussed, increase more than three percent is it 10 percent? Is it two? You know, three to five? Three to ten? So it's difficult to see kind of what really the impact is if we just know it's more than three, but we have no idea what the bookend is.

RETIRED HEALTH ACTUARY McCOLLUM: Okay. If you could hold that question --

ACTING COMMITTEE MEMBER HOLTON-HODSON: All right.

RETIRED HEALTH ACTUARY McCOLLUM: -- we'll get to that particular question in a little bit.

ACTING COMMITTEE MEMBER HOLTON-HODSON: Okay. Thank you.

CHAIRPERSON FECKNER: All right then. Next is Ms. Mathur.

COMMITTEE MEMBER MATHUR: Thank you.

I appreciate the methodology. I do have an observation or perhaps a question. Forgive my voice. So with an increase in -- an increase in the Los Angeles area is actually less in absolute dollar terms than an increase in Northern California, because premiums are already higher in Northern California. So the actual impact in dollar terms is less material, in effect, to the -- those in Southern -- in Los Angeles, for example than in Northern California, is that not an accurate -- is that accurate?

RETIRED HEALTH ACTUARY McCOLLUM: If the percentages are the same, yes, that would be a true statement.

COMMITTEE MEMBER MATHUR: If the percentages are the same, which, of course, is part of the question.

Okay. Yeah, thank you.

RETIRED HEALTH ACTUARY McCOLLUM: Okay.

CHAIRPERSON FECKNER: Mr. Slaton, did you change your mind for now?

COMMITTEE MEMBER SLATON: Same question.

CHAIRPERSON FECKNER: Okay. Very good.

All right. Continue on, Mr. McCollum.

RETIRED HEALTH ACTUARY McCOLLUM: Okay. Now, between the two tables, you have that statement that's sitting there. Forty percent are paying within 97 percent of the cost of care in their region.

Okay. This is what we were referring to as marketability. With an average cost relativity 0.854 that's in the southern region, and 1.166 in the northern region, what this says is that 40 percent of the members would have a cost within their county that's within three percent of the average cost for the region, as it exists -- or as proposed. So -- and again, we'll get into a little bit more of that as we go along.

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RETIRED HEALTH ACTUARY McCOLLUM: So if we move to Scenario B, this has four rating regions. And what we did essentially was split the two regions that were shown in Scenario A into two regions each. So Region 1 has a portion of L.A. County, along with San Bernardino and

Riverside counties. And Region 2 has the remainder of Los Angeles County and then 10 other counties included.

Now, Region 3 has the majority of the northern part of the state. As you can see, the -- I don't know is that peach colored maybe? I'm not sure what color that is. But Region 4 then has the that -- small yellow piece that's primarily central coast counties and some Bay Area counties stretching from Monterey County up to Solano County.

Now just a little more information on that little piece of Los Angeles County that we're including in Region 1, that's the San Gabriel Valley, if you're familiar with Los Angeles area, which is east of Los Angeles stretching out to -- essentially to Ontario.

So now in this scenario, 37 percent of the members would receive an increase, and 40 percent would receive a decrease. That's shown in that table on the top of the page. And if we look at within the regions, we see that the largest negative impact would be to L.A. County members that are in Region 2, and the largest positive impact would be to current Bay Area members that are being moved to Region 4.

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RETIRED HEALTH ACTUARY McCOLLUM: Now, in Scenario C, we offer -- we offer up five rating regions.

And here, the difference from Scenario B, the one you just looked at is that Region 3 and Scenario B has been split into two different regions, which we're calling Regions 3 and 4.

Now, in total, the impact to our members is essentially the same as in Scenario B. And within the regions, the difference from Scenario B is that more of the Bay Area members would receive an increase. And those would be the counties of Marin, Sonoma, Sutter, and Yuba.

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RETIRED HEALTH ACTUARY McCOLLUM: So if we move to Scenario D, we have six rating regions here. Now, again, there's no difference in the premium impact in total as the top table shows. And within the regions, here the Bay Area fairs better, and the Sacramento region has more members that would receive an increase.

Now we're going to think outside the box just a little bit. And we went with five regions that are based strictly on cost of the counties. Whereas the other regions had contiguous counties, this here, as you can look at the map, the counties -- regardless of where the county is, it's being placed into its region based on the cost of that county.

So you have, for example, two counties up at the very top of the -- of the state, and then you also have

Monterey County, which is that one just below the Monterey Bay.

Now, in this scenario, the premium impact in total is real close to a third for each of the county -- or each of the categories. Thirty-five percent of the members would receive an increase, 34 percent would receive a decrease, and 31 percent would be within that three percent range. And within the regions themselves, the impact on premiums is very similar to the other scenarios.

Okay. Now, if you'll return to the slides and go to slide 13.

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RETIRED HEALTH ACTUARY McCOLLUM: Here, we're showing the impact to total covered lives for each scenario on a side-by-side basis, so it makes it a little easier to compare the scenarios. And in addition, we're showing the marketability number down at the bottom.

Now, what's not shown is the marketability number for the current status quo. That number is 22 percent. So while you might be thinking that the 40 to 50 percent that's shown that as a marketability index is low, these scenarios are actually almost doubling the current marketability factor.

And remember, this was based on a threshold of three percent. So to return to Ms. Holton-Hodson's's question, if we move the threshold up to five percent, then the number for the status quo would be a 40 percent marketability factor. And the scenarios would have a marketability factor that ranges from 50 to 70 percent.

If we move the threshold up to 10 percent, we have marketability numbers that are within the 80 percent range. And if you desired to get the marketability number to 90 percent or above, you would need to have a threshold of 12 percent, so two percent more.

So just to go over those numbers real quick, because that was a lot of numbers thrown at you. On what we presented, this scenario with three percent threshold, you have 40 to 50 percent marketability factor. Increasing to five percent, you increase it to 50 to 70 percent. And if we increase the threshold to 10 percent, we get marketability factors in the 80 percent range. And 90 percent range requires a 12 percent threshold.

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RETIRED HEALTH ACTUARY McCOLLUM: Okay. Now, talking about marketability, we asked Milliman to provide a market comparison of regional rates.

So in California, most school districts participate in either CalPERS or a consortium of school districts. And Milliman had the ability to analyze two of those large consortiums, one of which is the Self-Insured Schools of California, or SISC. The other one is the California's Valued Trust, which is CVT.

Now, the chart on this slide compares 2017 composite monthly premiums for CalPERS for SISC and for CVT. And as you can see, CalPERS is very competitive. And you need to keep in mind that CalPERS' benefits are generally higher value. And especially when you factor in the fact that both SISC and CVT have significant enrollment in high deductible plans.

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RETIRED HEALTH ACTUARY McCOLLUM: So our final topic for me is the regional factors. As you know, once statewide premiums are set, regional factors are calculated by the HMO plans. And then those are used to set the regional premiums for the public agency and the school employers.

In the past few years, we've had some concern regarding the regional factors calculated by the plans. So going forward, CalPERS team members have identified three options for your consideration.

The first option would be just to leave things status quo, have the plans continue to calculate the regional factors as they have been doing.

Option 2 would be for CalPERS to provide a very prescriptive definition to the HMOs on how the calculate those factors.

Or Option 3 would be that CalPERS sets a range each year for the factors and require the plans to provide their factors somewhere within that range. Option 3 is the recommendation of the health team. It gives CalPERS greater control over those factors, but it still allows the plans some leeway within that range that we would provide to respond to trends and to their particular enrollment situations.

So that concludes my part of the presentation. I'll now turn it back to Shari.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: Thank you, Gary.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: So I wanted to go back to some of our stakeholder outreach. Along with our internal CalPERS Stakeholder Relations team, we launched a very aggressive outreach campaign. And we wanted to engage -- make sure that the employers and stakeholders were part of the conversation we're having.

In addition to setting up an avenue for discussion through a newly established mailbox, we also conducted a webinar. As of this morning, I think we had

609 views. And at the Ed Forum in October, we had another focus group where we met with additional employers, and some of you joined us there.

Thank you, Mr. Slaton and Ms. Taylor for participating. I think you wanted to hear directly from the employers what they needed. And among the comments we heard -- some of the comments that kind of struck us were things related about a fear of volatility, as well as some of the administrative challenges that come from some of our employers who have workforce among many different regions, and the challenges of administering those.

We want to continue to hear from our employers and our stakeholders about the scenarios they're seeing today, and any other feedback about regions. And we would encourage all of them to reach out to us. There is an email box, I believe, at the bottom of this slide, but you can also reach out to us here at this meeting. We'd be happy to share that with you.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: So moving forward. Next month, as I mentioned, we're going to have two decisions we're asking you to make, one is around regions, and one is around regional factors.

So today, we would ask for your input and any direction you might have for us in drawing the regions, and bring forward a recommendation next month to you. And in the interim, well continue to work with our employers and our stakeholders to see what they have to say as well.

And any changes you may make won't impact the '19 year. It will be for the 2020 rate development process, effective on January 1st of 2020.

So with that, I'll conclude my presentation and we'd welcome any questions you may have.

CHAIRPERSON FECKNER: Thank you. We do have a series of questions. I have one to start with. In your opinion, staff's opinion, what -- which can one of these regional of the scenarios you gave us is going to have the least impact of people trying to withdraw from the -- from our plan?

RETIRED HEALTH ACTUARY McCOLLUM: That's really a question that can't be answered. We estimated the impact on the 2019 premiums, which should be a fairly decent estimate on what would happen with the 2020 premiums. I suppose you would say that the -- the scenarios that had the largest number of members with the increase would be most prone to considering leaving. But even with that said, I think the competitiveness slide on slide -- whichever slide it was. I don't remember now. But it shows we're real competitive and going through the --

CHAIRPERSON FECKNER: It would be 14.

RETIRED HEALTH ACTUARY McCOLLUM: -- going through the increase, you'd have to keep in mind -- or they would have to keep in mind that that would be a one-time hit, so to speak, to their rates. It wouldn't be a continuous, you know, three percent or four percent increase. It would be an adjustment. And then going forward, the rates would be subject to their normal annual changes. So I can't really answer the question as posed.

CHAIRPERSON FECKNER: Very good. Thank you.

Ms. Mathur.

COMMITTEE MEMBER MATHUR: Thank you. Could you restate for me the definition of marketability?

RETIRED HEALTH ACTUARY McCOLLUM: Okay. But it's complexity enough that I need to look back at it.

(Laughter.)

COMMITTEE MEMBER MATHUR: Good. So it's not just me.

RETIRED HEALTH ACTUARY McCOLLUM: No. It is -- marketability is the number of members that would have a cost of care within the region that would be within the three percent figure of the cost of care of their particular area, whether it be a country or a zip code.

COMMITTEE MEMBER MATHUR: Okay.

RETIRED HEALTH ACTUARY McCOLLUM: So, for example, the 22 percent figure that's right now, it's essentially saying that 22 percent of our members that are within the regions have a cost of care in their particular county that's within three percent of the cost of care of the region that they're in.

COMMITTEE MEMBER MATHUR: It's actually within three percent to the positive or three percent to the negative --

RETIRED HEALTH ACTUARY McCOLLUM: It could either. Right it could be either side, correct.

COMMITTEE MEMBER MATHUR: -- so a six percent margin. Okay. And you were saying that the threshold would have to change. You mean the three percent threshold would have to change in order get it up to 80 percent, is that what you meant?

RETIRED HEALTH ACTUARY McCOLLUM: Right. If we -- if instead of looking at a three percent threshold, if we looked at a five percent threshold, that created a marketability number that was between 50 and 70 percent for the scenarios.

COMMITTEE MEMBER MATHUR: So it's really -- the question there then embedded in that is what is our -- what is our appetite or our sensitivity to members' premiums not reflecting the actual cost of care in their geographic area?

RETIRED HEALTH ACTUARY McCOLLUM: In the specific geographic area.

COMMITTEE MEMBER MATHUR: Specific geographic area.

RETIRED HEALTH ACTUARY McCOLLUM: Right.

COMMITTEE MEMBER MATHUR: Okay. And so -- you know, of course, it's not surprising that Scenario E is the most attuned or the tightly -- is the tightest to the actual cost of care. Although, I am surprised that it's not more signi -- it's not -- it doesn't have a higher marketability factor, given that you broke it out by -- you broke it out -- you tried to reflect more the -- in the region composition, more closely matched zip codes and counties, right? I mean, there's -- the only reason to do something like this is if you had a much more significantly positive marketability factor?

RETIRED HEALTH ACTUARY McCOLLUM: That would be one consideration, correct. That would -- that would be one of the main reasons for wanting to go to this scenario.

COMMITTEE MEMBER MATHUR: So were you surprised that it only has a marketability factor of 51 percent as opposed to 49 or 50 for Scenario D and C?

RETIRED HEALTH ACTUARY McCOLLUM: Well, no, because these regions were grouped in essentially 10 percent chunks, I guess, for lack of a better term.

COMMITTEE MEMBER MATHUR: Okay. Okay.

RETIRED HEALTH ACTUARY McCOLLUM: So in other words, the most expensive region are those counties that are greater than 20 percent above the statewide average. Region four was those counties that are between ten and 20 percent. So you've got a ten percent range that you're putting counties into.

COMMITTEE MEMBER MATHUR: Yeah.

RETIRED HEALTH ACTUARY McCOLLUM: So to talk about being within a three percent threshold, obviously you're going to have members on both sides of that three percent threshold --

COMMITTEE MEMBER MATHUR: Okay.

RETIRED HEALTH ACTUARY McCOLLUM: -- since we're grouping in ten percent groups.

COMMITTEE MEMBER MATHUR: And I appreciate that we don't want to have enumerable regions, a region for every cost -- every cost of care price point. That would be too complex. So I guess I would suggest that given that the benefits of this are not significantly greater -- of Scenario E are not significantly greater than Scenarios B, C, or D that we just drop -- we just drop this scenario. It seems complex and difficult to explain to members. And, you know, particularly if they are approximate to other counties or zip codes that are materially different in terms of their premiums. I guess it doesn't reso -- make sense to me that we would continue on the path with this one.

But I did have another question. And that is with respect to any of the scenarios really. There will be some counties or zip codes where a member on one side of the dividing line has one premium and a member on the other side of the dividing line has another premium, even if the member on the more expensive side of the dividing line could potentially see a provider in the less expensive region. Is that -- is that correct, is that a correct statement?

RETIRED HEALTH ACTUARY McCOLLUM: Yes, that's always an issue. If you're going to split the State into regions, you'll always have people that are along the edges of two regions that would be -- as Mr. Feckner once said, you could have two neighbors side by side --

COMMITTEE MEMBER MATHUR: Yeah.

RETIRED HEALTH ACTUARY McCOLLUM: -- and one would be in one region, and the other would be another region.

COMMITTEE MEMBER MATHUR: And I guess my question is -- excuse me -- given the DMHC's sort of 30-mile radius for care -- right? I think that's their radius for approving networks, is that right?

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

COMMITTEE MEMBER MATHUR: -- whether we would want to consider something -- and forgive my voice. I'm so sorry -- whether we'd want to consider something similar with the regions, where if you were actually seeing providers that are within 30 miles, but in a less expensive region, whether we -- I don't -- maybe this is too complex to implement, and so forgive me for asking this question. But is it possible to give a waiver to a member who might be actually get -- seeking all of their care in the less expensive region because it's within the 30-mile radius, or implementing -- execution-wise is that just too difficult to do?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I think that would be quite complex. Kathy Donneson speaking. We do have the live/work rule.

COMMITTEE MEMBER MATHUR: Yeah.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: And we have just updated all the documents around the live/work rule. And so if there is that close proximity, there is that option perhaps for a member to use the work address versus the home address, or vice versa.

COMMITTEE MEMBER MATHUR: Yeah. Okay. All right. Thank you. That's all my questions for now. Thanks.

CHAIRPERSON FECKNER: Thank you.

Ms. Taylor.

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

So I appreciate all of these options. It's a lot to take in. You guys did a lot of work on this. I didn't see, and am I wrong, are one of these the ones that we already have?

RETIRED HEALTH ACTUARY McCOLLUM: No.

CHAIRPERSON FECKNER: No.

VICE CHAIRPERSON TAYLOR: Okay. So could that be an option we include?

CHAIRPERSON FECKNER: Um-hmm.

RETIRED HEALTH ACTUARY McCOLLUM: That could be. You --

VICE CHAIRPERSON TAYLOR: Okay

RETIRED HEALTH ACTUARY McCOLLUM: One of your options would be to not accept any of these scenarios and keep the current regions as currently existing.

VICE CHAIRPERSON TAYLOR: Okay. And we're still looking at renaming the regions, however, correct?

RETIRED HEALTH ACTUARY McCOLLUM: (Nods head.)

VICE CHAIRPERSON TAYLOR: Okay. And then -- hod on. This is complicated. There's all kinds of things to turn to. On the factors -- regional factors, you recommended number three. Set a range for regional factors for plans to be within. Can you give me a little bit more of an explanation why you want to go there, as opposed to the other two?

RETIRED HEALTH ACTUARY McCOLLUM: Well we've had some -- we've had some issues with some of the plans in regards to their calculation of factors, and what we consider to be the appropriate factors. And if we were to make the regional factors where we set a range, and as long as they come in within that range, there's no issue, no question in regards to that. And so it would -- it would prevent a submission of a factor that we considered to be inappropriate, and then the discussion about it during the rate development process.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: I think we're looking for consistency. And we're not sure we've had it across all the plans in the past. So if we were to offer a range, we would explain that through the rate development process, and that way we'd have a little bit of latitude to be able to ascertain whether or not that they're providing a range that's acceptable.

VICE CHAIRPERSON TAYLOR: Right. And I think, as I recall, one of the problems we ran into during rate was this -- that very thing during rate setting last time. So I just wanted to make sure that we were clear with our -- why we are going this way. And I think -- I don't -- I'm not seeing any of -- any solutions in any of these scenarios. I just want to kind of make a commentary here. I think there's winners and losers in each and every one of them. So whether we have an appetite for change is where this would come in. I'm not sure that we have an appetite to change right now. And I don't know. Maybe we need a comparison of what that change would be versus what we currently have, whether -- the cost would be for the areas, our current regions? Is what these 75 percent more paying, et cetera?

Say I'm looking at Scenario D -- and I'm sorry, 94 percent, I can't read. Los Angeles area -- the increase for L.A. area under Scenario D is 94 percent of the members are going to have an increase. Is that what we're comparing it to, is currently -- our current region?

RETIRED HEALTH ACTUARY McCOLLUM: Yes. This was a --

VICE CHAIRPERSON TAYLOR: Okay. So then we already have it.

RETIRED HEALTH ACTUARY McCOLLUM: This was using the scenarios as we created and estimating the impact that would have been on the 2019 premiums, if these scenarios had been in effect for this year.

VICE CHAIRPERSON TAYLOR: Okay. Based on -- okay. I got it, so we already have that. That's -- that's a lot of people to impact. So I'm not sure the appetite for change, at least for me, is not there, but thank you very much.

CHAIRPERSON FECKNER: Thank you.

Ms. Holton-Hodson.

ACTING COMMITTEE MEMBER HOLTON-HODSON: Thank you. This is really challenging my math ability, but -- so let me -- just to clarify. So take Scenario A just as an example. So 40 percent are paying within 97 percent of the cost. So 60 percent of that are paying potentially under the cost or over the cost, right?

RETIRED HEALTH ACTUARY McCOLLUM: That's correct.

ACTING COMMITTEE MEMBER HOLTON-HODSON: So when we say they're paying less than the cost -- if it's less than the cost of care, who's making up that difference or they're just lucky and you've been able to negotiate much lower prices than the general cost of care?

RETIRED HEALTH ACTUARY McCOLLUM: Well, no, the -- a general group insurance principle is that you group a group together and some people pay more, some people pay less.

ACTING COMMITTEE MEMBER HOLTON-HODSON: Okay.

Great.

RETIRED HEALTH ACTUARY McCOLLUM: So those that are paying less are offset by those that are in need on the high side.

ACTING COMMITTEE MEMBER HOLTON-HODSON: Right. Okay. So given that, you know, is there one of these metrics that you suggest potentially should be the overriding rule? For example, if you look at Scenario 2, it just happens to have 41 percent of our lives get a decrease more than three percent, which I would think we would want to pursue. That seems to be the lowest. Is that sort of a good metric to sort of make a determination is I think how many -- what's the greatest we can -- greatest number of people that would be affected by a decrease? It also suggests to me that administratively, Scenario A also happens to be the least complex where it -- so there's probably some savings just there as well.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: So I think certainly there's -- that's a factor. I think what we talked about were that there were really three guiding principles, and it's really at the pleasure of the Board that they decide where they want to place the importance on that. One of them being the greatest good for the greatest number of people, one of them remaining competitive in the health care marketplace, and not disrupting that.

We have 99 percent retention rate right now. We'd like to see that -- we would like to maintain that and make sure that we're offering the best services we can. And then, of course, the PEMHCA compliance factor.

ACTING COMMITTEE MEMBER HOLTON-HODSON: Well, it would suggest to me actually Scenario 2, given that the others -- while there's some changes. It's not a lot. The greatest good for the greatest number is 40 percent would experience a decrease, of more than three percent, which would be a good thing.

CHAIRPERSON FECKNER: Anything else?

ACTING COMMITTEE MEMBER HOLTON-HODSON: No, that's it. Thank you.

CHAIRPERSON FECKNER: Very good. Mr. Jones.

COMMITTEE MEMBER JONES: Thank you, Mr. Chair.

The first question is you talked about the outreach to stakeholders, and you talked about the employers. And then indicated several concerns, implementation -- administrative requirements for implementation, et cetera. But what about the member, did you have a similar type of outreach to the members to get their input and their comments?

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

Our stakeholder groups and our -- were limited to the membership as well -- and not the actual members, but that's why we provided the webinar, so that we could get the feedback directly through the employers and other stakeholder groups. We had several meetings at our Stakeholder Relations sessions as well.

COMMITTEE MEMBER JONES: So can you discern comments from the webinar that were made by members versus employers?

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: I think what we heard most is what we talked about a little bit is really more confusion around the way that we set regions in general, and the way -- and what we call regions. That seems to be really a lot of confusion to most of our members.

COMMITTEE MEMBER JONES: And the next question is we talked about the cost of care, have you given any thought to the impact on the health care itself in terms of these strategies?

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

I'm sorry. I'm not sure that I understand the question.

COMMITTEE MEMBER JONES: We're looking at just the changes in terms of making these changes relative to costs. But what about the care itself, do we have any kind of --

VICE CHAIRPERSON TAYLOR: The quality?

COMMITTEE MEMBER JONES: The quality of care. Is that an impact, do you know?

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: The quality -- the quality would be as it is for all of our health plans. It would remain the same. It's the same health plans. It's just the way that we draw the regions is really the only difference in that -- from that perspective.

COMMITTEE MEMBER JONES: Okay. And then the last question is that we've -- I've been making a number of changes over the last few years. And so have we thought about for whether or not there's an intersect in these changes in some of the changes that we recently made, in terms of, you know, every -- it looks like every year we're making some major changes. And so have we waited to see what the impact of those previous just changes reflect before we then start to make additional changes?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Mr. Jones, we certainly agree, there's been a number of changes over the last several years. The most -- this most recent open enrollment and the changes in the Bay Area really reflect how we are trying to think strategically to manage the cost of care, to manage the challenges of negotiations between providers, and health plans, how to analyze competition between providers, as well as between health plans.

So we certainly have had our -- a lot of experience with change. And this -- this region analysis and review doesn't really affect the delivery of care or the competition of care, but it really -- it does reflect on our employers what will their members be paying in terms of premiums. We have some protections in place, such as the live/work rule.

So the question I think that we are asking the Board is we've -- they've given you the best analysis to this point in time. And really the question is going to be for the Board to answer, is this more change in an environment in which we've experienced several changes?

COMMITTEE MEMBER JONES: Okay.

CHAIRPERSON FECKNER: Thank you.

Mr. Rubalcava.

BOARD MEMBER RUBALCAVA: Thank you, Chairman. Appreciate you giving me the opportunity to ask a few questions.

So, first, I want to thank the staff for all the data and the analysis you've provided. I know this is something very hard to drill into. So just to -- so if the goal -- if the intent is to have the regions reflect the actual cost of care in that region, I guess that would be based on what networks are available and the contracts they have with their hospitals and providers, is that correct?

RETIRED HEALTH ACTUARY McCOLLUM: That's correct. That's the main component in --

BOARD MEMBER RUBALCAVA: Okay. So the follow-up, because it's so -- for example, so looking at Scenario D, and I think Scenario E -- no, D and C, so the assumption here is then, based on your data, that the San Gabriel Valley that the cost factors are more closely aligned to San Bernardino and Riverside County than L.A. County, is that what you're saying? Because there's less networks or more -- less hospitals, so they can charge higher to the carriers, is that correct? I'm just trying to understand why is San Gabriel Valley carved out?

RETIRED HEALTH ACTUARY McCOLLUM: It's more reflective of tow two counties, San Bernardino and Riverside, correct.

BOARD MEMBER RUBALCAVA: So given the cost relatively, the cost of care is less expensive in Los Angeles area than it is in San Gabriel Valley, just to understand the --

RETIRED HEALTH ACTUARY McCOLLUM: No, it's actually the reverse.

BOARD MEMBER RUBALCAVA: -- what I'm seeing?

Say it again. So --

RETIRED HEALTH ACTUARY McCOLLUM: San Gabriel Valley is being put into a region that's less expensive.

BOARD MEMBER RUBALCAVA: Less expensive.

RETIRED HEALTH ACTUARY McCOLLUM: Right.

BOARD MEMBER RUBALCAVA: Thank you.

Then -- so that's right. So the closer you to get one, then the closer to neutral, I guess?

RETIRED HEALTH ACTUARY McCOLLUM: Well, one is just a statewide average.

BOARD MEMBER RUBALCAVA: Okay. Statewide average. Okay. Thank you. Now, the -- I'm getting to -- one more question. So I understand that you're trying to get the regions to reflect the cost relativity. And this is interesting, because in the concept -- I mean, the -- I always keep hearing from the agencies in Ventura County that somehow, because of the name probably, they think they're being overpriced. But given the charts, they're actually in -- they're not being separated out, like I say, San Gabriel Valley. So I think that's interesting. So at some point, I'd like to hear what those agencies say.

But my final question is if we move to -- if the Board decides to move to a rating system that's based on cost and not geographic, like before, would there be --

would one of the long-term impacts be like perhaps rate stability or would you see -- or would that be a factor in rates going forward?

RETIRED HEALTH ACTUARY McCOLLUM: I don't think it would have -- be a big factor one way or the other. The -- in Scenario E that you're talking about, the counties are just being grouped by their relative cost to the statewide average.

BOARD MEMBER RUBALCAVA: So I guess what I'm trying to understand is so is the -- okay. So I know one of the goals is to try to make sure people are paying the correct premium relative to where they live or where they access care, but -- so the cost -- I'm just trying to understand would the carriers be cost neutral or would they be able to game the system in their favor? I'm just trying to understand the -- we've -- other questions have been asked about, you know, how the employers will see it, how the members will see it.

But I just want to make sure that we thought about does this advantage or disadvantage the carries, or are they neutral? I just want to make sure. That's why I asking about the rate stability. Is this going to force everybody to have even playing field as we go forward, so nobody tries to take advantage of us, or is this neutral? I don't know if you thought about it that way?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I think I'm -- I understand the question that you're asking is how will the carriers respond to -- because they do have to be competitive within their own geographies. And if you look at the past few years, there has been some wild swings in terms of what carriers are charging in terms of premiums in specific areas.

And I think no matter what direction you decide to take, what has been offered here is that we need to bring some discipline to this practice. A 79 percent increase is not acceptable when we're having an overall aggregate increase of three percent.

So I think regardless of whether we keep the regions as they are, move to what makes sense on some new geographies, we have to bring discipline to the carriers. And that has to be in terms of how much is -- how much latitude do we give the carriers in setting their own regional factors, which affect the premiums.

So I think that's what the team is -- has built into this presentation that I want to make sure is clear. No matter what happens, there has to be discipline brought in terms of how regional factors are determined by our health plans.

BOARD MEMBER RUBALCAVA: Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Slaton.

COMMITTEE MEMBER SLATON: Thank you, Mr. Chair. Your last comment was interesting bringing discipline to regional factors. You know, when I look at attachment 3, page 14, which is the overall competitiveness compared to the other plans, it appears like we have discipline currently. Would that be fair to say?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I would -- I think it's fair to say the methodology is disciplined. It's really how the plans are determining their own internal factors within each region, and then what is that impact on the regional premiums. And we have -- we have seven carriers within different geographies. And each carrier is doing their own factor analysis.

Back when we actually set up regional pricing, we did a lot of internal factor analysis. When I say discipline, I'd like to bring discipline back to our internal analysis in terms of how we work with our plans --

COMMITTEE MEMBER SLATON: I see.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: -- during the rate development process.

COMMITTEE MEMBER SLATON: But when I compare -- when we compare CalPERS to -- in this single example, compared to these other two alternatives that employers have and are using, we're competitive. So that's at least one metric that you could say the system is in somewhat balance today.

So I have two questions. One is an overall question. So you said you have a 99 percent retention rate. And you have, what, 468,000 lives in this plan. So those two data points would tell me that you -- you're stable. Is that a good expression? So assume that's right. I see shaking of heads. So you're in a stable mode today.

So it raises the question in my mind, you know, there's that expression if it ain't broke, don't fix it. So are we trying to take from California's value trust and self-insured schools of California or are we trying to move more people, and are we creating a situation where we're going to -- we're creating winners and losers within the existing base in order to grow the size? And do we need to grow the size, or are we all -- do we have enough lives that adding more lives doesn't necessarily increase the competitiveness?

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

It's a great question. Thank you, Mr. Slaton. We do have a great retention rate. It's just that we haven't really evaluated this for quite some time. And as

Dr. Donneson said, we want to create discipline and assess every few years. And that's really again at Board direction. If you feel like it's not broken and we don't need to make a policy change, we don't need to make a policy change. But it -- we wouldn't be doing our due diligence --

COMMITTEE MEMBER SLATON: Sure.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: -- if we didn't take a look every so often.

COMMITTEE MEMBER SLATON: No, I understand brining it to us.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: Right. Right.

COMMITTEE MEMBER SLATON: Absolutely, it's the right thing to do. So let me come back now and drill down to a specific question. And as you said, I was at the employer forum, and the issue was raised regarding employee -- employers who have employees in different regions and trying to reconcile all that and manage it from their perspective.

And I think there was a discussion about trying to have a little more flexibility within the 30 mile rule. And so there was a discussion about, obviously, you have the home address, work address. Is there -- help me understand why you can't have a care address, a care zip code? Why can't you have three?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Could you -- a care address?

COMMITTEE MEMBER SLATON: Well, for example, if I -- if my work address and my home address happen to be in the same region, and it's very expensive for me to get care, but I can drive 10 miles, and if I'm willing to commit that my care has to come in that zip code, why would I not be permitted to do that? What in our system would make it so difficult for us to do that?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: The Department of Managed Health Care manages all of our HMOs and sets the rules. The rules for care delivery are set based on zip code. The provider zip code, as well as the member zip code. So from our Health Maintenance Organization perspective, that is outside of our control in terms of how the DM -- DMHC sets the rules. We build our systems really under the DMHC requirements.

COMMITTEE MEMBER SLATON: So is the rule it -- does the rule actually say it has to be a work or home address or does it saw you can have up to two? What's the rule?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: The DMHC rules relate to where the member's residence or work, whatever zip code they're using -- the live/work rule was set by this Board back in 2000. So that is -- that's the Board's policy. The DMHC regulations require providers to be within a 30-mile radius of the member no matter whether it's a live or work address.

COMMITTEE MEMBER SLATON: Right. So let me just paint the scenario. So this Board could decide that a member, someone who's receiving a plan under one of these plans, could specify a zip code different from the work or home, as long as it's within the 30-mile radius of their home?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I think we would have to take that back and ask that question, especially of our Legal Office.

COMMITTEE MEMBER SLATON: Yeah, I'm just trying to see if there's -- if there's a way to have flexibility where people can optimize their care, because people are pretty good at making informed decisions when it comes to these kinds of issues. And I've heard people say, you know, gee, it's five miles away, but I -- you know, I'm stuck over here to have care.

So I would just ask the Chair. Maybe if it's not overly burdensome to understand, what options we might have in that arena to improve the flexibility?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF

DONNESON: We'll take that as a direction.

CHAIRPERSON FECKNER: Thank you.

Anything else, Mr. Slaton?

COMMITTEE MEMBER SLATON: No, that's it.

CHAIRPERSON FECKNER: Mr. Lofaso.

ACTING COMMITTEE MEMBER LOFASO: Thank you, Mr. Chair. Thank you, staff. You're doing a good job of showing how complicated this is.

I actually go back to the question Mr. Feckner asked at the beginning of the discussion. And, yes, I anticipated your answer that it's complicated and it depends on the data. And as I grapple with that, I'm watching myself do what I'm watching everybody else do, which is how can I take all this complex stuff and try to isolate what I think is important to make it manageable.

So I have a couple questions in that regard, but a threshold one beforehand, which is did I understand you to say, Mr. McCollum, at the beginning of the discussion that all of these numbers here are designed around examining individual covered lives, that is to say, they're individual specific not employer specific?

I mean, the reason I ask the question is we could have all this -- my touchstone in my questions is going to be about the extent of the disruption. If I'm an employer and 20 percent of my employees had a 20 per -- excuse me.

Half of my employees had a 20 percent increase, and half of my employees had a 20 percent decrease, that's a lot of -- that's a fair amount of disruption on paper, but I can manage that, because it's -- well, it won't be an exact wash, because for reasons you understand.

But again, do I understand that this analysis is individually oriented? It doesn't necessarily tell us the relationship of those individuals to the agencies. DoI understand that correctly?

RETIRED HEALTH ACTUARY McCOLLUM: That is correct. This analysis was done on a member basis.

ACTING COMMITTEE MEMBER LOFASO: Okay. I'll get to that in a minute. So apropos to my early question about just trying to manage the data, I had a similar reaction to Scenario E, as Ms. Mathur did, which is to say not a lot of difference in the cost of care relative to Scenarios B, C, and D. But then I noticed that Scenario E has a much more substantial number of individuals who have less change in their rate. But I also noticed that most of that population is eaten up, as it were, by individual -- by fewer individuals who have a decrease.

So my sort of attempt to kind of group all this to make it more manageable was I sort of combined those who got the decrease and those who got no change and then focused in on those who had the increase. Because that seems to me the area of the greatest potential disruption, that, in my view, invokes the question Mr. Slaton asked, which is, you know, is the -- is the tonic worse than the disease as it were?

So I'm continuing along my line of thought. But one little issue is I'm not 100 percent sure, and I don't know what Ms. Holton-Hodson thinks that you entirely answered her question, because -- when your answer to her question was to show us the change in the analysis if you loosened up the sensitivity of the three percent range to make it 10 percent.

What I'm curious about is say for an example in Scenario C, 37 percent of covered lives would have a increase of more than three percent. To understand disruption, it would help me to know of that 30 percent, do more than 50 percent have an increase of greater than 10 percent or 20 percent, or say, for example, is 70 percent of that increase contained in some kind of three to 10 percent range?

I don't know if you have that data available or you can -- you can develop it. Because where I'm going is I'm looking for places where there's a lot of disruption. Another place I'm thinking about is again trying to compare or contrast the employee issues with the -- all this data we have about which region is going to have an

80 percent increase in their total covered lives with a greater than three percent rate increase, or which is going to have 100 percent decrease.

I don't know if you can compare -- take the issue of the extent of the increase, relate the individual increases with their public agencies, and take that data and look a little bit more granularly where we have some of those places in some of the scenarios where they have large increase -- rate increases for some of those particular areas, and look for hot spots? Can you figure out -- say, for example, if a change is going to substantially increase the rates of a lot of people say in the Sacramento area, can you figure -- can you help us figure out if that's -- if that is related to a particular part of the Sacramento area that's making the change, if that's going to have a particularly hard impact on a couple of -- a couple public agencies who are going to be more disproportionately impacted in their experience relative to this change than others?

And my last comment on this looking for disruption, which is the theme I'm sounding here, the -- if I understand correctly, the comparison to the other two benchmarks, the schools and the other plan, you broke them down by region. I guess I'm not quite clear on how that would be impacted, again along this line of where are the hot spots. So I'm trying to take a lot of data, and I'm trying to make it make sense.

My theme is where is the greatest area of disruption, and do you think with all that I've laid out, you could look for hot spots?

RETIRED HEALTH ACTUARY McCOLLUM: Well, we -- okay. We could -- we could take -- let's take a specific example, if you have Scenario C. And in Region 2, the Los Angeles region, they've got 93,000 -- the current Los Angeles region has 93,000 members that would receive an increase -- or, excuse me, 94 percent of those members would receive an increase greater than three percent.

So if I understand you correctly, you're asking could we break that 94 percent figure into like ten percent would have a three to five percent increase, and 17 percent would have a five to seven percent increase, and 20 some percent would have seven to ten percent, like that?

ACTING COMMITTEE MEMBER LOFASO: That's part of the question. I'd accept it with slightly less granularity. I mean, how many of those -- how many of these are three to 20, how many are 20 to 50, and how many are over 50? Even that would be helpful.

RETIRED HEALTH ACTUARY McCOLLUM: Okay. Well --

ACTING COMMITTEE MEMBER LOFASO: I mean, if everybody in that 94 percent is going to have a five percent rate increase, that's not as disruptive as 50 percent of them having a greater -- a 50 percent or greater rate increase.

RETIRED HEALTH ACTUARY McCOLLUM: Okay. That could be done. You know, you're just getting into an awful lot of numbers, if we were to do that for all the different regions --

ACTING COMMITTEE MEMBER LOFASO: And that's why I say look for the outliers. I mean, if you give us every number for every life, and every agency, and every zip code, that is totally unmanageable. If you could figure out the way to look for the outliers or, what I'm calling, the hot spots, I think that might make it more manageable.

RETIRED HEATH ACTUARY McCOLLUM: But you'd have to define hot spots for me. Would that be by number of members, or would that be by percentage that are receiving an increase, or would you want to look at the percentage that are receiving a decrease?

ACTING COMMITTEE MEMBER LOFASO: I actually am focused entirely on increases.

RETIRED HEALTH ACTUARY McCOLLUM: On increases. Okay.

ACTING COMMITTEE MEMBER LOFASO: That's why I grouped together the non-change of the decrease. And I think I'm trying to rationalize members versus agencies. Again, if I'm an agency and half my members have 20, and half my -- half my members have a 20 percent increase and half have a 20 percent decrease, that's a lot easier for me to live with than if 50 percent of my members have a 50 percent rate increase, and 50 percent of my members have, I don't know, a two percent decrease. That's a completely different experience.

RETIRED HEALTH ACTUARY McCOLLUM: Well, we do not have the information broken down by agency, so that would not be available. We would be able to break it down by current region and show that within the region, like I said, the -- for example, the Los Angeles -- current Los Angeles region where 94 percent of those people would receive an increase, we could tell you how many of those would receive this much increase, or this much increase, or this much increase.

And so if you consider hot spots to be the greatest number of people impacted or the greatest percentage of the number of people impacted. So, in other words, the largest number, 92,000, or the largest percent -- for example, on this page, you've got 99 percent down at the bottom of the other northern region that are -- would receive an increase, but it's only on 13,000 members. So is 99 percent of 13,000 a hot spot?

Obviously, not as hot as 94 percent of the 93,000 So it would be a question of how granular you want me to -- or you would want us to present that data back to you.

ACTING COMMITTEE MEMBER LOFASO: That's a good question. I guess I need to think about that. But again, I am looking for where there's substantial disruption. What agencies are going to have substantial rate increases that are going to be difficult to absorb, or where are places that the large number of people with a relatively modest increase is probably not that challenging to absorb or -- and/or there are offsets to that public agency where, you know, some increases offset.

And again, if you don't have the agency-specific data, again I'm just -- my bottom line is -- you know, Mr. Slaton asked a great question is the tonic worse than the cure?

And it seems to me that understanding where the greatest elements of disruption are are a good way of figuring that out. That's my bottom line.

RETIRED HEALTH ACTUARY McCOLLUM: Well, we could go back, and essentially I would suggest that using our discretion, we would decide where these hot spots are and bring that data back.

ACTING COMMITTEE MEMBER LOFASO: I have

confidence in you.

RETIRED HEALTH ACTUARY McCOLLUM: Thank you.

ACTING COMMITTEE MEMBER LOFASO: Just one more question completely switching gears. And I think this is sort of along the lines of something Ms. Donneson -- Dr. Donneson said earlier. So just on the issue of the rating methodology -- sorry. I think you call it rating factors.

So between Options 2 and 3, the prescriptive definition or the, what in essence I think you communicate as, flexibility to deal with member migration and emerging geographic trends, can you just give a little bit more texture from a plan perspective on what that means?

I mean, you're implying in the option that Option 2 was -- is too rigid. It doesn't let plans do what they need to do to have -- to function what they do -- it's overreach, I think is the implication. But I don't -- I don't -- I can't -- I'm trying to get my head around what I'm doing as a health plan that a more prescriptive range or definition would prohibit me from doing, and what I would be limited in doing to deal with geographic trends and member migration that is appropriate to do in the context of more discipline that I wouldn't be able to do under the other option?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I'd like to clarify. I was not speaking to any of the options. So if I misspoke, it's not about the options themselves. It's about how the plans set their own geographic factors, that then affect the premium -- the statewide is the statewide rate around which the public agency premiums are developed.

And so when you have some wild swings as we've seen in these past few years, as we've added more plans, we have added more ways to cut geographic factors. And so if you look at two years ago, when we saw one plan with a 79 percent increase in the Bay Area, while the methodology is actuarially the same, what our plans are doing is balancing their regions too, in terms of competitiveness.

So the Bay Area we know is expensive. And through our -- the way we've handled our regions and our regional rating, there is a little bit of offset in the south versus the offset in the north, so that the greatest number and the greatest good are being served.

I've just seen over the last few years that if we don't -- maybe discipline isn't the right word, but if we aren't thoughtful about how our plans are setting their geographic factors, all actuarially sound, but again if -- what I think we need to do is come back with a set of standards and ranges. As has been proposed in this agenda item, no matter whether we keep the regions the same, pick a new set of regions, I just think that after 13 years a review of how we manage the regional rating for our contracting agencies is in order.

And I think the -- the range approach is actually a very good approach. It gives the plans flexibility to manage their regional factors in their competitive markets, but it also, I think, would give us the opportunity to avoid some of the -- some of the big swings that we have seen in terms of contracting agency premiums within certain geographies.

ACTING COMMITTEE MEMBER LOFASO: Okay. I must confess, I'm of the -- I'm schooled in the idea that the challenge that we have is that when particularly a plan with a small population has a sudden member migration, that they look at the data from the members, and there's experience -- health experience that gets mixed into that. And so when you say member migration, when you say a range you're going to say -- you're seeing -- the way you want to analyze costs, you're seeing a 50, 100 percent increase. But no matter what, you can't see more than a 20 or 30 percent increase in that range.

I don't understand what the -- what's prescriptive about a range versus -- you can tell I just don't understand what this model looks like.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Gary, could you speak to the range approach.

RETIRED HEALTH ACTUARY McCOLLUM: Okay. In a region, there are provider groups, and there are hospitals that have different cost patterns, different negotiating contracts with the health plans. So a health plan's membership, depending on where they're going for their care, Hospital A or Hospital B, to Provider Group A or Provider Group B, would have slightly different costs involved.

We have the data available to us on an aggregate basis for the region, and we can calculate an aggregate average cost of the region. But the specifics that the plan has available, based on their own members, and where they're going for care, and what care they're receiving is the reason why we propose a range, because we can come up with the average for the region and then provide a range that would encompass the plan's ability or allow the plans to have the flexibility to come in within that range depending on whether their membership is going a little bit more toward the more expensive hospitals or a little bit more towards the less expensive hospitals and providers.

ACTING COMMITTEE MEMBER LOFASO: So if I understand you correctly, the difference between Options 2 and 3 to be really simplistic are: Option 2 is we take our data and say this is what our data says, you have to follow it. Option 3 says, this is what our data says, we know you have more information, so you can have, I don't know, 10 percent swings based on our -- our data and our model because we know there's lots more you know because of the management you're doing on the ground. Is that a simplistic way of understanding the difference?

RETIRED HEALTH ACTUARY McCOLLUM: That is.

ACTING COMMITTEE MEMBER LOFASO: Okay. Thank you very much. Thank you, Mr. Chair.

CHAIRPERSON FECKNER: Thank you.

Mr. Miller.

COMMITTEE MEMBER MILLER: Thank you.

A couple thoughts and maybe a question or two. One of the things that strikes me is with Scenario E or with any of the scenarios, to me it's not so much about the scenario, or the map, or what it appears like, it's the fundamental approach. And it seems to me that the approach that gave us Scenario E is a rational approach. It's coherent. It's consistent. It's something that the approach can be applied today, tomorrow, into the future, regardless of market dynamics, regardless of what a map would look like, regardless of whether we end up with two regions or 10 regions out of that.

It's -- the fundamental approach is based on experience, the numbers, kind of an empirical approach that's explainable and understandable. I think a lot of my impression is a lot of the issues around maps, and zones, and regions is because we've got this -- it's an artifact of using geographical nomenclature and trying to stick with these continuous or contiguous areas and chunks on a map that really have little or nothing to do with the delivery of health care per se, but was a way of thinking about organizing things to be simple and easy for people to get, but you end up with people saying I'm not Bay Area.

I'm -- you know, and that -- whereas, to do it based on what's actually going on empirically and with the delivery of health care in a way that everyone can understand, not only I think makes more sense, but I think it also helps us with, you know, where are those hot spots, where is the market going, how are we doing this, both for our employers, for our members, for policymakers.

So to me the appeal of going to a more, you know, scientific, you know, approach to doing that makes sense. I think the challenge to me is moving to a more coherent rational approach and hoping that it's reasonable. That's where the deployment comes in and where looking at how do we move to this kind of more rational approach without having undue disruption.

Likewise, with looking at the three options for how we work with these regional factors, it seems like to me that, you know, the middle option is basically the average. So we're taking some measure of central tendency, but we're not looking at variation or the range at all, which you wouldn't want to sell your house or buy a house based on that.

So the third option of looking what does -- what does that number really mean in terms of ranges just inherently makes sense to me as a scientist.

So my question is in terms of what we've seen in this marketplace, and with the drivers to change the behavior of both members, and employers, and providers, the value of moving to a more rational approach, rather than one based on trying to draw lines on a map and then fit the numbers to it, how do we see that playing with providers and policymakers out there? Do you think that will appeal to them or make sense to them and allow them to make better decisions?

RETIRED HEALTH ACTUARY McCOLLUM: Everything you just said is true on a mathematical level. The issue with Scenario E would be the implementation, and the -- especially for the employers how they would deal with, as has already been said, if they have members in different regions, or they live/work in different regions, you have more of a chance that you get into that different region issue using Scenario E than you do using the other scenarios, which have contiguous regions.

So in other words, you have a lot more boundaries in region -- in Scenario E. Whereas, you have fewer boundaries in the other scenarios that you would worry about the issue of someone living and working in the two different regions or even as has been brought up, the possibility of living, working, and then site of care as a possibility. So it just would -- it just would make it -- it would make it much tougher to implement.

COMMITTEE MEMBER MILLER: Right. So it kind of -- that complexity of -- without -- if we had -- even if we had contiguous regions, if we had ten of them, we'd have that same issue the -- you know, the border lines. An employer who might have people on both sides of it. So really, to me that comes down to more of a, you know, how many regions we have versus what's the rationale for establishing them.

So, yeah, again, I think that's where I'll be real interested to see what our employers have to say about how much disruption that kind of approach would cause them, and also trying to take a little bit more of a longer term view of moving to that kind of approach in the long run knowing that there will be, you know, the short-term pain curve of any change.

But -- so, yeah, I'll just -- it remains to be seen, so...

CHAIRPERSON FECKNER: Thank you.

Mr. Cobb.

ACTING COMMITTEE MEMBER COBB: Thank you, Mr. Chair. I just had one question about the regional factors. Most of what I was -- my question has been answered by the explanation, but what I'm wondering about is it seems like the motivation for the carriers to adjust the rate within a region has to do with competitive factors, which typically go to things like gaining market share, and that sort of thing.

So what I was trying to understand is how does allowing them a range within which to play versus prescribing a regional factor benefit the local agency employers and members in those different regions? You know, is it really to their benefit that we allow a range or should -- would they be just as well off if we prescribed it?

RETIRED HEALTH ACTUARY McCOLLUM: Okay. I -- we weren't looking at it as a benefit to the employer. We were looking at it as a methodology or a method that would create the most appropriate regional factors and how to get those most appropriate regional factors.

And we feel that providing a range that the plans could then move within, and they could -- like I said, they could go within that range based on their membership, based on where their membership is going, or as you just pointed out, there could be a little bit of competitive position involved in their decision making.

CHAIRPERSON FECKNER: Anything else, Mr. Cobb?

ACTING COMMITTEE MEMBER COBB: No. Thank you.

CHAIRPERSON FECKNER: Thank you.

Ms. Mathur.

COMMITTEE MEMBER MATHUR: Yeah. I have a couple of suggestions. One is clearly there's a concern about what does greater than three percent mean? And I heard that from a couple of Board members -- Committee members.

And I would suggest two things. One is to have a chart that by region does -- you know, breaks it out by, you know, what three to five percent, five to seven, seven to ten, and then greater than 10 by both percent of the region and number of lives, because as you point out, the percent of a region, depending on -- the number of lives really depends on how large the region is. And that -- so I think that would be -- I think understand -- that would help us understand what the impact truly is and perhaps even also a visual distribution. I don't know that might be more -- that might be more than necessary, but sometimes it helps to have a picture to show where the impact is, you know, maybe by lives and sort of distribution graph.

I think it -- you know, the underlying issue here is that the costs vary dramatically across this state. And that is a key problem that we have worked to address but haven't really obviously successfully solved here in the State of California. It's not something we can't do alone. And I often hear from public agencies what can we do. We recognize that it's more expensive here. But also our -- you know, for other reasons, our employees get paid less. So their -- so the cost for them is actually extraordinarily -- it's a significant burden for the employees and the employers in some of these jurisdictions.

And I'm wondering if we can take what we've learned here in terms of the cost of care and develop some kind of a collaborative strategy. We've done something similar before. We had roundtables many years ago, where we had roundtables around the state and tried to activate some of the employers to engage their provider communities. But maybe there's something more structured that we could try to initiate, take this learning and try to impact.

And so I guess, that's -- that's one question. And I know that's a whole other body of work. But I guess

I would suggest that we try to initiate something, or at least provide some suggestions of what employers themselves could do to impact their -- the cost of their legion.

But that really only works if there is a high correlation or fairly high correlation between the cost of their region and the actual cost of care in that market.

And so that then would suggest that we should consider an alternative region to the one -- the regions to the structure that we have today, which I think you said was 22 percent marketability. So the correlation really is much lower than the scenarios that you've proposed today or that you've offered up today.

So I recognize that, you know, disruption always creates a lot of work, and discomfort, and unpredictability. And there will be winners and losers. And people will -- some will be happy and some will be unhappy. But I guess I would suggest that we don't -- we don't just out of hand dismiss the option of changing the regions based on the real cost of care in the region and then try to tie some kind of strategy to really improve the cost in those areas that are truly out of sync with what we think the real cost should be, so...

CHAIRPERSON FECKNER: Mr. Miller.

COMMITTEE MEMBER MILLER: Just one final thing I just wanted to bring up. When -- Priya's comments related to the marketability. It kind of brought to mind is I think it would be valuable for me to understand, you know, while we're retaining -- doing tremendous job retaining, what is the total market -- what is the market potential, and what is the potential to serve a lot more folks than we are -- that to kind of balance the potential of some losses through disruption or whatever versus what could be gained in terms of being able to serve a lot more folks with plans that would meet their needs that perhaps currently don't now in terms of, you know, their employer selecting to partner with us?

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: Thank you, Mr. Miller. In fact, right now, we are taking a look. We are doing an analysis and looking at what we currently have in our book, and what would be beneficial, and how we can serve those that we don't serve or where we need -- where we -- what makes sense in terms of the suite spot of how many agencies are in that pool and how many are not and school districts.

CHAIRPERSON FECKNER: All right. Thank you.

I now have a request to speak from the audience. Marc Fox. Please come forward to the seats on my left. Please give your name and affiliation for the record, and you'll have up to three minutes for your comments.

MR. FOX: Thank you so much. I'm Marc Fox. I'm director of human resources for the county of Solano. And base on the information presented to date, including the information that has been shared at stakeholder meetings, I would ask that the Committee and the Board consider Option A. I know next month you'll probably get some additional formation.

Before I explain the reasons for Option A, let me go back in terms of history. I've been a public agency CalPERS member since September of 1990. And at that time, there was a region for Kaiser, Kaiser North, Kaiser South. And to this day, I still right Kaiser as KN, Kaiser North. It is embedded in my soul in terms of how that was done.

At the time PacifiCare, Health Net, MaxCare or a number of other HMOs that some exist, some no longer exist were statewide. There were no regions. So you heard -- as members of this Board that have been members or policymakers for a significant period of time, you heard from employers that said, particularly Southern California employers, we're subsidizing the cost of care as a public agency of Northern California.

Unlike State employees, we as a public agency employer can go out on the market. And there was a concern by the Board, by CalPERS, that perhaps that wasn't necessarily fair, and so you developed regions. Regions, despite having been in existence for 13 years, I heard, are not particularly popular with all employers.

The current regions -- every time you've discussed the current regions, particularly Northern California employers come and say we don't like this makeup. We don't like this set up.

As a body, you've made some policy changes that impact the ability and competitiveness of your marketplace. You're still the second largest provider of health insurance in the nation, and your lives covered have grown significantly in the last two decades by some -- from about a million to a million four, million five today.

Some of the changes you've already made is you've split up the regions that you established before by creating the Sacramento region, parsing out part of Northern California.

In Solano County, our employees today are potentially in three regions. Option E moves us to potentially four regions, never mind not only the challenges that we would have, but the challenges that the providers would have.

You've also changed the member employer contribution, increasing that so that it makes an impact in retiree health. Retiree health is probably your single largest impediment for new business coming in, because not only all employers -- for example, Solano County as an employer did not have retiree health as part of our collective bargaining agreements.

You've also changed the ability for an agency to reenter into PEMHCA if they leave by changing the withdrawal and re-enrollment processes and timelines, making it more difficult for somebody who has left to come back in.

In terms of Region A, it is the most simplistic for employers to administer, and also for the health -- the health care providers to administer as well, because they have their own regions within these regions in terms of how they do pricing. It has the greatest number of lives that have an in -- have a decrease in premium, and the fewest number of lives that have an increase in premium. So it is simple to administer --

CHAIRPERSON FECKNER: Thank you. Your time has expired.

MR. FOX: -- and it is of the best available option base on the information today. And I would ask that you support Option A.

Thank you.

CHAIRPERSON FECKNER: Thank you. All right. Seeing no other requests to speak. Thank you all. I'm sure you have plenty to work on now.

(Laughter.)

CHAIRPERSON FECKNER: That bring us to Item 7b, Strategy for Prescription Drug Preference Pricing.

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, Melissa Mantong, CalPERS team members. Agenda Item 7b provides the information update on reference pricing of prescription drugs by therapeutic class.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: In September, the team updated the Committee on options for administering a reference pricing program for drugs by therapeutic class. We spoke about different activities that could be accomplished in terms of not just the PBM and CalPERS, but also bringing in a second vendor customer facing to assist us on in terms of enhancing customer support.

We talked about the three classes we wanted to reference price as a pilot, estro -- or oral estrogens, nasal corticosteroids, and thyroid medications. We introduced you to the University of Massachusetts School of Medicine, which does state-to-state contracts in terms of a number of different programs, of which customer service, provider contracting, and education are some of the things that they do.

I want to just briefly give you a little more information on the University of Massachusetts, School of Medicine. They support programs -- a variety of clinical programs in 14 states. In Massachusetts alone, they serve over one and a half million lives.

And just to briefly cover some of the things. And one thing that's really important I think is pipeline tracking, new to market, pre-release of pipeline tracking. They make formulary recommendations. They do rebate management. They do retrospective and prospective drug utilization review. They have a variety of programs that support clinical programs, such as member level education, prescriber engagement, and adherence support. They also could hepatitis C medication management, pediatric behavioral health medication initiative and opioid management.

So I did want to actually introduce the idea of the University of Massachusetts School of Medicine as a potential future resource for us, whether it's this project or something else. And, in fact, through state-to-state agreements, they are exempt from competitive bidding, and they do service the Medi-Cal population in quality assurance programs.

So I wanted to let you know that this may be a potential resources for us in the future.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Now, let's look at some of the components of the direction that you've asked us to consider. You've asked us to consider the direction of a three drug pilot, and I've described what those therapeutic classes are, or what would it look like, if we did a full solicitation and a broader implementation of reference pricing by therapeutic class.

There are certain -- this slide shows you that there are certain things that the pharmacy benefit manager has to do, because reference pricing relies on a claims processing system. They have to manage the claims processing. They have to -- they have to do -- look at the appeals in patient safety aspects of reference pricing, and member outreach, and prescribe -- to the prescribers, and the pharmacies, and the members is part of their contractual obligations to CalPERS.

Now, does that mean there -- that there can't be other aspects of the program that a second entity could support? No. We could do -- we could have data analysis. There are companies that look at reference -- you know, make recommendations on reference pricing. You could have monitoring and reporting, enhanced outreach to our members, enhanced outreach to prescribers and to pharmacies.

So those are capabilities that a secondary customer-facing entity could do.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: So we've discussed what a pilot might look like. We have missed the window for launching the three classes of drugs that we were going to launch in 2019. So the next available opportunity would be 2000 -- or 2020.

Now, what would a full solicitation look like? We've considered three drugs and the savings is about two and a half million dollars. But in our analysis over about the last 18 months, we've looked at what could -- would happen if you reference priced all 70 therapeutic classes that could be reference priced. And what we have found that, yes, you could save about $34 million, if you did every -- all 70 of those therapeutic classes.

What if you did the top 10 therapeutic classes? That is those that have a lot of interchangeability, those for which there are different pricing options. And in attachment 2, I showed you what 70 classes look like. Attachment 3 shows you what the top 10 classes look like. And the top 10 you might save $15 million.

But then we did something that I think is pretty innovative. We produced a heat map, because there are going to be some drugs that simply are never going to be able to referenced priced, either for clinical reasons or because there's not enough interchangeability. There are not enough alternatives.

And so that heat map, which you see in attachment 4, identifies some drugs that are red that are never going to really be eligible for reference pricing. I give you the example of antipsychotics. These treat severe depression, bipolar disorder. Oftentimes, physicians have to try difference regimens, oftentimes, the patients start being noncompliant for behavioral reasons, and so there's a lot of different -- there's a lot of different work that happens between the prescriber or the physician and the patient. So there are just going to be some that you're not going to be able to reference price safely.

But what I've done is I've provided you with a range of greens and a range of yellows. The greens have the highest interchangeability index. And if you look below on Attachment 4, it tells how the heatmap is developed. If you were to do the green drugs, as this rolled out as a full program, that would save about $13 million. If you add the yellow categories, that ups it to about 15 million. So that's what we would be looking at long range.

If you consider -- the next slide, Carl.

--o0o--

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: If you consider our workload in how we're going to roll-out a full program, what I have produced for you here is what our current PPO solicitation timeline looks like, what our RDP contract negotiations look like. And then we put the three classes against a full solicitation. And as you can see under the full solicitation, we would do an RFI. And through the RFI, we would find out who else in the industry is supporting reference pricing.

We would then, as based on the results of the RFI, we would develop the solicitation in the three to four phases we normally do as a solicitation. I have compressed the timeline for a solicitation, because if we were to -- because we either have to start Q1 of 2020 or Q1 of 2021.

And if you look at the compression, that would be our timeline against our other workload. And then we would be looking at a PBM solicitation for 2022, but the activities would start in 20 -- at the last couple quarters of 2020. So this gives you an idea of competing priorities and workload for our teams.

And moving to the next slide, Carl.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: We really just need your guidance. We need to look at reducing -- we've offered three. How many more? How many how often? That would be part of a broader solicitation. So we seek your direction. And once we have your direction, we would kind of reorient our timeline that I've produced for you. That concludes our presentation.

Dr. Mantong, our pharmacist, and I are here to answer your questions.

CHAIRPERSON FECKNER: Thank you. We do have a couple of requests from the Board and a couple from the audience.

Ms. Taylor.

VICE CHAIRPERSON TAYLOR: Yes. Thank you, Mr. Chair. Kathy, thank you for the presentation. I really appreciate it. It was really good too. I get that the solicitation process, the RFI process is timely -- or timely -- time-consuming, but I kind of really feel strongly about saving more money. And I think the three drugs really doesn't do that for us. It just sort of -- I don't know that a pilot works in this particular area. So I -- I'm of the mind that I think that we should do the green and the yellow drugs to -- that comply, that we think would work, and do a solicitation. That's where I'm at. I just -- I am trying to find that heatmap. There it is.

I think it's important that we -- because then we can phase-in and phase-out, right? Like, if ones is not working, it's not saving us money, we could phase it out. If we find others that fit into the criteria, we could phase them in, as we're doing the program, correct?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Well, we -- we selected the three that we did as -- on the basis of great interchangeability, less noise from disruption. So that was the one we were going to test out. And then if it -- after a year or so, if it didn't seem to be working, we could phase that one out.

For the broader solicitation, you could actually still start with the three, and then phase others in. But I think that we do need some type of trial period to determine the demands on our resources, demands on our members. You remember this is -- this is going to save the members money, we think. But we just -- we need to be -- I just think we need to be careful, because pharmaceuticals are so important to our membership. So we can --

VICE CHAIRPERSON TAYLOR: I agree. And maybe we just start with the green, right? I'm just thinking that -- I think just -- I don't know that starting with three for a whole year is productive. That's my particular feeling, and that's up to the rest of the Board, but that's my particular feeling.

Thanks.

CHAIRPERSON FECKNER: Thank you.

I mean, there's no reason why we couldn't do the full procurement, and then analyze that as the pilot project, is there, other than workload?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I think a full procurement gives us the opportunity. The market is changing. It's changing quickly. Especially a request for information gives us the opportunity to find out what is going on in the market. This is new to the United States. It's been -- well, it's well known that it's been used in Europe. So I think at least as a minimum, an RFI, we could phase the RFP -- or we call it a solicitation, because we -- it's the nature of how we do our business with our procurements.

So I think that if we were to do a solicitation, we do have to look at the other competing priorities too, in terms of staffing.

CHAIRPERSON FECKNER: Thank you.

Well, we incurred more interest here.

So, Mr. Miller.

COMMITTEE MEMBER MILLER: Yeah I think you really kind of touched on it, but I think I would also support moving to a full solicitation, but with the caveat that, you know, anything like this is going to have to be a phased or staged deployment. And so it will require prioritizing where we get the most, not only bang for the buck, but most useful information for further cycles for implementation.

So that -- I'm sure that would all be built in. And so the real question would be what kind of time frames, and what kind of pace, and what kind of acceleration of that pace as we have as we go through that stage deployment, so...

CHAIRPERSON FECKNER: Thank you.

Ms. Mathur.

COMMITTEE MEMBER MATHUR: Sorry. Well, I agree. And I think actually -- you know, it's very common to structure a solicitation with options or a contract with options to -- that can be triggered by any -- it doesn't have to necessarily be a time trigger. It could be at the option of CalPERS to proceed. And once -- at whatever time we think is appropriate.

So I guess I -- is it -- are you looking for a motion on this? Do you think a motion would be appropriate or can it just be direction.

CHAIRPERSON FECKNER: You know, I think just direction, but they're coming back. This was an information item, so...

COMMITTEE MEMBER MATHUR: Okay. Well --

CHAIRPERSON FECKNER: But if you want to put a motion forward, go right ahead.

COMMITTEE MEMBER MATHUR: I guess I would say -- whether it's direction or a motion, I'm happy to make a motion, that we proceed with the full solicitation that is -- has some phasing embedded in it options or however you want to structure it, that will give us as much control as we need to ensure that the first phase is successful and effective, and that we're happy with the direction -- with the results, and believe that further expansion of the program is warranted.

CHAIRPERSON FECKNER: So that will be the direction. We don't need a motion.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: No, I was going to say we accept the direction.

CHAIRPERSON FECKNER: Great. Thank. You

(Laughter.)

COMMITTEE MEMBER MATHUR: Okay. Terrific. Thank you.

CHAIRPERSON FECKNER: Mr. Slaton.

COMMITTEE MEMBER SLATON: Yeah. Thank you. I just wanted to clarify that a full procurement is an RFI, is that -- is that the process that you'd use?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: The Request for Information allows us to scour the market, and pull the best ideas that are out there as requirements for a solicitation like an RFP.

COMMITTEE MEMBER SLATON: Yeah, so it just -- it just seems to me that an RFI is a smart way to do that to start that process, so that you glean -- so you end up with the best procurement at the time you go out. So I'm hoping that's part of the understanding that that's your strategy.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: It is.

COMMITTEE MEMBER SLATON: Yeah. Okay. Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Lofaso.

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

Just following quickly on Mr. Slaton. So this question of yellow and green, you want to use the RFI to get more information on how to structure that, do I understand correctly?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: The RFI is looking at the market for who are the experts in terms of reference pricing by therapeutic class, and what are the company's capabilities. We know there are at least two out there, perhaps there's more. We also know that the PBMs themselves are working in this direction. So it's really -- the RFI is to find out what is the state of the market. And from there, we use those findings. We summarize those findings, and we use them as requirements for the RFP procurement process.

ACTING COMMITTEE MEMBER LOFASO: Thank you. I won't belabor it. I guess I was under the impression that some entities would have different views on interchangeability than others, but I'll just let that go.

I'm a little -- so you keep talking about red and -- excuse me, green and yellow.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yes.

ACTING COMMITTEE MEMBER LOFASO: And on attachment 4, I think there are several different color variations. And I'm a little --

HEALTH PLAN ADMINISTRATION DIVISION CHIEF

DONNESON: Correct.

ACTING COMMITTEE MEMBER LOFASO: I always struggle with color, because I'm color blind. It looks to me -- I guess, the simple -- how man classes are green, and how many glasses are green plus yellow?

DR. MANTONG: Mr. Lofaso, we can tally it up that information for you. But generally speaking, the dark green are the desirable therapeutic drug class to implement reference pricing. For example, within the subclass or the class, there are adequate interchangeability. They are no negative patient outcome with switching, so patient safety, as well as whether the therapeutic class will achieve savings. So those are the desirable therapeutic class for the green.

ACTING COMMITTEE MEMBER LOFASO: Thank you. I did appreciate that. I'm trying to interpret the quantity. I understand the qualitative explanation you just gave.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I think I -- okay. So starting with the reds, because that's the ones you don't want to work with right now - it doesn't mean that things won't change - there's 12. The -- and then the yellows are 23. And if I did my math right, the greens there's 35.

ACTING COMMITTEE MEMBER LOFASO: Okay. SO the difference between green and yellow is about between -- is about 35 versus almost 60.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Correct.

ACTING COMMITTEE MEMBER LOFASO: Okay. Appreciate that. Last question. Can you just -- so there's this discussion about if there's a -- if there's reasons to move more precipitously phasing in versus if problems arise phasing out. Can you just draw us a picture as to what it looks like if say, for whatever reason, we included a couple of yellows that were less interchangeable, and there was some problem, like I don't know, large, large numbers of individuals having issues with interchangeability, and making physician requests, and a backlog at the PBM on, you know, those requests, something like that. What does phasing out look like?

DR. MANTONG: Well, once the therapeutic reference price classes have been established, there's processes that the PBM can utilize to address individual patient needs. So, for example, if there are a yellow therapeutic class that we decide to implement, there are individual patient needs.

For example, they did not tolerate the preferred brand, and there's a medical necessity component to using a reference price item. There's processes already in place with our PBM. We call it going through the medical necessity review or the prior authorization process to seek coverage of that medication under the normal tiered coverage, rather than it being subject to the reference price. So that's already built in.

ACTING COMMITTEE MEMBER LOFASO: So we go back to the old -- the old prior authorization process, but with a different benchmark.

DR. MANTONG: With a different what?

ACTING COMMITTEE MEMBER LOFASO: Benchmark.

DR. MANTONG: Yes.

ACTING COMMITTEE MEMBER LOFASO: Okay.

DR. MANTONG: So there's always a medical necessity component with a -- with the prior authorization. And then there's additional appeals rights in the event that doing that prior authorization review is still -- have a negative determination. The members still have the right to pursue coverage under the normal tier coverage.

ACTING COMMITTEE MEMBER LOFASO: Thank you.

Thank you.

CHAIRPERSON FECKNER: Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you, Mr. Chair. No, I just wanted to indicate that I support the RFI process first, because that will give you some clues of what the marketplace is, and inform your decision making to go forward. So I support that process.

CHAIRPERSON FECKNER: Thank you. Now, moving to the audience. We had David Henka and Neal Johnson. Please com down.

MR. HENKA: I withdraw.

CHAIRPERSON FECKNER: Mr. Henka withdraws. Thank you for your wisdom.

(Laughter.)

CHAIRPERSON FECKNER: Microphone is on, Mr. Johnson. You have up to three minutes.

MR. JOHNSON: Neal Johnson, SEIU Local 1000.

The are of reference pricing is very important. You've done it in some other arenas. We're now talking about expanding into the prescription drug market. The original concept of a pilot is appealing. But I think when we know enough that we can move further into actually trying to implement it, and in doing so, you know, issue an RFP, and you can stage the implementation of that by expanding classes, you're going to, you know, try to gather data, so that those elements will be there.

And, you know, if it doesn't work, those contracts aren't in perpetuity. They have a set time. And you will figure out how, during that process, how well this works. And you, in some sense, have a pilot that really is more the first step of an ongoing program. And so I really think you really want to go to think about how to acquire that as an ongoing process, and start with the RFP process.

Thank you.

CHAIRPERSON FECKNER: Thank you.

Seeing no other requests. Thank you very much. It takes to us Item 7c, Summary of Committee Direction.

Ms. Donneson.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: So with Renee's help, this is what we have captured. In terms of the -- in terms of Agenda Item 7a, what options are available to improve the flexibility of providing care, not just based -- for HMOs, not just based on the work -- live/work area address, but also the side-of-care address. And we're going to take that back, and work with our Legal Office to see what flexibility might exist with the Department of Managed Health Care.

We also captured that there's a request to look at where there is substantial disruption in terms of the scenarios that have been offered in the regional agenda item.

We've been asked for a visual for a chart by region that sets certain ranges, three to five, five to seven, seven to ten, and ten plus. And then we've also been asked to look more strategically at a collaborative strategy to address what employers might do or what CalPERS might do in terms of working with other entities in terms of dealing with the regional price variability in this State.

And then I did have one question about Scenario E is the advice to continue to explore Scenario E along with the others? We heard some different opinions, Mr. Chair.

CHAIRPERSON FECKNER: There didn't seem to big a big flavor for that one.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Okay. Thank you. And then just one final note. In January, we will be bringing forward a panel that is going to look at the competitive markets within California as part of the January off-site. So that will, I think, help to begin the exploration on strategies of how to address variability in our competitive markets.

Thank you.

CHAIRPERSON FECKNER: All right.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Oh, and then -- Renee reminded me that we'll start a full solicitation.

(Laughter.)

CHAIRPERSON FECKNER: We figured you catch that one.

(Laughter.)

CHAIRPERSON FECKNER: Very good. Thank you.

And thank you both for filling in today. Appreciate that.

Brings us to Item 7d, Public Comment. I have two requests to speak from the public, Tim Behrens and Larry Woodson. Please come forward. Microphones are on. Identify yourselves for the record, and you'll have up to three minutes.

MR. BEHRENS: Chairman Feckner, members of the Committee, Tim Behrens, President of the California State Retirees. I wanted to publicly thank the CalPERS staff for their great reaction to the catastrophe that happened in Paradise. And there further follow-up in Chico, they now have brought back Anthem to the bargaining table -- or not bargaining table, but contract table with that hospital in Chico, which is now going to be the only place for the people that are displaced in Paradise. So that was great news. I appreciate the timeliness of that information getting out. We shared it in our newspaper, and we sent it out on all our social media areas in the state and got a lot of positive feedback from our members.

Regarding regional health care, I would like to see the Board pursue what a couple of the Committee members brought up today and that is looking at the rules.

I feel like the rules were related to zip code and 30-mile rule create problems for members. And I think those hotspots that you were referring to are probably usually thought of as Northern California remote areas.

I'm going to give you one from the San Joaquin Valley where I live. Had a member there that worked for the State for 30 years, an institution. Used that as their address for their health care at a Kaiser. Retired. Lived in the same home they'd been in for 30 years, but the zip code was not in the area where the Kaiser was, according to the lines drawn by CalPERS. So it turned their entire health care delivery system upside down. They had to find a new hospital, new doctors, new areas where they could be treated, et cetera, because of the rigidness of that particular rule.

A second example is a member moving out of state. We have a member that lives in Idaho, had formerly been a Kaiser member. There's a Kaiser 31 miles from where they live in Idaho in another state. They can cross the state line and go to that Kaiser, but the 30-mile rule prohibits them from doing that. So they go the through same process as the first example I gave you, and they have to completely find a new hospital, new doctors, et cetera.

So I would urge the Board and staff to try to work together and come up with some flexibility in the rules currently, where at least a member could ask for permission to be heard, and then the Board could make a decision on whether or not they could give them flexibility on their health care.

Thank you.

CHAIRPERSON FECKNER: Great. Thank you for your comments.

MR. WOODSON: Larry Woodson, California State Retirees. And, Chairman Feckner, members of the Committee, thank you for the opportunity to speak.

And I ditto Tim's thanks for the great efforts that your health team staff has had in Butte County. And I've been very closely connected and communicating with staff on that, as well as the breakdown in the contract with Enloe, and I'm happy the Enloe stepped up and has agreed to extend it. And hopefully talks will go well.

I want to speak on a little different issue here, and I'll be brief, which I think means I can do it in three minutes, the health benefit annual report for 2017. On page 13, the actuarial value for basic plans is defined as a plan's actuarial value is the average share of medical spending that is paid by the plan rather than out of pocket by member. And so the higher the AV the better for us as members.

Each plan is then rated in this document with a the highest being Kaiser at 98 percent AV down to the lowest of 84 percent for PERS Select. And that's the lowest of all the plans. And I found that that basically is an average out-of-pocket cost per member of almost $1,000 a year. And that's average, so it would be higher for some.

Also, the member satisfaction rate was interesting in the -- there was a survey sent out. And so the PERS Select had the lowest satisfaction rate of all your plans. And the survey showed -- I was able to figure out about 12 percent of the -- 12 percent of the respondents had no HMO access. And this -- the report says that -- people in rural counties are the people that don't, and we knew that.

So that -- now, I just want to comment about two initiatives that CalPERS undertook this last year with that as back-drop information. And that first is the -- you know, the pushing of the value-based insurance design to draw people into PERS Select. And I think the health prevention aspect is really good, but -- and then the other is the abandonment of risk adjustment.

And so both of those factors are pushing people into PERS Select. We don't know yet, haven't heard how many. But the result is that members in rural areas are forced into these lower actuarial value plans and are having to -- also will have the lowest satisfaction in that plan.

And so that's of concern to us. We'll be making some suggestions in the months to come about how the health team might better deal with that. And so thank you for your comments.

CHAIRPERSON FECKNER: Thank you.

MR. WOODSON: Oh, for your time -- my time.

CHAIRPERSON FECKNER: You kept it pretty close.

(Laughter.)

CHAIRPERSON FECKNER: Thank you.

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

(Thereupon the California Public Employees' Retirement System, Board of Administration, Pension & Health Benefits Committee open session meeting adjourned at 12:13 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 20th day of November, 2018.

JAMES F. PETERS, CSR
Certified Shorthand Reporter
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