MEETING

STATE OF CALIFORNIA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

BOARD OF ADMINISTRATION

PENSION & HEALTH BENEFITS COMMITTEE

OPEN SESSION

ROBERT F. CARLSON AUDITORIUM

LINCOLN PLAZA NORTH

400 P STREET

SACRAMENTO, CALIFORNIA

TUESDAY, DECEMBER 18, 2018

8:30 A.M.

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

A P P E A R A N C E S

COMMITTEE MEMBERS:

Ms. Rob Feckner, Chairperson

Ms. Theresa Taylor, Vice Chairperson

Mr. John Chiang, represented by Ms. Ruth Holton-Hodson

Ms. Adria Jenkins-Jones

Mr. Henry Jones

Ms. Priya Mathur

Mr. David Miller

Mr. Bill Slaton

Ms. Betty Yee, represented by Mr. Alan Lofaso

BOARD MEMBERS:

Ms. Margaret Brown

Ms. Dana Hollinger

Mr. Ramon Rubalcava

STAFF:

Ms. Marcie Frost, Chief Executive Officer

Ms. Liana Bailey-Crimmins, Chief Health Director

Mr. Matt Jacobs, General Counsel

Ms. Donna Lum, Deputy Executive Officer

Mr. Danny Brown, Chief, Legislative Affairs Division

Dr. Kathy Donneson, Chief, Health Plan Administration Division

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

STAFF:

Ms. Jennifer Jimenez, Committee Secretary

Ms. Shari Little, Chief, Heath Policy Research Division

Mr. Gary McCollum, Retired Health Actuary

ALSO PRESENT:

Mr. Tim Behrens, California State Retirees

Ms. Dolores Duran-Flores, California School Employees Association

Mr. Marc Fox, Solano County

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 Committee meeting to order.

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: Adria Jenkins-Jones?

COMMITTEE MEMBER JENKINS-JONES: 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: Please note Mr. Rubalcava, Ms. Brown, and Ms. Hollinger joining the Committee this morning. We welcome you.

Next is the Item 2, Approval of December 18th minutes. What's the pleasure?

VICE CHAIRPERSON TAYLOR: So moved.

COMMITTEE MEMBER MATHUR: Second.

CHAIRPERSON FECKNER: Moved by Taylor, seconded by Mathur.

All in favor say -- or any discussion on the motion?

Seeing none.

All in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, say no?

All right, motion carries.

Item 3, Executive Report, Ms. Bailey-Crimmins and Ms. Lum. Who's first?

Very good.

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

This morning I have a couple of updates for you. First, regarding our efforts to support our impacted members at the Camp Fire, as well as some updates with our

year-end processing operationally. As you know, this is a very busy time of the year for us, as we are processing year-end retirements. And lastly, I'll give you some updates regarding our -- the remaining CalPERS Benefit Education Events that we have scheduled for this fiscal year.

It seems very unfortunate that this year I've had to start my updates with a couple of pieces of information regarding natural disasters and other disasters, whether it be in the State of California or elsewhere, where our members have been impacted. But I'm happy to say that with the experiences that we've had, our team members have been very diligent, very quick to move into action upon our notification that we have members that are in any of these impacted areas.

So I want to give you an update on our more recent efforts related to how our team members have been assisting impacted members by the Camp Fire, which is in the Paradise area. CalPERS has had a number of team members that -- who were actually on site at the disaster recovery center in Chico. Our first team members arrived on November 16th, and our last team members left this Saturday, December 15th.

They remained on site the entire time working extended hours throughout the weekdays and over the

weekends. And during this period of time, they were able to assist approximately 900 members.

During that -- the way that they assisted them was by providing retirement counseling as needed, assisting them with power of attorneys, address changes, direct deposit forms, and, in some case, they were there to help lend some moral support.

Having talked to some of our team members that were there on site, they have really expressed a lot of gratitude for the opportunity to be able to serve our members there on site.

In addition to the team members that we had on site, we also have a number of team members here in headquarters and at our regional offices that have also been helping. They've been expediting services for these members as they have been seeking additional service from us.

I have to say that I'm very proud of our team members and their commitment to consistently providing high levels of quality customer service, even during the busiest time of the year for us, and knowingly that the service that they're providing is really making a difference. You'll hear more about these efforts in Marcie's report tomorrow.

Moving on operationally. Again, as I mentioned,

this is a very busy time of the year. We are working through the year-end retirements. But one of the other processes that we have is the processing of our retiree 1099Rs. We are on track to deliver more than 780,000 1099 tax forms to benefit payees for 2018. And the forms are scheduled to be released in the mail in mid to early January.

We've also received over 6,300 retirement applications for December retirements. This is approximately three times as many applications as we process during any normal time of the month -- of the year. Although, 6,300 is slightly lower than the pace that we were at last December, we do know that there will be many more applications coming in before the end of the year.

In preparation for the high call -- high volumes of processing, team leaders have done a lot of work to ensure that we will not have a lapse in our service level agreements and we will ensure that our members are paid timely.

Moving on to the contact center, again, very busy for the contact centers. They are preparing for, what we call, high volumes for first calls of the year. Generally, the types of calls that we get at the beginning of the year are centered around tax -- they want to know

what's happening with taxes, heath changes, as well as retirements.

Our team leaders have done an excellent job preparing for the high call volumes, and our team members have been reviewing all of the necessary materials and are also very prepared to assist our members during this period of time.

And then lastly, I just want to give you a final update on the CalPERS Benefit Education Events, of which we have two remaining for this fiscal year. We have two in January. The first is on January 11th and 12th in Seaside, California, and then January 25th and 26th in Cathedral City.

As you know, these CBEEs, is what we call them, is our premier outreach for member education. And we can't do this without the tremendous amount of partnership that we have, not only throughout CalPERS, but through our third-party vendors who also play a significant role in educating our members. Just to name a few, we do have representatives from CalHR, Social Security, and others, our retiree associations.

The remaining schedule for the CBEEs is located on the CalPERS website. And members that are interested in attending a CBEE are welcome to view the schedule of the locations. And we also have detailed information

about what's being presented.

And so, Mr. Chair, that completes my report, and I'm happy to answer any questions you may have.

CHAIRPERSON FECKNER: Thank you.

Seeing none.

Ms. Bailey-Crimmins.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Good morning, Mr. Chair and members of the Committee. Liana Bailey-Crimmins, CalPERS team member. For my opening remarks, I have three items. The first is to share some details regarding the CalPERS 2019 Health Plan Member Survey, which kicks off in January. The second is to highlight our year, and the Health Program 2018 accomplishments that were achieved in support of delivering affordable quality health care on behalf of our members. And then lastly what to expect from today's Pension and Health Benefits Committee agenda.

So on January 8th, CalPERS will kick off the Annual Health Plan Member Survey. Survey questions relate to CalPERS member's experience with their health plans for the 2018 health plan year.

Members will have until March 1st, 2018 to submit and to respond to the survey. And as a reminder, member's responses are anonymous. The data is used to -- for us to collect and to hold our health plans' performance

accountable to the measures that we put into the plans' contracts, and also to report on certain population health measures that is in the CalPERS strategic plan.

2018 has been an amazing year, and we faced difficult but very important decisions. First, CalPERS adopted its first set of Health Beliefs. They now sit juxtapose next to the Investment and the Pension Beliefs. And these beliefs serve as guides for decisions today and the decisions that we are yet to be made.

And in the area of benefit design, CalPERS approved the PERS Select value based insurance design. And we also expanded reference pricing program to now include pharmaceutical therapeutic drug classes, which will go through a solicitation the beginning of 2019.

Both are innovative approaches to lowering cost on behalf of our members. The CalPERS teams look forward to providing you updates through 2019 on our progress. In the area of strong contract negotiations, we awarded new five year contracts to seven carriers. We also did a new contract to the data warehouse that is pivotal to establishing our rates on an annual basis. And in 2018, CalPERS negotiated the lowest overall premium increase of 1.16, which takes effect this January. While some plans did have larger increases, 2018 marked the lowest increase for CalPERS in over two decades.

And during open enrollment, our members were offered a new mobile experience where they were able to use an app to explore their health plan information, and for retirees actually to change that information, and to also change their plans using a smartphone or tablet.

And in September, CalPERS made an important policy decision on the PPO excess reserves, and their -- how we annually evaluate them and apply those monies to reduce future premiums.

And lastly, our employer retention. Nearly 1,200 public agency and school employers. Our total covered lives in 2018 continued to grow, and we hit our target of 99 percent retention rate.

Today, at PHBC, we will be asking the Committee to make a decision on regions and regional factors. CalPERS established five health care regions 13 years ago. And currently, the HMO carriers are permitted to establish their own regional factors. The CalPERS team will present a recommendation today based on six months of analysis, based on cost of care, comprehensive stakeholder outreach, and listening to employers and members. Any change that you elect to make will take effect in 2020.

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

CHAIRPERSON FECKNER: Very well. Thank you.

Seeing no requests, we'll move on to Item 4, action consent items.

VICE CHAIRPERSON TAYLOR: Moved approval.

CHAIRPERSON FECKNER: Been moved by Taylor.

COMMITTEE MEMBER MATHUR: Second.

CHAIRPERSON FECKNER: Seconded by Mathur.

Any discussion on the motion?

Ms. Mathur.

COMMITTEE MEMBER MATHUR: Oh, sorry.

CHAIRPERSON FECKNER: Okay. Seeing nothing.

All in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries.

Item 5, information consent item. There's been a request to withdraw the item 5b, the Population Health Report. And I believe Ms. Mathur wishes to talk on that.

COMMITTEE MEMBER MATHUR: Thank you very much, Mr. Chair.

So in reviewing the Population Health Report, I note -- and this page -- attachment one on Agenda Item 5b, page one of three and page two of three. It looks like there hasn't been a material change for most of these chronic conditions, and lifestyle risks, and even the clinical quality measures between 2016 and 2017.

I recognize that there's a lag. We don't have the 2018 numbers yet, but I guess I'm -- the question that I have is how can we challenge the plans or to really try to at least on one, two, three, maybe five of these to really make a significant effort to reduce -- reduce or increase, depending on which is better the performance?

And I wonder -- I was just thinking that maybe some kind of competition or bonus where if they achieve some significant reduction, without negatively impacting the other measures, because, of course, we don't want to -- them to just switch resources from one place to the other, but someway to really, really get at these, because they are just so sticky these numbers.

Anyway, so that's my question.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Wonderful question. We are dealing with member's behavior to get them to adhere to their medications, adhere to their exercise routines. I mean, that's -- you're actually asking us, and we take this very seriously as our mission, to try to continue to move for improved health. And this is a reflection of really the health of our population.

What's not reflected here that might help answer the question is we did not put the 2015 data in here. So I think had we done that, you would see that it is moving.

We're happy that it's not in go -- in many instances, it's not going up. We have for our five chronic conditions, at least we've gotten some stability.

COMMITTEE MEMBER MATHUR: Yeah.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: But I do like the idea of a competition, and I'll take that back. The other thing I want to say is that I'm in the process of recruiting two physicians. I'm -- both of my physicians left to get promotions, so we're going to be recruiting. And this is -- this is at the core of what our Chief Medical Officer is responsible for. And when I get that new person in, certainly this is one of the -- their direct responsibility is to work with the plans, to continue to press for greater medication adherence, greater healthy -- healthy living experience, chronic conditions, treatments, et cetera. So at the heart of our clinical team is this population health dashboard.

COMMITTEE MEMBER MATHUR: Well, thank you. I recognize it's a very challenging problem and that it has not been solved by any purchaser in the market, you know, fully, so -- but obviously, it's sort of the core of what we want to do is to have our members have better, healthier -- bet health status. And so I just -- as one of my last requests, I just ask that we continue. I know

the team will be very diligent in continuing to work on that really challenging problem.

If I -- if we could turn for a moment to the HMO dashboard, and I know it's only for the large basic HMO plans, is there a -- was there a cutoff -- is there a cutoff for that? Is there -- do we say that under 50,000 members or lives we're not going to -- we're not going to include them on the dashboard? What is the threshold for that?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I think it really was to look at the larger plans, but we certainly can design our dashboard to include the other HMOs. There's no intent to try to have a threshold by any means. And perhaps we should take that back and look at how we can portray all the -- all the health plans

COMMITTEE MEMBER MATHUR: I guess I'd leave it to you and the rest of the Committee, but I -- just in looking at it, there's quite a bit difference between some of the plans in their performance. And I'm -- and I know that they compete with each other, but I wonder if there's something that we can learn from how -- how each of the plans is handling various other chronic conditions, or managing on the clinical side that we can sort of propagate throughout our plans, so that all of our members

are, you know, getting the best care and we're addressing these issues.

Now, obviously, some of the at least chronic condition prevalence numbers, that might just be the population that the plan has, the risk of the population, but -- anyway just...

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Well, we continue to make -- as I said, this is our --

COMMITTEE MEMBER MATHUR: Yeah.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: This is fundamental to our mission. And we continue to explore new ways to incentivize or get our plans to stay on top of their requirements. They're contractually required, and -- thank you.

COMMITTEE MEMBER MATHUR: Yeah. Okay. Thank you so much.

CHAIRPERSON FECKNER: Thank you.

Ms. Holton-Hodson.

ACTING COMMITTEE MEMBER HOLTON-HODSON: Well, thank you for this report. Really interesting, but two questions. So are the percentages higher for the PPO and PERSCare, in particular, because they attract a sort of a sicker population or are the treatment modalities different?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: They do have a sicker population. I mean, we've been studying these -- our own populations for years and years. And, yes, there is a higher disease burden in the members who are in that plan.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: The only thing I'd like to add is the average age is between 40 and 45, but it has a 90 percent coverage versus an 80 percent coverage. And so depending on if you look at the next year, if you're going to have surgery or you're going to have some kind of condition, you may elect to choose that as your plan, because of the higher coverage.

ACTING COMMITTEE MEMBER HOLTON-HODSON: Oh, right, right.

And then the second question is that the emergency room usage for Kaiser is obviously considerably higher than everybody else. Now, is that because - I recall from past discussions I think - that Kaiser has just decided to -- not to triage and then have everybody come in through the emergency room and then triaging versus having urgent care clinics and whatnot?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yes, that is consistent with their model that they -- they want care to be delivered when it's needed. Even though it might come into the ER, it's triaged to

more primary care delivery.

ACTING COMMITTEE MEMBER HOLTON-HODSON: And in the end is that more expensive for us or have they figured out ways to make that care as competitive as if they had, you know, this other -- other urgent care facilities?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I believe it is consistent -- excuse me. It is consistent with the way they globally budget and then allocate those budgets to the different parts of their service delivery.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Just as a clarification, Kaiser does have urgent care and emergency care. We recently did a study and integrated health care -- obviously, Kaiser it's capitated, so they're bearing the risk. What we find is people go to that, because the copays and things are a lot more reasonable.

We find that when someone goes to a PPO, they actually end up being admitted to the hospital, and it's not just an emergency situation and they leave. So it is an interesting situation where it is more cost effective. It's easy to get to, so people use it. But in Kaiser's case, they are actually bearing the risk pretty much on most of that. I mean, out of the full thing, I think they have 98 percent capitation and two percent fee-for-service.

So -- but they do -- I just wanted to clarify, they do have urgent care centers and they do promote that.

ACTING COMMITTEE MEMBER HOLTON-HODSON: Yeah, I think it's sort of a little -- it doesn't look -- when you're thinking about emergency care and you see this, you don't assume -- you assume that that's going to be the most expensive kind of care, but unless you know, in fact, that Kaiser has this other model.

So thank you for that.

CHAIRPERSON FECKNER: Thank you.

Mr. Slaton.

COMMITTEE MEMBER SLATON: Thank you, Mr. Chair.

I want to come back to attachment one, page one of three. And in the lifestyle risk -- and I presume -- and the number that really jumped out at me was percentage of adults who are obese. And the number went up. You know, we're at 43 -- over 43 percent of the population. That's just unbelievable.

I presume -- this is Kaiser numbers, and are they the only ones that -- you only have it for them, because they're the only ones who are tracking that?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yes. Kaiser considers that -- when you go to a Kaiser facility, they do -- they do the height, blood pressure, weight. They ask additional questions in terms

of what they look as their intake. And then because they do and they document it on the record, it comes across to our data warehouse.

COMMITTEE MEMBER SLATON: Do you -- in your opinion, do you think that number probably, if it were to be surveyed across all the plans, would be comparable across the rest of them? I know that's a guess, but...

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: We're working on how -- other than self-certification, we're working on how we can get that information from the other plans. But to answer your question, yes, I believe it's consistent with the population. One of the things I would caution is that measures change based on the CDC and what they require. Like blood pressure could be going -- normal blood pressure is being reduced, and so you may see some changes in the numbers as a result of some of these measures.

The BMI itself though for obesity is over 25 inches on the waste. So it's -- having been in the military a long time, keeping a waste line under 25 inches is rather difficult.

COMMITTEE MEMBER SLATON: Yeah.

(Laughter.)

COMMITTEE MEMBER SLATON: So -- but it does point out that -- oh, and the other question I had about that

particular number, how does that compare with the general California population? Is there any data for that or the United States, in terms of obesity measured by a BMI of 30 or greater?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: There are benchmarks. We can take this back. I'm not prepared to answer that in terms of how we benchmark against California and the U.S., but we can certainly look at that.

COMMITTEE MEMBER SLATON: Okay. The other question I had is colorectal cancer screening, which is in the 50s. Is that the whole population or is that population over 50?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: That would be the population over 50.

COMMITTEE MEMBER SLATON: So we're still only at little over 50 percent on the population that needs to be screened.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yes. We're working on that in terms of some of these screenings don't -- in fact, in our PPO, through Quest Analytics, we will be -- we mail kits, so that you don't necessarily have to go to the lab to participate in a colorectal screening. It's not as invasive, but at least it's getting the members to pay attention to that --

to that aspect of continuing good health.

COMMITTEE MEMBER SLATON: Yeah, it just seems like that's an area, where we just need tremendous improvement to keep people healthy, but okay.

Thank you very much.

CHAIRPERSON FECKNER: Okay. Seeing no other requests to speak.

Anything else on that item?

Very good.

That brings us to Agenda Item 6, the Evaluation of Health Regions for Public Agencies and Schools.

Ms. Little.

(Thereupon an overhead presentation was presented as follows.)

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

Good morning, Mr. Chair and members of the Committee. Shari Little, CalPERS team member.

Today, we're going to continue our discussion of health -- public agency and school health regions in Item 6a.

We brought back some of the information that you requested at our November meeting, and we took a more granular look at scenario A to create a slightly modified option that we're calling scenario A1. I believe Mr. McCollum is going to walk through that a little bit more

as we progress.

It basically breaks out Southern California into two regions. And that's something that we're going to recommend. It's a Northern California region, a Southern California region, and Southern is split in two.

In addition to asking you for a decision on regions, we're also requesting that you adopt our approach to regional factors in setting a range. Also, we do know we're going to do -- regardless of whether we stay status quo or make a different decision, we're going to be renaming the way that we call the regions. We think that there's a lot of confusion about that. And I think you've heard about that a little bit in our past conversations. For example, we decided we would start from north to south and in numerical order 1, 2, 3.

Gary McCollum, our Retired Health Actuary, is actually here for his last day. And he's going to be helping me walk through this presentation with you.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: So this is the last of four presentations in our plan series, and represents a six-month evaluation and a lot of research done by the team to measure the costs in the regions as they compare to the statewide average.

Our strategy was comprehensive. We first had an

evaluation of health care costs throughout the state. We then scanned the market and got feedback from our employers and our stakeholders to assess if changes were warranted. In July, we talked about why regions were first established and how. And we also talked a little bit to you about the challenges of them. Milliman shared their methodology that we used in first creating regions and provided the current day market scan for reference of where we should be today.

We had extensive stakeholder reach-out. I think you've heard a little about on that as well. On some of the areas of concern that we heard, current themes were that the geographically based names used were a little bit confusing to our members and our employers. We heard that premium volatility from year to year significantly impacts a budget process. And it's difficult to estimate as they move forward on an annual basis.

And we heard that the premiums in the Bay Area and Northern California were -- where the cost of health care is greater compared to the Southern California areas has been really challenging.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: So before we move on to the recommendation we're going to be speaking to you about today, I want to go back to the

beginning just for a moment.

Thirteen years ago, CalPERS decided to adopt regions and we did it for three reasons. We wanted to create a stable risk pool by attracting and retaining as many lives as we could. We wanted to develop some regions that made economic and geographic sense for the CalPERS public agency membership, but provide as much stability as we could in that process. We needed help -- we needed regions to help retain and attract new public agencies, where we're competing with other health care plans.

So today our objectives haven't changed, but our question is do we really have a problem that we need to solve? When we embarked on the journey in January, I'm not sure we knew that we did. But as we've progressed, I think we think we have a better solution.

We knew it was time. As I mentioned, we haven't heard. We haven't done anything on it for 13 years, and we've heard some complaints from our employers and our member agencies. We heard about high barrier costs, premium volatility, and the nomenclature of how we used our regions. And it definitely became apparent during our rate development process this year that we need to address the calculation of regional factors.

With our analysis on regions themselves, we now have information on the cost of care by both county and by

three digit zip code. We haven't had that for a while.

From that, we determined the current five regions have lower marketability compared to each of the new scenarios that we brought before you in November.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: So you might ask what's marketability? Just as a refresher, marketability refers to the cost of care -- the average cost of care. It's the percentage of total covered lives that are paying between 97 and 103 percent of the cost of care in their particular area. The higher the marketability percentage, the more our members' premiums are aligned with their local cost of care.

Today's five scenarios have 22 percent of members aligned to the costs of care. We can improve on this marketability. Every scenario under consideration today nearly doubles that, ranging from 38 to 50 percent.

Adopting a near region model will increase our total covered lives with premiums more closely aligning them with the actual costs of care. And it will ultimately benefit members and employers to reduce the premium volatility and overall competitiveness of the program of the health program.

For the stability and success of our program, we need both public agencies and schools. We don't want to

lose them because our premiums aren't closely aligned with the marketplace.

And Gary is going to talk a little bit about the recommendation that we are proposing today, and present information requested in November for all of the scenarios.

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RETIRED HEALTH ACTUARY McCOLLUM: Thank you, Shari. Good morning, Mr. Chair, members of the Committee. Gary McCollum, CalPERS team member.

After receiving Board and stakeholder input at the November meeting, taking a final look at the data, and doing the greatest good for the greatest number of individuals, while still being competitive in the marketplace, the team is recommending scenario A1, as shown here. Now, this is a slight modification from scenario A that was presented last month. The difference is the separation of the southern part of the State into two regions. Look at the third region that we created, which is the three counties of Los Angeles, San Bernardino, and Riverside, and look at the cost relativity that's on this slide.

Those three counties have an average cost relativity of 0.821, while the rest of the southern part of the state has a cost relativity of 0.914. We felt that

that difference was significant enough to warrant creating the third region, and recognizing the cost differences in those three counties.

So the team considers this the less-is-more recommendation. By moving to less regions than the five that we currently have in place, we achieve the following:

More marketability, the marketability nearly doubles from 22 percent to 38 percent; more population in the regions, which will improve premium stability year over year.

Currently, the Sacramento and the other northern regions each have fewer than 40,000 lives. With scenario A1, the smallest population will be in region 2, which is the southern part of the state. And that has over 62,000 lives. Now, premium volatility was one of the top concerns from employers as we talked to them.

We'll also create more administrative ease for employers. And we get more total covered lives with an estimated premium increase of three percent or less.

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RETIRED HEALTH ACTUARY McCOLLUM: As requested, we also identified what we're calling hot spots. Now, a hot spot was defined as either a large number of lives with an estimated premium increase and/or a large estimated premium increase. We identified the four areas

shown on this slide, along with the scenarios that are associated with them.

Now, the Sacramento region has a large number of lives that get an estimated increase. The counties of Monterey and Stanislaus that are in the middle of the state there, they have a large estimated increase that applies to a small population of approximately 1,000 lives. And then finally, the Los Angeles region has a small number, approximately 2,700 with a large estimated increase.

Now, while all our scenarios contain some examples of premium increases for certain members, it's important to note that these examples are for illustrative purposes only, not predictions of next year's rate increases. They're estimates of potential premium impacts to the 2019 premiums. Actual premium impact will remain unknown until after the 2020 rate development process is completed. And additionally, the decision you make today on HMO regional factors will influence those 2020 rates.

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RETIRED HEALTH ACTUARY McCOLLUM: So as directed at the November 2018 PHBC meeting, the team took a closer look at the estimated increases to 2019 premiums for each scenario. The analysis included various impact thresholds, counting the number of total covered lives

experiencing an estimated premium increase between three and five percent, between five and seven percent, between seven and ten percent, and then finally greater than ten percent.

This information can be found in detail in attachments 1 and 2 that were provided. Here is a graphical representation of the estimated premium increases for each scenario. Each bar in this graph represents one of the scenarios, and then the different colored sections of each bar represent the number of members in each increased category.

So moving from top -- or, excuse me, from the bottom to the top of the bar, if you look scenario A, there's 112,000 lives with an estimated increase between three and five percent. And as you move up the bar, the top space, there's 1,085 lives with an estimated increase greater than ten percent. And that applies to each of the bars.

So the key takeaway from this graph is a quick look easily shows what scenario A1 accomplishes. It immediately jumps out at you that the total number of covered lives that are impacted is significantly less than A1 than in the other scenarios.

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RETIRED HEALTH ACTUARY McCOLLUM: So we created a

scorecard for you to look at. And this slide provides a comparison of the scenarios. It shows the number of members with estimated premium increases in the different categories that you requested in the yellow. It also shows the estimated premium decreases in the green, and then finally, the marketability of each scenario in that salmon color, I guess it is.

So that the first section in yellow is the same as the data that was on the previous bar chart. Now, there's two things to note regarding estimated premium increase. First is a significantly smaller number of total lives, about 79,000, that are impacted in scenario A compared to the other scenarios. And that was illustrated in the bar graph that I pointed out.

Second, the largest estimated increases in the two columns labeled seven to ten percent and greater than ten percent, they total about 30,000 lives for scenario A1, about 40,000 lives for scenario A, and almost double that number at approximately 70,000 for scenarios B, C, and D.

Now, the number of lives with estimated decreases in excess of three percent is similar across all the scenarios. And you can see the marketability numbers essentially double from the status quo.

But there's two items not on this chart that I

want to highlight for scenario A1. First is the average premium that corresponds to the average estimated increases and decreases. Now, in scenario A1, those 79,000 that are estimated to get an increase, they have a average premium of about $540. And that would see an estimated increase of about $41. That's about seven and a half percent.

Now, those 170,000 lives with an estimated decrease of more than three percent, they have an estimated -- or, excuse me, they have an average premium of about $607, with that average decrease of about $25, which is about four percent decrease.

So the second item of note is a significantly higher number of lives that are projected to fall within the three percent threshold. That number is over 215,000 for the recommended scenario A1, while the next closest scenario is A with about 120,000 lives within the threshold. So again, it's almost double the number of lives that are within the threshold.

So one of our guiding principles for this study of regions was to remain competitive, so that CalPERS could retain the public agencies currently in place, and also attract new ones. The marketability factor of scenario A1 at 38 percent is not the highest marketability factor of the options, but it is a significant increase

over the current number.

Another guiding principle was to provide the greater good for the greatest number of people. With scenario A1, the estimated premium increase to members is minimized, and the estimated number of members falling within the threshold is maximized.

So the team is asking for a decision on regions today, and we're recommending that you choose A1.

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RETIRED HEALTH ACTUARY McCOLLUM: Now, we move to the other decision we're asking you to make, which is on the HMO regional factor decision. As you know, a regional factors is used along with the State premium to determine regional rates for public agencies and school employers. In November, we provided three options for how the regional factors are to be developed.

The first option was to continue the current practice, which is to let the plans interpret the directions and calculate factors and provide those factors to CalPERS. A second option would be for CalPERS to provide a very prescriptive definition to HMO plans for calculating the factors, or in essence, calculating the factors ourselves. And the third option was to create a range for HMO regional factors that the health plans must stay within.

So to avoid extreme regional factors and create consistency among the health plan's calculations in the future, we recommend that CalPERS set a range for the HMO factors for the plans to stay within.

This will give us great control, but it also provides the plans with latitude to respond to trends and their particular enrollment that they have. So that concludes my presentation. I'll turn it back to Shari.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: Thanks, Gary. As you can see, the team has done a tremendous amount of research and evaluation over the past six months. And we've been trying to bring forward the best scenarios we can for you.

I want to thank Gary for coming back and doing this with us, and the team for working so diligently on this as we approach the rate process again. And I want to remind you that regardless of the decision you make today, we're going to be adopting a new naming convention for less confusion and for ease that sequentially numbers regions. We're going to start from north to south 1, 2, 3, that sort of scenario. And that will take effect whether regions stays status quo or we make a new decision.

After you make the decisions, everything will be

incorporated into the 2020 rate development process. And that won't take effect till January 1 of 2020. So it wouldn't happen for the upcoming year. And as we move forward, we want to continue to proactively reach out to our employers and our stakeholders to prepare for any potential change that might arise because of this.

We asked employers in a survey what they would want, if we do make a change, and they just requested further communication, ongoing communication, and education about why the decisions were made.

And majority responded that the early notification would be most important in their budgeting practices and administrative practices.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: So today, you have before you two decisions, as Gary mentioned. One is on regions and one is on regional factors. You can elect to make separate motions or you can do them addressing both decisions at once. So at this point, I would like to thank you and conclude my presentation, open it up for any questions you may have.

CHAIRPERSON FECKNER: Thank you very much, and thank you for the presentation. Also, Mr. McCollum, thank you for including the question that I asked the other day about the average -- the increase versus the decrease.

The way I look at it, unless my math is wrong, on average, there was a difference of $67 a month on the premiums. And now by this new addition, it's a $1 difference, which makes it a more level playing field. So thank you for sharing that information.

Ms. Mathur.

COMMITTEE MEMBER MATHUR: Thank you. Well, I think this represents such a strong body of work. And I really appreciate the efforts of the entire team. I particularly find page eight, which is the scenario comparison view really helpful in helping to crystallize the questions and factors that are before us and the decision that we have to make.

Now, I have a question -- and I like that you've included this scenario A1, which I think is a strong alternative. I have a question about why the team is recommending A1 versus A. And it -- what I'm hearing, and tell me if I'm incorrect in this, is that it's really because this affects the fewest number of members of covered lives, is that the basis for the recommendation.

RETIRED HEALTH ACTUARY McCOLLUM: Yes, that along with the fact that the -- those three counties that we've identified really do have a difference in relativity. And we felt that it would be most competitive for attracting and retaining public agencies in those three counties to

recognize that almost ten percent differential between that and the rest of Southern California.

COMMITTEE MEMBER MATHUR: Okay. Because if I -- as I look at it, if I -- it seems to me that scenario A remains more attractive, even though it affects more covered lives, but the severity of the increase, the magnitude of the increase is smaller, and -- for -- the number of people who have a more significant increase is quite substantially smaller. Those getting a greater than ten percent increase is about 1,000 versus -- so, you know, almost four times smaller. And those getting a seven to ten percent increase is 29,000 versus 37, which is a third smaller.

So to -- plus, we get greater marketability 40 percent as opposed to 38 percent. So I guess I'm inclined -- I'm inclined towards scenario A actually after reviewing all of the information that you've presented. Although, I do see A1 as an attractive alternative. I think the fact that -- I know it's -- I mean it's 100,000 more members getting an increase, but it's an increase of three to five percent which is a much less significant increase. And I have a hard time imagining that that would -- that a three to five percent increase would prompt a departure from our plan.

Although I'd be interested in your thoughts on

that, if you've thought about whether -- how significant that might be for driving public agencies out of the plan.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Well, Ms. Mathur, Liana Bailey-Crimmins. So you're absolutely right, one of our guiding principles was to -- for marketability, which is -- a reminder, marketability is the average cost of care for the members in their location and for their families. You'd always kind of go to the one that has the higher number. But we heard you at last session in November. And disruption for members is something we all have to consider. And as we were going through and talking about disruption, increases, decreases, but still, you know, remaining true to that principle, that's one of the reasons why the team had come up with A1, and in addition, to ensure that in Southern California all things are not equal. And so to ensure that we were able to recognize that as well.

COMMITTEE MEMBER MATHUR: So you think that A1 will provide the most stability in the plan in terms of retention of public agencies, et cetera?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: It provides -- it is a 38 percent marketability, which means there is still room to grow. And remember, every five years, we're going to bring back analysis to you to see if there's anything that needs to change. So we'll always be

moving towards that needle, but we also just have to really be conscious of the disruption factor to our -- to our membership.

COMMITTEE MEMBER MATHUR: Sure. Okay. Thank you.

CHAIRPERSON FECKNER: Mr. Rubalcava.

BOARD MEMBER RUBALCAVA: Thank you, Mr. Chair.

I had a -- thank you for all the work. That was very detailed. And I just have some questions for clarity purposes. I understand that the whole exercise, the whole -- is to try to align cost of care with premiums. And one of the stated goals is to improve premium stability. So how -- how will this process help stabilize premiums if -- I'll give some -- like, for example, County of Ventura. In the old scenario -- in the current scenario, they're in the same grouping with L.A. County, and San Bernardino. In scenario A1, they're out -- they're into -- they're into group 2.

So for those people, I mean, like you -- the document says -- and then on the earlier scenario, there will be increases -- total lives will be -- the number of total lives impacted will be -- they'll be -- everybody will be impacted. And under A1, it would be less. But nonetheless, there will be impact.

So on County of Ventura using that as an example,

how would that lead to stable premiums, if they're moving to a different group? And your memo says that the L.A. area has the lowest cost right now. So how would they -- it seems counterintuitive to me how that would help them stabilize premiums.

RETIRED HEALTH ACTUARY McCOLLUM: Okay. Well, for the County of Ventura, there would be an impact, because they would be moving from the grouping they're currently in which is Los Angeles, San Bernardino, and Ventura counties, and they would be moving to the -- be a part of what -- what would be the rest of the Southern California. Thirteen years ago when the regions were established, Ventura was considered to be part -- they thought the best fit was that Ventura should be with Los Angeles and San Bernardino.

Things have changed over those 13 years, and now it looks like a better fit for Ventura County would be with the rest of Southern California.

There's going to be an impact to some of those counties that get moved from a region. This -- we were attempting to minimize that impact on our members. And we felt that A1 did that the best. But you're correct, Ventura County would experience a one-year change, and then hopefully would be stable after that.

BOARD MEMBER RUBALCAVA: But -- I understand --

explain how the premium would be stabilized. Let's look long term. How does this process help stabilize premiums?

RETIRED HEALTH ACTUARY McCOLLUM: Okay. The stability would come from a larger number of members within the grouping. Like I said, in the -- in my presentation, currently we have two regions that have less than 40,000 lives -- or about 40,000 lives. The smallest number of members in this proposed would be in the Southern California region, which would have over 60,000

Now, those numbers in themselves, 40,000 and 60,000 are big numbers. But when you carve them up between the different plans, you have the potential for getting down to much smaller numbers, which then create the possibility of premium volatility year to year,

BOARD MEMBER RUBALCAVA: Okay. I think I get it. Then just to speak to the regional factors. I think I do support the -- establishing a range, but how would -- how will those guardrails, if you will, be established? How will they be set? What are the criteria that would go into that deliberation?

RETIRED HEALTH ACTUARY McCOLLUM: Well, we haven't finalized the decision making on how we would set those -- the upper and lower limits on the range. That would be part of the process upcoming as they prepare for the rate development process in 2020, or for the 2020

rates.

BOARD MEMBER RUBALCAVA: And a final question. In your memo, it talks about how these are estimates on the impact, because you won't know until the actual rate development process. What impact on the rate development process do you think this -- these recommendations will have? Again, it goes to the whole thing about how we're going to try to stabilize rates. So changing the size of the population to be carved up among the carriers, how does that -- what impact do you think that would have on the rate development for 2020?

RETIRED HEALTH ACTUARY McCOLLUM: Well, there are going to be some members who would experience a rate increase and there will be some members who will experience a rate decrease. The actual amount of the increase or decrease is unknown.

What we did here was create a model that used 2019 premiums to provide an estimate of where those increases and decreases might occur. But it's not to be taken as a -- as a prediction of the amount of the increase that would happen.

BOARD MEMBER RUBALCAVA: Thank you.

CHAIRPERSON FECKNER: Thank you.

Ms. Taylor.

VICE CHAIRPERSON TAYLOR: Thank you, Mr.

President.

I want to thank you guys for the presentation. I know we had a lot of questions. It seems like you got them all answered. I wanted to go over one more time -- Mr. Feckner caught the numbers. I think I was in the middle of writing. For the average premium increase - and again, thank you for bringing those forward - I think the number was -- the average premium for the increase was 541, is that correct, Mr. McCollum

RETIRED HEALTH ACTUARY McCOLLUM: It's 540.

VICE CHAIRPERSON TAYLOR: 540. And then that's plus a $41 increase. And then the average decrease premium was 607, is that correct?

RETIRED HEALTH ACTUARY McCOLLUM: Correct.

VICE CHAIRPERSON TAYLOR: Plus -- minus $25. Yeah, it ends up stabilizing to have really a very similar premium.

And then I think why I see what -- why A1 is so attractive, so rather than 112,000 people having a three to five percent increase, there's only 11,000 people. And then we only increase the -- between seven to ten percent about 10,000 So the 112,000 over in scenario A, was that mostly Los Angeles area, is that -- once we broke that out, that's where that stabilized that area.

RETIRED HEALTH ACTUARY McCOLLUM: Yes. That --

you're talking about the 112,000 or whatever it is and --

VICE CHAIRPERSON TAYLOR: Right. In the little pretty graph you guys did.

RETIRED HEALTH ACTUARY McCOLLUM: Yes, that's primarily the Los Angeles area.

VICE CHAIRPERSON TAYLOR: Okay. So that's how that -- and wasn't it -- clarify my memory. I think I heard this some time ago that when this first started, Los Angeles was one of our problem areas in terms of maintaining our pool of employees, was that correct?

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: That's exactly right. They were lower than the statewide average. And that's when we experienced the first threat of exodus and that's why the regions were created. And what our hopes were in creating the A1 scenario was to prevent that in the future. We still have a northern and southern, but we're breaking out the pieces in Southern California to really minimize the impact to the overall population.

VICE CHAIRPERSON TAYLOR: And then my last question is, and I can't remember where you mentioned this. Oh, here, the disruption hot spots. So Sacramento ends up being a fairly large increase with a larger number of folks. Sacramento, it looks like that might be Monterey and I forget the other two.

Was that a -- I don't know if that's broken out. Was that a more than ten percent increase, is that where that disruption hot spot is?

RETIRED HEALTH ACTUARY McCOLLUM: No, the Sacramento region is identified because it would be a fairly large number.

VICE CHAIRPERSON TAYLOR: Of increases.

RETIRED HEALTH ACTUARY McCOLLUM: I believe the number of members was somewhere in the neighborhood of about 30,000, I think, but not a large --

VICE CHAIRPERSON TAYLOR: And the increase was three to five.

RETIRED HEALTH ACTUARY McCOLLUM: -- but not a large increase. It was -- I think it -- I believe it was anywhere between three and seven.

VICE CHAIRPERSON TAYLOR: Three and seven.

RETIRED HEALTH ACTUARY McCOLLUM: Between the three and five, and the five and seven. And then --

VICE CHAIRPERSON TAYLOR: And then the other three spots were about the same. It was --

RETIRED HEALTH ACTUARY McCOLLUM: No, the two spots in the middle are specifically Monterey County and Stanislaus County. There's about 1,000 members in those two that the model indicated would get a large increase.

VICE CHAIRPERSON TAYLOR: A large increase.

RETIRED HEALTH ACTUARY McCOLLUM: Yes.

VICE CHAIRPERSON TAYLOR: Ouch.

RETIRED HEALTH ACTUARY McCOLLUM: In excess of ten percent.

VICE CHAIRPERSON TAYLOR: And that's because they're rural counties, right? That's one of our biggest complaints from our folks is the rural county prices.

(Laughter.)

RETIRED HEALTH ACTUARY McCOLLUM: That plays a part in it.

VICE CHAIRPERSON TAYLOR: Okay.

RETIRED HEALTH ACTUARY McCOLLUM: I can't say that's the only reason.

VICE CHAIRPERSON TAYLOR: Okay. All right.

Well, I'm inclined to accept scenario A1. So thank you guys for the great report.

CHAIRPERSON FECKNER: Thank you.

Ms. Holton-Hodson

ACTING COMMITTEE MEMBER HOLTON-HODSON: I just wanted to also add my thanks to the report and for expanding upon the divisions in the rate increases. That was really illuminating. And I, too, like Ms. Mathur and others, sort of struggle between A and A1, and was landing on A. But I think given your explanation, I will support A1. Thanks very much.

CHAIRPERSON FECKNER: Mr. Lofaso.

ACTING COMMITTEE MEMBER LOFASO: Thank you, Mr. Chair. Again, thank you all for all the analysis. It's very responsive to the last meeting. In deference to a robust process, I don't think you could have gotten there without all the other stuff you did. More compliments on your process.

I do like the fact that the discussion is zeroing in on between A and A1. I saw the elegance in A1. And I think you already addressed this, Ms. Little, which I think the bottom line is both A and A1 take our existing north/south division and retain it. And the only remaining question is what we do within those two divisions. That is both A and A1 say lose the three divisions in Northern California. And I'll ask them a question in a moment. But it seems to me that, in general, the disruption from doing that is comparatively minor. And then the only remaining question is, I think you already outlined, Ms. Little, is do we retain the division in our Southern California area?

I'm curious about something, especially apropos -- I'm going to back myself up. Apropos to your comment, Ms. Little, about confusion on names, when you comment about a hot spot, are you -- do you mean L.A. County or L.A. region?

RETIRED HEALTH ACTUARY McCOLLUM: It was -- those hot spots we're referring to the L.A. region.

ACTING COMMITTEE MEMBER LOFASO: And that's very important, because --

RETIRED HEALTH ACTUARY McCOLLUM: And the Sacramento region. But the two spots in the middle were the specific counties of Monterey and Stanislaus.

ACTING COMMITTEE MEMBER LOFASO: Got it. If I understand the table that accompanies the detail of the proposal which is, well, page 36 in the iPad, my device is -- oh, I'm sorry attachment -- attachment two, page five of 11. It seems to me what's interesting is that the hot spot in the Los Angeles region is driven by the portion of the old Los Angeles -- I'm going to have to say this right. It seems it's driven by the portion in the old Los Angeles region that is now -- that would now be region 3 that comes from the old Southern California region. It seems to me it has something to do with the impact of moving Ventura onto the other formally non-L.A. counties, not actually Ventura itself.

I'm not sure I said that very well. It doesn't seem to me Ventura is hurt much at all. It's the -- it's the impact of everything around it that's really the issue. And I'll --

RETIRED HEALTH ACTUARY McCOLLUM: Well, those --

those 2,700 members are essentially in Ventura County. It's -- it is the impact of moving Ventura County from its current location in the Los Angeles region to the other southern region, which you'll notice from the earlier chart, there was about a ten percentage point differential between the cost relativities. And so you're seeing that impact on the Ventura region -- or excuse me on Ventura County.

ACTING COMMITTEE MEMBER LOFASO: Okay. The reason I came to that conclusion was that the table on the page I cited indicates that 22,218 lives have an increase of two five and 17 percent. And you identified them as from the current other Southern California region, which doesn't include Ventura. That's why I came to that conclusion.

RETIRED HEALTH ACTUARY McCOLLUM: Oh, those 22,000 members?

ACTING COMMITTEE MEMBER LOFASO: Yeah.

RETIRED HEALTH ACTUARY McCOLLUM: Okay. Yeah, those -- right. Those would not be Ventura only.

ACTING COMMITTEE MEMBER LOFASO: Okay.

RETIRED HEALTH ACTUARY McCOLLUM: Those would -- that would be part of the overall structure -- or restructuring.

ACTING COMMITTEE MEMBER LOFASO: And just

continuing on the same theme in Northern California, the bottom line in both scenarios, A and A1 -- and it seems to me that some of the most difficult discussions we've had in the time I've been around are which count -- which county is the cusp between say other Northern California and Sacramento, or Sacramento and Bay Area? Underscoring that we have these counties on the cusp that underscore how challenging it is to maintain the integrity of these regions, which, if I follow, suggests that the regions themselves are problematic, which is why both A and A1 say, let's -- so the impact of that -- it seems to me that the small impact on those two counties, Monterey and Stanislaus, which are at the southern edge of our current northern regions, plural, which would remain -- not the northern edge. The southern edge of our current northern regions, plural, would remain at the southern edge of our northern singular region. And it's -- what we're stud -- what we're examining in the hot spots there is this is the impact, both in Sacramento and those two counties, of collapsing the north from three regions to one.

RETIRED HEALTH ACTUARY McCOLLUM: That is correct.

ACTING COMMITTEE MEMBER LOFASO: Okay. I mean, in the grand scheme of things, it's relatively -- it's relatively modest.

I'm not going to belabor my -- what I observed on the average premium increase, because I think that Mr. Feckner and Ms. Taylor got to it better. It seemed to me that that number came out the way it did, because it's a smaller denominator, because there are so many fewer people with that minor increase of three percent or so. And the denominator of the fraction is so much smaller in A1 compared to A, that's why that number as an average came out higher, not the -- the actual numbers of people got a higher increase.

RETIRED HEALTH ACTUARY McCOLLUM: I'm not sure I followed that actually.

(Laughter.)

ACTING COMMITTEE MEMBER LOFASO: Yeah. Okay. Well --

CHAIRPERSON FECKNER: I'm not sure he did.

(Laughter.)

ACTING COMMITTEE MEMBER LOFASO: If -- I won't take up everybody's time. But the bottom line is if you go to the page -- attachment three, page eight, you know, it's divided by a total of 79,000 lives not 153,000 lives. And if you go to the table beforehand, you see how much smaller that light shaded area is.

But anyway, I'll move on.

RETIRED HEALTH ACTUARY McCOLLUM: Oh.

ACTING COMMITTEE MEMBER LOFASO: The bottom line is think -- I think you're illustrating that you've done a good job of doubling the marketability, that is the alignment to the market to the cost of care, and minimizing the disruption.

Just moving on to the factors, sort of a bit of a follow-on to Mr. Rubalcava's question. What's the data source for staff to define the ranges? It seems to me when we do this exercise back the last time we did it and the current, Milliman did a very extensive study using a lot of data that was very intensive for a snapshot in time to drive this complex analysis. I guess the question I'm trying to get my head around is are we going to have that kind of robust data to support our factors going forward on an annualized basis?

RETIRED HEALTH ACTUARY McCOLLUM: Yes, we do. And what we have are the cost relativities by county, and we can combine those and get a cost relatively for a region. What we don't have, the reason why we're recommending a range, is we don't have each individual plan's contracts with their hospitals and their providers, and then the mix that they have of members that go to those different hospitals and providers.

So we can come up with an average cost in the region. That gives you a general cost relativity. For

example, the Los Angeles region was 0.81 in our new proposal. So we know that the Los Angeles region is 20 percent cheaper than the statewide average. But the plans that are within that region have individual hospitals and providers that they're contracting with that will move their average cost somewhere north or south of that 0.81 figure, depending on their -- on their particular membership and where they're going.

And so we would figure out, and this will be the Actuarial Office going forward, would figure out the average cost, and then a range that is sufficient to allow the plans to project their own membership and what number they need, but not too large that it becomes, what you'd call absurd, which we had a couple of absurd regional factors in the last couple of years.

ACTING COMMITTEE MEMBER LOFASO: Thank you very much. Thank you for all the work. Thank you, Mr. Chair.

CHAIRPERSON FECKNER: Thank you.

Mr. Miller.

COMMITTEE MEMBER MILLER: Yeah. Thank you for the work and the presentation. And I find that you've been very responsive, not just to the stakeholders, employers, advocates of our members and us, but it seems to me that proposal 1A it's logically consistent. It's rational and reasonable, which, to my mind, are two

different things.

But it also -- beyond just a snapshot in time with what we're looking at now, it's responsive to the changes that have been happening since we first started with these regions. It's responsive to putting us in a better position going forward to address changes in that marketplace, in the real world as they happen over the next few years. And I think it makes -- it makes sense to me. I think it will make sense to our stakeholders. The nomenclature change I think is just -- it seems like an obvious improvement that -- and I think moving to a model where we're actually putting ranges in for those factors in kind a formal way, it just seems like a logical way to do things, when, in fact, when we do that work, we've got to have that kind of concept in mind anyway. This kind of formalizes it and makes it so everyone is on the same page.

So I support both the staff's recommendations for A1 and -- I mean, 1A and for moving to ranges for the regional factors.

Thanks.

CHAIRPERSON FECKNER: Ms. Mathur.

COMMITTEE MEMBER MATHUR: Thank you.

I agree with you about the absurd regional factors experience. And I'm wondering if there's some

middle ground between us setting a prescriptive definition and setting a range. And if that is that we have a prescriptive definition, and that the plans can come back to us with evidence that there's a need for them to -- so sort of like a comply or explain. Like you either -- you either accept what we've defined as the regional factor for your -- for the region, or you bring back an alternative that you can then explain and back up with data and evidence about your mix of members and your contracting rates.

Now, I don't know if that might be a much more intensive process from the staff's perspective, but I guess that's -- I'm wondering if that would be a feasible solution?

RETIRED HEALTH ACTUARY McCOLLUM: That is a suggestion I -- I think that lends itself though to the potential that we would get back to the situation where we have differences -- bigger differences than what they would want to have to contend with in the rate negotiation process.

COMMITTEE MEMBER MATHUR: But we could still -- we could still sort of have the range as a -- it will -- we will not accept anything that's outside of the range. But if you want to do -- if you need to -- if you're going to deviate from our recommendation, then you need to

defend it? I don't know. Maybe -- maybe, Shari, you can talk about whether it's going to be an onerous task for the team to manage that.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: Well, it's not so much that it's an onerous task, but I think some of the experiences we've had in the last couple of years in the rate development process have been that not all plans view things in the same ways. And for consistency, and in order to also be able to validate and verify where we land, and also using that with our third-party actuaries, it makes a lot more sense to have that range. It gives the plans a little bit of flexibility, so that nobody is so severely impacted. It gives us a little bit of flexibility, and it gives us better negotiating power, I think.

COMMITTEE MEMBER MATHUR: Okay. Okay. Well, I am -- after hearing the conversation about scenarios A and A1, I am persuaded that the staff's recommendation of A1 is the sensible choice, and I'm happy to make a motion for that, and then also -- to adopt scenario A1 and to adopt the staff recommendation with respect to the regional factors.

VICE CHAIRPERSON TAYLOR: I'll second it.

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

We still have a couple of requests to speak, plus some from the audience.

Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you, Mr. Chair. I am inclined to go with A1, because you've mentioned that it's the greatest good for the greatest number of our members. And that's always my objective.

And talking about objectives, and the objectives that you've stated for the regions, create stable public agency, risk pools, reflect cost of health care regionally, retain and attract public agencies. And I've often said that when we embark upon these major policy changes or redirection of processes, et cetera, I've also asked for where is the evaluation tool?

At some point in the future, this decision needs to be evaluated, to say whether or not it's working as it's intended to reach these objectives.

So I would like to hear what are you thinking. Because you mentioned earlier that 15 years ago, we embarked upon these regions. So the question is if we had an evaluation five years after implementation, would we have ten more years of that before we make a change? So could you respond to that process, please?

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

That's a great Comment. And we really did

realize that it's been 13 years. It's been too long and we have made a commitment to do this every five years, just to make sure that we're on track.

COMMITTEE MEMBER JONES: Okay. And that's true for many of these policy changes, I would suggest --

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: Correct.

COMMITTEE MEMBER JONES: -- that we have an evaluation tool.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: I also want to point out that now that we've had this rigorous model put together, it will be the same model, the same level of analysis. We went down to the zip code. We had third party valuation. That is what is going to be expected at the five-year point to ensure that we're always on -- reflecting the greatest good for the greatest number of our members.

COMMITTEE MEMBER JONES: Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Slaton.

COMMITTEE MEMBER SLATON: Thank you, Mr. Chair. Whenever I look at this, I always think that I'm -- we've got a big balloon and we're pressing at one point, and it's coming out on the other side, but there's still X amount of air that has to be in the balloon.

I'm leaning toward accepting A1. But here's my question, for public agencies this is optional from the agency standpoint. They could be with CalPERS or they could come up with another alternative to provide adequate health for their members. So help me understand the difference between A and A1 when it comes to two components, retention and acquisition? So acquiring new agencies versus retaining current agencies, what's the difference between A and A1, in your opinion?

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: So I'm going to let Mr. McCollum talk to some of this. But I would like to say that really it's truing up the cost to the actual costs of health care within a market, which was really the driving process when we first established regions. We want to make sure that everyone is as closely aligned with the care.

And we determined that just the north/south wouldn't be the optimal solution. But just breaking that out slightly further, so that everyone is true to cost, it wouldn't be fair to increase most of the Southern California area for a very small portion that is slightly higher than that, or risking losing a lot of the public agencies and school districts within the Southern California region.

RETIRED HEALTH ACTUARY McCOLLUM: Well, the

difference between the two regions is the acknowledgement that those three counties, Los Angeles, San Bernardino, and Riverside are significantly lower in their average cost than the rest of Southern California.

So we felt that that difference in cost relativity was large enough to warrant that third region that we've created in A1.

COMMITTEE MEMBER SLATON: So that will help both with retention and acquisition, but we run the risk of some retention loss by those who are going to have significantly higher premiums.

RETIRED HEALTH ACTUARY McCOLLUM: Are you referring to the estimated increases that are -- you're looking at?

COMMITTEE MEMBER SLATON: Yes. I'm talking about the larger -- you know, for those populations that will have significant increases in A1 creates pressure to find alternatives for that care, or are you saying that the cost is so well balanced that the agency is not going to find a better alternative?

RETIRED HEALTH ACTUARY McCOLLUM: Well, that remains to be seen every year really, whether they can find a bet alternative or not. But we feel that the regions that have been created here in scenario A1 best positions CalPERS to be competitive in the three regions

that we've created.

COMMITTEE MEMBER SLATON: Okay. I see one other advantage in A1 that we haven't talked about, which is, you know, we had that situation, particularly in Northern California, where someone has -- if they just went across a county line, they would be able to save money, because the scenario is either your workplace or your homeplace. And if they drove 20 miles, they could be in a different region. So at least we're eliminating a lot of that confusion or problem it seems like by narrowing this down just to the three. We're going to have fewer county border problems, as I would call them.

Thank you very much.

CHAIRPERSON FECKNER: Thank you.

Seeing no other requests from the Board, we have two requests from the audience. Ms. Duran-Flores and Mr. Fox, please come down to the dais on my left, your right. The microphones will be on. Please identify yourselves for the record, and you have up to three minutes for your comments.

MS. DURAN-FLORES: Good morning, Mr. Chairman, and members.

CHAIRPERSON FECKNER: Good morning.

MS. DURAN-FLORES: I'm Dolores Duran-Florez with the California School Employees Association. We are in a

unique position today. We are not in support or in opposition to any of these regions, but we do want to express some of the concerns we had. We believe that, you know, these changes are significant and we should be on the record.

But before I do, I want to thank all of the work that your staff did on this. They had a very collaborative process, and they did seek our input. And for that, we are grateful.

We also recognize that you are going to be making a very tough decision today. The decision you are going to make could potentially increase rates for thousands. And on the flip side, it could decrease rates for thousands. This is a tough choice, and we recognize it.

Well, CSEA has tried to evaluate all the regional options. And I tell you, it was very complicated trying to overlay the current regions with the new proposal. And we're not experts, so it took a lot of time tinkering around with that. But ultimately, it was zero sum game, just like Board Member Slaton said. You know, you press it here and it pops out another area.

So we know that any changes you make in these regions are -- some of our members will win and some of our members will lose.

So with that in mind, we explained these

proposals -- we examined these proposals from the do the least amount of harm philosophy. That's where our vision was on this. My remarks are going to focus solely on scenario 1A, since that is what is being recommended by staff today.

Taking the numbers from your charts, we see the estimates that 173,000 people are going to get premium increases of three percent or more, averaging $25 a month. But on the flip side, you're going to have 79,315 people receiving a premium increase of at least three percent averaging $41 a month. The greatest increase we've seen are in the band of seven to ten percent, followed by the five to seven percent band.

And the 41 is, you know, nearly double what the decrease is with 25. And we've seen that some of the premium increases from staff, we've discussed, they could go as high as 35 percent. We also know that the 216,000 members will see a premium increase up to three percent. And we thought maybe that number should have also been included in the increase side.

And these numbers are just estimates again. They're based on the 2019 premiums. So in 2020, when this is actually effective, the rates actually could be higher. So it's like an add-on to what our members are going to see. And the decrease in premiums could actually be less.

So based on this information, we don't see any compelling reason to adopt any of these regional scenarios at this time. It does not pass our do-the-least-amount-of-harm philosophy. The number of people who will see a premium increase is just too staggering for us.

We would recommend that actually you maintain the current regional model at this time. But if you decide to adopt one of these regional changes, we just urge you to take this year to educate all members enrolled in CalPERS health care. This way, they can prepare for the potential premium increases and decreased.

CHAIRPERSON FECKNER: Your time is up.

MS. DURAN-FLORES: Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Fox.

MR. FOX: Thank you very much Mr. Feckner, members of the Committee and the Board. My name is Marc Fox. I'm the Director of Human Resources for Solano County. And I disagree in part with the previous speaker fro CSEA. CalPERS, as you've heard from staff, as you've heard from me last month, has a very long history of these regions. And last month, I asked that you consider region 1. This month I ask that you support the staff recommendation support the motion from Member Mathur and

support 1A.

It makes your marketability of the program better. It improves the regional set-up that you established 13 years ago. Staff has been very open, and has had a very -- a number of commitments made and honored to a variety of stakeholders. The stakeholder group that's most impacted is obviously the public sector group, the public agencies whether at schools as in the prior speaker or myself as party of counties and special districts and cities.

So I think 1A accomplishes your goal of being fair to a variety of employers, being fair to the participants in the plan, and being fair to CalPERS itself in terms of trying to have a plan that is continuing to honor the goal of the PEMHCA program, continuing to be as open and as marketable. And the numbers from staff show that this proposal -- option 1A achieves those objectives.

I ask that you support this -- the staff recommendation and the motion before you.

Thank you very much, Mr. Feckner

CHAIRPERSON FECKNER: Thank you.

Seeing no other requests to speak, there is a motion before us.

All in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries. Thank you.

That brings us to Item 6b, State Legislative Proposal. Mr. Brown.

LEGISLATIVE AFFAIRS DIVISION CHIEF BROWN: Good morning, Mr. Chair and Committee members. Danny Brown, CalPERS team member.

This agenda item is asking for your approval to sponsor legislation to make some technical and minor policy changes to the statutes that CalPERS administers.

I'll just briefly highlight three of them. First, while it might sound intuitive that if you go out on a disability retirement or an industrial disability retirement that you couldn't come back and work as a retired annuitant doing the same job duties or job that you were disabled from performing. However, the law doesn't expressly state that. So this proposal will just kind of expressly prohibit that situation. It doesn't prevent you from returning or working as a retired annuitant. It just prevents you from working as retired annuitant in the job that you retired from on disability.

The next one would clarify that if you retire and you choose unmodified allowance, or return of your contributions upon your death, that you can make a change, if you have a qualifying event, such as marriage. And

that you can choose a new beneficiary and a new optional settlement. This one will just clarify that this qualifying event of marriage is a marriage after retirement, again very technical, clarifying change.

And then the last one would just clarify that all schools would be considered one employer when a member -- school member converts their sick leave to service credit upon retirement, so this would mean all school districts, community college districts, and the county superintendent. This aligns with the Education Code, which allows school employees to transfer their sick leave when they move from one employer to another employer.

These last two changes we really feel are clarifying and are consistent with existing practice, so they would have no impact on members.

And with that, I'm open to any questions you may have.

CHAIRPERSON FECKNER: Thank you.

Ms. Mathur.

COMMITTEE MEMBER MATHUR: Thank you.

So I think this is a sensible proposal. Just a question about marriage after retirement. Does that also include a legal partnership like a same-sex. It's not an actual marriage.

CHAIRPERSON FECKNER: Domestic.

LEGISLATIVE AFFAIRS DIVISION CHIEF BROWN: Yes.

COMMITTEE MEMBER MATHUR: Yes. So the language is clear about that?

LEGISLATIVE AFFAIRS DIVISION CHIEF BROWN: We'll draft the language, because the qualifying event includes a marriage. And I think in our statutes a marriage includes domestic partnerships and also any type of marriage. So I think we've changed the definition of marriage in our PERL. Anthony can correct me if I'm wrong.

COMMITTEE MEMBER MATHUR: Okay.

LEGISLATIVE AFFAIRS DIVISION CHIEF BROWN: But we'll make sure that it includes all of those -- both those situations.

COMMITTEE MEMBER MATHUR: Terrific. Well, with that then, I will move staff's recommendation.

VICE CHAIRPERSON TAYLOR: Second.

CHAIRPERSON FECKNER: I noticed Anthony nodding his head, so you must have been right.

LEGISLATIVE AFFAIRS DIVISION CHIEF BROWN: Okay.

CHAIRPERSON FECKNER: All right. It's been moved and seconded.

Mr. Lofaso.

ACTING COMMITTEE MEMBER LOFASO: Thank you, Mr. Chair. Just to clarify this marriage issue, not to open

up a thing. So if I understand correctly, the -- way back to the 2000s -- excuse me 1999 bill that added registered domestic partners to the CalPERS program and the long challenging history of the evolution of same-sex marriage in our state over the last 20 years, the CalPERS statutes contain registered domestic partners and a marriage. And though we struggled between the Baehr v. Lewin decision, and Proposition 8, and the U.S. Supreme Court decisions between our pre-Proposition 8 marriages, and our period of legally recognized out-of-state marriages that were legal in California under the Leno Bill, the bottom line is you're either a legally married individual in California, regardless of the gender of the two partners, or you're a registered domestic partner under the 1999 statute, and that's to whom this applies. Do I understand correctly?

LEGISLATIVE AFFAIRS DIVISION CHIEF BROWN: That is correct.

ACTING COMMITTEE MEMBER LOFASO: Thank you very much.

CHAIRPERSON FECKNER: All right. Thank you.

Seeing no other requests to speak.

All in favor of the motion, say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries.

Thank you.

Item 7a, Summer of Committee Direction. Ms. Bailey-Crimmins.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: My microphone doesn't want to agree with me today. I just -- I did take note. It wasn't necessarily Board direction, but there are improvements with the population health dashboard, so we have taken note of that, and talked about competition and obesity. So I have no Board direction, but I have noted that I will be making improvements in those areas.

Very good. All right. Thank you.

That brings us to 7b, public comment. I have one request. Mr. Behrens.

MR. BEHRENS: Chairman Feckner, members of the Committee, I wanted to take this opportunity to commend the CalPERS management team who sent several CalPERS staff up to the Paradise fire to work and find our stakeholders up there, that either were receiving a hard check, and that check was burned up, or receiving a direct deposit, the bank burned up, and did an outreach to these stakeholders - ninety of my members were affected by this fire - and helping them through that, the financial part.

The other thing I want to commend them for is reaching out and establishing, through Walgreens, the

ability for the stakeholders to continue to receive their medication in a timely fashion, much of -- was left behind because they only had time to get in their car and run, or just run.

So again, this kind of a outreach and this kind of a service to our stakeholders, I think, deserves a hand. And I want to thank them personally. And that's all I have to say.

CHAIRPERSON FECKNER: Thank you very much for your comments. And we all certainly thank our staff for working very hard.

(Applause.)

CHAIRPERSON FECKNER: It's a difficult time and staff did a great job. So thank you, and thank you for your comments, Mr. Behrens.

I want to please note for the record that on Item 6b Ms. Adria Jenkins-Jones has abstained. So please note that for the record.

Seeing no other public comment, this meeting is adjourned. Everybody enjoy your holidays and Performance and Comp will start at 10:15. Very good.

(Thereupon the California Public Employees' Retirement System, Board of Administration, Pension & Health Benefits Committee open session meeting adjourned at 9:58 a.m.)

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

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

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

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

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

IN WITNESS WHEREOF, I have hereunto set my hand this 18th day of December, 2018.

JAMES F. PETERS, CSR
Certified Shorthand Reporter
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