VIDEOCONFERENCE MEETING

STATE OF CALIFORNIA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

BOARD OF ADMINISTRATION

PENSION & HEALTH BENEFITS COMMITTEE

OPEN SESSION

ROBERT F. CARLSON AUDITORIUM

LINCOLN PLAZA NORTH

400 P STREET

SACRAMENTO, CALIFORNIA

TUESDAY, SEPTEMBER 15, 2020

8:04 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

Mr. Ramon Rubalcava, Vice Chairperson

Ms. Margaret Brown

Mr. Henry Jones

Mr. David Miller

Ms. Eraina Ortega

Ms. Theresa Taylor

Ms. Shawnda Westly

Ms. Betty Yee, represented by Ms. Karen Greene-Ross

BOARD MEMBERS:

Ms. Fiona Ma, represented by Mr. Frank Ruffino

Ms. Lisa Middleton

Ms. Stacie Olivares

Mr. Jason Perez

STAFF:

Ms. Marcie Frost, Chief Executive Officer

Mr. Matt Jacobs, General Counsel

Dr. Donald Moulds, Chief Health Director

Mr. Anthony Suine, Deputy Executive Officer

Ms. Marta Green, Chief, Health Plan Research and Administration Division

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

STAFF:

Mr. Kelly Fox, Chief, Stakeholder Relations

Ms. Pam Hopper, Committee Secretary

Ms. Kimberly Malm, Chief, Strategic Health Operations Division

ALSO PRESENT:

Mr. Tim Behrens, California State Retirees

Ms. Deborah Berger

Mr. Al Darby, Retired Public Employees Association

Ms. Joanne Hollender, Retired Public Employees Association

Mr. J.J. Jelincic, Retired Public Employees Association

Mr. Larry Woodson, California State Retirees

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1 P R O C E E D I N G S
2 CHAIRPERSON FECKNER: I'll call the Pension and
3 Heath Benefits Committee to order. The first order of
4 business will be to call the roll.
5 Ms. Hopper.
6 COMMITTEE SECRETARY HOPPER: Thank you, Mr.
7 Chair.
8 Rob Feckner?
9 CHAIRPERSON FECKNER: Good morning.
10 COMMITTEE SECRETARY HOPPER: Margaret Brown?
11 COMMITTEE MEMBER BROWN: Good morning.
12 COMMITTEE SECRETARY HOPPER: Henry Jones?
13 Henry Jones?
14 COMMITTEE MEMBER JONES: Here.
15 COMMITTEE SECRETARY HOPPER: David Miller?
16 COMMITTEE MEMBER MILLER: Here.
17 COMMITTEE SECRETARY HOPPER: Eraina Ortega?
18 Eraina Ortega?
19 She's muted, but I show she's in.
20 COMMITTEE MEMBER TAYLOR: She has the yellow
21 triangle from what I'm looking at.
22 CHIEF EXECUTIVE OFFICER FROST: Yes.
23 COMMITTEE SECRETARY HOPPER: Ramon Rubalcava?
24 VICE CHAIRPERSON RUBALCAVA: Here.
25 COMMITTEE SECRETARY HOPPER: Theresa Taylor?

1 COMMITTEE MEMBER TAYLOR: Here.
2 COMMITTEE SECRETARY HOPPER: Shawnda Westly?
3 COMMITTEE MEMBER WESTLY: Here.
4 COMMITTEE SECRETARY HOPPER: Karen Greene-Ross
5 for Betty Yee?
6 ACTING COMMITTEE MEMBER GREENE-ROSS: I'm here.
7 And I'm asking for my tech support to find out why it's --
8 my camera is filming the window and not me.
9 (Laughter.)
10 ACTING COMMITTEE MEMBER GREENE-ROSS: That didn't
11 happen yesterday, so I don't know what's going on, but I'm
12 here.
13 COMMITTEE SECRETARY HOPPER: And one more time,
14 Eraina Ortega?
15 Mr. Chair, I'll go ahead and mark her in
16 attendance as well.
17 CHAIRPERSON FECKNER: Very good. Thank you.
18 Good morning, everyone. We're now going to move
19 into recess into -- moving into closed session for items 1
20 through 3 from the closed session agenda. So at this
21 time, the Board members will exit the open session meeting
22 and connect to the closed session meeting.
23 For the members of the public watching on the
24 livestream, the open session Pension and Health Benefits
25 Committee meeting will reconvene following our closed

1 session.
2 Thank you. So if everybody can please leave the
3 open session and we're see you on the other side.
4 (Off record: 8:06 a.m.)
5 (Thereupon the meeting recessed
6 into closed session.)
7 (Thereupon the meeting reconvened
8 open session.)
9 (On record: 8:47 a.m.)
10 CHAIRPERSON FECKNER: We're back -- reconvened in
11 our open session.
12 The first a business will be to approve the
13 September 15th, 2020 PHBC meeting timed agenda. What's
14 the pleasure of the Committee?
15 COMMITTEE MEMBER BROWN: Move approval.
16 COMMITTEE MEMBER TAYLOR: Second.
17 CHAIRPERSON FECKNER: Is there a second?
18 COMMITTEE MEMBER MILLER: Second.
19 CHAIRPERSON FECKNER: It's been moved by Ms.
20 Brown, seconded by Ms. Taylor.
21 Any discussion on the motion?
22 Seeing none.
23 Ms. Hopper, can you please call the roll.
24 COMMITTEE SECRETARY HOPPER: Thank you, Mr.
25 Chair.

1 Margaret Brown?
2 COMMITTEE MEMBER BROWN: Aye.
3 COMMITTEE SECRETARY HOPPER: Henry Jones?
4 COMMITTEE MEMBER JONES: Aye.
5 COMMITTEE SECRETARY HOPPER: David Miller?
6 COMMITTEE MEMBER MILLER: Aye.
7 COMMITTEE SECRETARY HOPPER: Eraina Ortega?
8 COMMITTEE MEMBER ORTEGA: Aye.
9 COMMITTEE SECRETARY HOPPER: Ramon Rubalcava?
10 VICE CHAIRPERSON RUBALCAVA: Aye.
11 COMMITTEE SECRETARY HOPPER: Theresa Taylor?
12 COMMITTEE MEMBER TAYLOR: Aye.
13 COMMITTEE SECRETARY HOPPER: Shawnda Westly?
14 COMMITTEE MEMBER WESTLY: Aye.
15 COMMITTEE SECRETARY HOPPER: Karen Greene-Ross
16 for Betty Yee?
17 I do not see Karen in yet, Mr. Chair.
18 CHAIRPERSON FECKNER: Okay.
19 COMMITTEE SECRETARY HOPPER: I've got Margaret
20 Brown making the motion, Theresa Taylor seconding it. And
21 as of all the votes, they're all ayes.
22 CHAIRPERSON FECKNER: Very good. Thank you.
23 Moving on to Item 3 is the Executive Report. Mr. Suine,
24 Mr. Moulds, who's going first?
25 DEPUTY EXECUTIVE OFFICER SUINE: I'm going to go

1 first, Mr. Feckner, if that's all right with you.
2 CHAIRPERSON FECKNER: Very good. Perfectly Fine.
3 DEPUTY EXECUTIVE OFFICER SUINE: All right.
4 Good morning, Mr. Chair and members of the
5 Committee. Anthony Suine, CalPERS team member. And it's
6 great to be with you again to share about activities and
7 trends in customer service and in education, since I last
8 had the chance to appear before you in June.
9 I'm pleased to report that our team continues to
10 successfully telework and meet our customer service
11 performance goals. Within CSS, more than 90 percent of
12 the branch is consistently working from home and the
13 number of our contact center team members working from
14 home is up above 95 percent. Our benefit payments remain
15 timely and our customer satisfaction scores continue to be
16 strong as well.
17 These results are encouraging, especially as we
18 have some team members periodically faced with a variety
19 of challenges from remote connection issues, to managing
20 distance leaning with their children, to providing care
21 for family members, and even some of evacuations from the
22 recent wildfires.
23 I'm impressed with the team's resiliency and
24 flexibility in balancing the changing priorities in home
25 and life while also demonstrating unprecedented commitment

1 to our customers and meeting all their needs.
2 Related to customer education, the last time we
3 met, I shared with you that we'd be conducting our first
4 virtual CalPERS Benefit Education week at the end of July
5 to continue educating our measures -- our members despite
6 our inability to have large in-person gatherings.
7 I'm happy to say that the event had over 3,000
8 attendees, many who participated in multiple member
9 education sessions.
10 This was a remarkable turnout for our first
11 event. Overall, our class satisfaction for the week was
12 an astonishing 98 percent. And as a result, I'm extremely
13 proud of this and especially considering it was our first
14 attempt at a virtual event of this magnitude. We're
15 currently exploring our opportunities for another virtual
16 CBEE week before the end of the calendar year.
17 Speaking of disasters and disaster assistance for
18 our members, between the wildfire -- wildfires and
19 hurricanes, it seems everywhere we're experiencing these
20 disasters that are currently impacting our members. I
21 want you to know that we're proactively working to meet
22 their needs during these uncertain times. We have team
23 members identifying Post Office closures, identifying
24 which retirees are receiving paper checks and might be
25 impacted, and reaching out to all those members and trying

1 to enroll them in a direct deposit option or identifying
2 alternative means to deliver their past or future
3 retirement checks.
4 Due to the circumstances, many of which involve
5 evacuations, it can be difficult to get in touch with
6 these members, but we've reached out to over 200 members,
7 we leave messages if we can't reach them directly, and
8 we've also informed our contact center with all the
9 information to look out for their calls and make efforts
10 to get them their funds.
11 We're also providing assistance to our
12 employer -- our employer community. As you know, in
13 March, the Governor issued an Executive Order lifting some
14 of the restrictions for retired annuitants. And if they
15 were hired to provide adequate staffing as a result of
16 this pandemic, there were certain exceptions for those
17 individuals. And our Post-Retirement Employment
18 Determinations team was worked through over a thousand
19 exemptions that have assisted our employers in getting
20 those retired annuitants back to work.
21 For our active members, we have recently released
22 our electronic annual member statements. And this allows
23 them to review their accrued service credit for the year
24 and contributions. And those are now available in their
25 online myCalPERS accounts. We informed our members that

1 those statements are available through various means, that
2 includes email and social media, as well as announcing it
3 in the upcoming issues of our PERSpective newsletter.
4 The service credit they earned is based on
5 employer reporting throughout the year. And this till
6 help them if they're close to planning for retirement. As
7 a result of efficiencies over the last couple years, we
8 were able to release these in August for the second year
9 in a row, as opposed to October or November in previous
10 years.
11 Lastly, I want to inform you about some
12 retirement trends that are amongst us related to COVID,
13 social unrest, the disasters, the PLP program, and a few
14 observations around what's been happening with those
15 retirement inceptions in the recent months. From March
16 through July, our overall retirements have decreased 23
17 percent compared to the same time last year. However, we
18 have seen an increase in State employee retirements of 14
19 percent. That would reflect that our public agency and
20 school members are decreasing their retirements at even a
21 greater rate.
22 We suspect the bargain PLP program and
23 corresponding pay reduction is a factor in the increase
24 for our State members. And we are aware that school
25 members are being paid through the end of the year, so we

1 may see more school retirements there, most likely holding
2 on until the fall period of time, fall and winter. So
3 we'll keep track -- keep tracking these trends and update
4 further -- update you further as we know more.
5 So, in conclusion, I just want to thank our team
6 for working so hard to deliver on our mission of serving
7 our customers, especially during these difficult times.
8 And I'd like to thank the Board for your support.
9 And this concludes my report and I'm happy to
10 take any questions.
11 CHAIRPERSON FECKNER: Very good. Thank you for
12 your report. I see no requests for questions, so thank
13 you very much.
14 DEPUTY EXECUTIVE OFFICER SUINE: Thank you.
15 CHAIRPERSON FECKNER: Mr. Moulds.
16 CHIEF HEALTH DIRECTOR MOULDS: Okay. Good
17 morning, Mr. Chair, members of the Committee. Don Moulds,
18 Chief Health Director.
19 I have two items for the Committee today. The
20 first is an update on our work with the health plans to
21 gather COVID-19 data among the CalPERS health membership
22 and the second is 2020 enrollment.
23 First, I'd like to update the Committee on data
24 we've been gathering with the health plans to better
25 understand COVID among our members. Early on, we didn't

1 have a clear picture of COVID cases due to coding and
2 claims lag. We typically at CalPERS see claims about 90
3 days after they first come in with health plans.
4 But what we heard from the plans was that CalPERS
5 members' data was tracking with the State's COVID-19
6 trends and that remains the case today as well. The data
7 provided from the plans that we've gathered represents
8 roughly 90 percent of our membership, not including the
9 association plans, represents March through July numbers,
10 so it does not include August.
11 Here's the data -- what the data shows. Roughly
12 84,000 COVID tests have been performed on CalPERS members.
13 There were fewer tests in March and April, about 2,500 and
14 6,500 tests respectively. Fewer tests were performed in
15 March and April when State and federal testing guidelines
16 were more restrictive and the prevalence of COVID was
17 lower in California.
18 Testing then increased as we saw surges of cases
19 throughout the state to roughly 19,000 tests in May and
20 29,000 tests in June, and then 26,000 tests in July.
21 The positivity rate is another number that we're
22 tracking. The positivity rate is an important measure,
23 because it gives us an indication of how widespread
24 COVID-19 infection is and whether levels of testing are
25 keeping up with the levels of disease transmission. For

1 March, April and May, prior to the post-Memorial Day
2 surge, the positivity rate among CalPERS members was about
3 5.4 percent. So this means that 5.4 percent of the
4 diagnostic tests processed in those months were positive
5 for COVID-19.
6 The positivity rate increased in June and July to
7 8.7 percent. Again, very similar to what we've been
8 seeing statewide on the positivity rate. Our COVID-19
9 hospitalization rate in March, and April, and May was 15.9
10 percent. It then decreased in June and July seven and a
11 half percent. So these rates also correspond to what
12 we're seeing statewide, but it -- it is an encouraging
13 trend obviously to see.
14 Just a couple of notes about this plan data. One
15 is that reporting is based on claims and may not include
16 COVID tests performed at State testing sites or also by
17 the CDC. Also, the number of tests may include CalPERS
18 members who were tested more than once.
19 Given our size, we know this information is of
20 interest, not only to our members and stakeholders, but
21 also to other State health agencies and large health care
22 purchasers. We will continue to collect the data from the
23 plans and provide regular updates to the Board and the
24 stakeholders.
25 Collecting this data also reminds us how

1 personally this pandemic has impacted our members and
2 their families. And while I just reported some large
3 numbers and rates, I'm very aware that these numbers
4 represent individuals and lives, in many cases irrevocably
5 changed.
6 For these reasons, we're working closely with our
7 health plans to ensure our members continue to feel safe
8 while seeking health care and remain as healthy as
9 possible, especially through the winter months this year
10 when COVID and flu are going to be circulating together.
11 Our health plans are re-doubling their efforts to get
12 members vaccinated against the flu this year in a
13 reimagined socially distant way.
14 My second item is open enrollment. I want to
15 remind our members that open enrollment starts next
16 Monday, September 21st and ends October 16th. This is the
17 time to make any plan changes or add or remove dependents.
18 Yesterday, member health plan statements became available
19 in myCalPERS accounts or were mailed to members who
20 requested that. Various other open enrollment information
21 is also available and we have regular communications
22 planned over the next months as do our health plans.
23 We have a meaty agenda today, so I'm going to
24 stop there. Today, I'm going to kick things off with a
25 discussion of a proposed one-year extension of our

1 pharmaceutical benefit manager contract with OptumRx.
2 After that, you'll be hearing from Marta and her team
3 about the modeling work they've been doing over the last
4 few months to explore risk mitigation options. She also
5 plans to discuss the robust stakeholder engagement effort
6 that she'll be leading on the issue over the next couple
7 of months. After that, you're going to hear from me again
8 about long-term care.
9 So that concludes my remarks. And I'm happy
10 either to take questions or to move straight into the
11 discussion of the OptumRx contract.
12 CHAIRPERSON FECKNER: Okay. I'm not sure we have
13 any questions right now. I see we do have some callers
14 for later on. But before we get into some of the
15 discussions, we do have requests to pull something off the
16 consent item calendar. So do you want to do this part
17 now, Mr. Moulds, or further in the agenda?
18 CHIEF HEALTH DIRECTOR MOULDS: You know what,
19 it's at your pleasure, Mr. Chair. If it's -- is it --
20 what's the item? Is it the Committee delegation?
21 CHAIRPERSON FECKNER: They want to pull Item 4b.
22 Yes.
23 CHIEF HEALTH DIRECTOR: Yeah. Kim -- we need to
24 promote Kim Malm whose been working on this with me.
25 CHAIRPERSON FECKNER: My question is do you want

1 to continue with your report now or do you want me to go
2 on to Item 4 and then get to your report.
3 CHIEF HEALTH DIRECTOR MOULDS: You know what, I'm
4 good either way. Why don't I continue and why don't we
5 just take it in order, if that's --
6 CHAIRPERSON FECKNER: There you go.
7 CHIEF HEALTH DIRECTOR MOULDS: All right. Okay.
8 So shall I go ahead with the Optum --
9 CHAIRPERSON FECKNER: Yes, please.
10 CHIEF HEALTH DIRECTOR MOULDS: Okay. Great.
11 So first item we have for you today is a proposed
12 extension of the contract with our pharmaceutical benefit
13 manager, OptumRx. The proposal would extend the term of
14 the contract by one year with an option for a second year
15 at CalPERS's discretion. As far as it --
16 CHAIRPERSON FECKNER: Just a second, Mr. Moulds.
17 CHIEF HEALTH DIRECTOR MOULDS: Yes.
18 CHAIRPERSON FECKNER: Don, if you could wait a
19 second.
20 CHIEF HEALTH DIRECTOR MOULDS: Sure.
21 CHAIRPERSON FECKNER: Isn't that agenda item 6a
22 that you're talking about?
23 CHIEF HEALTH DIRECTOR MOULDS: I -- I am.
24 CHAIRPERSON FECKNER: So we've got to get to 6
25 first.

1 CHIEF HEALTH DIRECTOR MOULDS: So I --
2 CHAIRPERSON FECKNER: We're on 3. We're
3 currently on item 3.
4 CHIEF HEALTH DIRECTOR MOULDS: Correct. So those
5 are both action consent items.
6 CHAIRPERSON FECKNER: That's Item 4.
7 CHIEF HEALTH DIRECTOR MOULDS: Right.
8 CHAIRPERSON FECKNER: So we need -- we need to
9 take it -- we need to take them in order. So we're going
10 to go to Item 4 first. That's the approval --
11 CHIEF HEALTH DIRECTOR MOULDS: Okay. Sorry about
12 that.
13 CHAIRPERSON FECKNER: That's all right.
14 It's approval of the June 16th Committee meeting
15 minutes. There's been a request to remove Item B, which
16 is the review of the delegation. So the action consent
17 item before us is the approval of the meeting minutes.
18 What's the pleasure of the Committee?
19 COMMITTEE MEMBER MILLER: Move approval.
20 VICE CHAIRPERSON RUBALCAVA: Move approval.
21 COMMITTEE MEMBER BROWN: I'll second.
22 CHAIRPERSON FECKNER: All right. Moved by Mr.
23 Rubalcava. Is that who that was?
24 VICE CHAIRPERSON RUBALCAVA: Yes. No.
25 CHAIRPERSON FECKNER: And the second is Ms.

1 Brown?
2 COMMITTEE MEMBER BROWN: Yes, sir.
3 CHAIRPERSON FECKNER: Very good. All right. Any
4 discussions on that motion?
5 Seeing none. Ms. Hopper, please call the roll.
6 COMMITTEE SECRETARY HOPPER: Margaret Brown?
7 COMMITTEE MEMBER BROWN: Aye.
8 COMMITTEE SECRETARY HOPPER: Henry Jones?
9 COMMITTEE MEMBER JONES: Aye.
10 COMMITTEE SECRETARY HOPPER: David Miller?
11 COMMITTEE MEMBER MILLER: Aye.
12 COMMITTEE SECRETARY HOPPER: Eraina Ortega?
13 COMMITTEE MEMBER ORTEGA: Aye.
14 COMMITTEE SECRETARY HOPPER: Ramon Rubalcava?
15 VICE CHAIRPERSON RUBALCAVA: Aye.
16 COMMITTEE SECRETARY HOPPER: Theresa Taylor?
17 COMMITTEE MEMBER TAYLOR: Aye.
18 COMMITTEE SECRETARY HOPPER: Shawnda Westly?
19 COMMITTEE MEMBER WESTLY: Aye.
20 COMMITTEE SECRETARY HOPPER: Karen Greene-Ross
21 for Betty Yee?
22 ACTING COMMITTEE MEMBER GREENE-ROSS: Aye.
23 COMMITTEE SECRETARY HOPPER: Mr. Chair, I have
24 Ramon Rubalcava making the motion, Margaret Brown
25 seconding it, and it's all ayes.

1 CHAIRPERSON FECKNER: Thank you. Motion carries.
2 Next item that we pulled was Item B, review of
3 the Committee Delegation. Ms. Brown.
4 COMMITTEE MEMBER BROWN: Thank you, Mr. Chair.
5 In reviewing this Committee delegation, there's a
6 lot of strikeouts here. And I realize that some of this
7 is just redundancy. I know that we've been doing this as
8 part of our make it simpler to understand. But I'm not
9 sure why we're crossing out Resolved E, because that tells
10 us or reminds us that the Committee must discharge its
11 duties solely in the interest and for the exclusive
12 purposes of providing benefits to participants and their
13 beneficiaries, and it goes on, and on, and on.
14 But -- and then it also says that we must
15 discharge the duties with care, scale and prudence. And
16 so I'm wondering why we're crossing that out?
17 CHAIRPERSON FECKNER: Thank you.
18 Ms. Malm.
19 STRATEGIC HEALTH OPERATIONS DIVISION CHIEF MALM:
20 Thank you, Ms. Brown. What I did was copy
21 exactly what you did with your Governance delegation and
22 your Risk delegation, in order to follow the Workstream 3
23 of making things simpler. So it was only removed because
24 it's the same thing that you removed under those other two
25 delegations.

1 COMMITTEE MEMBER BROWN: Great. So -- so by
2 removing it, we're not removing our responsibilities, is
3 that correct?
4 STRATEGIC HEALTH OPERATIONS DIVISION CHIEF MALM:
5 That's my understanding. And I don't --
6 CHAIRPERSON FECKNER: Absolutely not.
7 STRATEGIC HEALTH OPERATIONS DIVISION CHIEF MALM:
8 Yeah.
9 COMMITTEE MEMBER BROWN: Thank you for that.
10 GENERAL COUNSEL JACOBS: Yeah. This is -- if I
11 may, this is -- this is Matt Jacobs. This was deemed to
12 be just simply duplicative of provisions in the
13 Constitution and throughout the governing documents
14 otherwise. So it was just simply an effort to streamline
15 this document and make it more readable.
16 COMMITTEE MEMBER BROWN: With that explanation, I
17 would move approval. Thank you.
18 STRATEGIC HEALTH OPERATIONS DIVISION CHIEF MALM:
19 Thank you.
20 CHAIRPERSON FECKNER: Thank you. So we have a
21 motion. Is there a second?
22 COMMITTEE MEMBER JONES: Second.
23 COMMITTEE MEMBER MILLER: Second.
24 VICE CHAIRPERSON RUBALCAVA: (Raised Hand.)
25 CHAIRPERSON FECKNER: It's been moved by Ms.

1 Brown, seconded by Mr. Rubalcava.
2 I do have Mr. Rubalcava for a question or
3 comment.
4 VICE CHAIRPERSON RUBALCAVA: (Waved hand.)
5 CHAIRPERSON FECKNER: Waved it off. Okay. Any
6 discussion on the motion?
7 Seeing none.
8 Ms. Hopper, please call the roll.
9 COMMITTEE SECRETARY HOPPER: Margaret Brown?
10 COMMITTEE MEMBER BROWN: Aye.
11 COMMITTEE SECRETARY HOPPER: Henry Jones?
12 CHAIRPERSON FECKNER: You're muted.
13 COMMITTEE MEMBER JONES: Aye.
14 COMMITTEE SECRETARY HOPPER: David Miller?
15 COMMITTEE MEMBER MILLER: Aye.
16 COMMITTEE SECRETARY HOPPER: Eraina Ortega?
17 COMMITTEE MEMBER ORTEGA: Aye.
18 COMMITTEE SECRETARY HOPPER: Ramon Rubalcava?
19 VICE CHAIRPERSON RUBALCAVA: Aye.
20 COMMITTEE SECRETARY HOPPER: Theresa Taylor?
21 COMMITTEE MEMBER TAYLOR: Aye.
22 COMMITTEE SECRETARY HOPPER: Shawnda Westly?
23 COMMITTEE MEMBER WESTLY: Aye.
24 COMMITTEE SECRETARY HOPPER: Karen Greene-Ross
25 for Betty Yee?

1 ACTING COMMITTEE MEMBER GREENE-ROSS: Aye.
2 COMMITTEE SECRETARY HOPPER: Mr. Chair, I have
3 Margaret Brown making the motion, Ramon Rubalcava
4 seconding it, and I have all ayes.
5 CHAIRPERSON FECKNER: Very good. Thank you.
6 Motion carries.
7 That takes us to Agenda Item 5, the information
8 consent items. Having no request to remove anything,
9 we'll move on to Item 6.
10 6a, is the pharmaceutical benefit manager
11 contract with OptumRx. Mr. Moulds, here we go.
12 CHIEF HEALTH DIRECTOR MOULDS: Excellent. Good
13 morning, Mr. Chair, members. Don Moulds, CalPERS Chief
14 Health Director. First item we have for you today is a
15 proposed extension -- I shouldn't say the first item. I
16 should say this item is the proposed extension of the
17 contract with our pharmaceutical benefit manager OptumRx.
18 The proposal would extend the term of the
19 contract by a year, within an option for a second year at
20 CalPERS's discretion. As part of the terms of this
21 agreement, OptumRx has agreed to transition beginning
22 January 2021 to an acquisition cost-based contract. The
23 monetary terms are also an improvement on our current
24 contract. There are a few reasons why we think this is
25 beneficial -- it's beneficial to extend the OptumRx

1 contract under the proposed term.
2 First, and most importantly, it allows us to
3 maintain continuity of our pharmaceutical benefit manager
4 relationship for the likely course of the COVID-19
5 pandemic. This has been an issue of concern for CalPERS,
6 given the challenges we've been seeing in the
7 pharmaceutical supply chain, as well as difficulties our
8 members may face if we were to transition to a new PBM
9 during the pandemic.
10 As you know, our current contract is set to
11 expire in about 15 months, which means that if we were to
12 recompete the contract now, a PBM transition would start
13 next summer. So I'm hoping COVID will be in the rear-view
14 mirror by then, but we can't know that, and I don't --
15 would -- I would not bet on that.
16 As several of you have experienced, PBM
17 transitions can be bumpy. And the environment we're in
18 right now is an extremely challenging one for both
19 acquiring drugs and for distributing them. There were
20 very real supply chain challenges created when the
21 pandemic shut down pharmaceutical manufacturing sites
22 earlier in the spring in China and in India, and when runs
23 on drugs being touted as COVID cures were creating
24 shortages for people who actually needed them.
25 On the distribution side, many of our members

1 have migrated from retail to mail-order pharmacy, which is
2 the safest way to receive pharmaceuticals during COVID.
3 We've been monitoring these changes closely and we think
4 that Optum has done a pretty good job of managing them.
5 We worry about our ability to ensure smooth delivery of
6 drugs, if 2021 is a transition year however.
7 The proposed transition to an acquisition
8 cost-based contract is another important benefit of the
9 extension. As we discussed at the off-site in July, an
10 acquisition cost-based contract, wherein our PBM would be
11 compensated for costs associated with procuring and
12 dispensing drugs, rather than on the margins they profit
13 from through drug manufacturer rebates and acquisition
14 price spread is the future for CalPERS, at least we see it
15 that way.
16 It is far more transparent than the traditional
17 PBM contract and it allows us the flexibility to integrate
18 other cost saving initiatives, reference pricing for
19 example, and to participate in CalRx when that is up and
20 running. When I talked to you about acquisition
21 cost-based pricing in July, we were looking at building it
22 into the RFP for next year's contract. Starting it a year
23 earlier as is proposed here, the assessed transitioning
24 earlier, and gives us time to work out any kinks before we
25 move into it permanently.

1 Last, this proposed extension comes with monetary
2 improvements over our existing contract. It improves our
3 price guarantees for both 2021 and 2022 and offers other
4 cash concessions. We're seeking your approval of this
5 contract extension along with the more favorable financial
6 terms. I'm happy to answer any questions.
7 CHAIRPERSON FECKNER: Thank you very much. I
8 have Ms. Brown.
9 COMMITTEE MEMBER BROWN: Thank you, Mr. Chair.
10 Thank you, Mr. Moulds for that -- the information and the
11 work on this. I think the transparency is excellent. I
12 did have a question. In your write-up, you talk about,
13 "We will have the ability to tailor our formulary". And
14 so I'm wondering for our members we always worry when we
15 start talking about tinkering with the formulary. So can
16 you tell me what you have in mind, because, you know,
17 changing the formulary really upsets people and their --
18 and their budgets, if we're going to, you know, take
19 people from their regular drug to a generic or something
20 else, or maybe not even cover it. Move something up a
21 tier. So can you tell me a little bit about what the
22 plans are for tailoring our formulary.
23 CHIEF HEALTH DIRECTOR MOULDS: Sure. And we
24 have -- we have -- I should add that we have a -- we have
25 a basic authority for approval of formulary already. But

1 what this really does is allows us to be -- allows us to
2 move to alternative sites where we can potentially get
3 better deals on drugs. So we would conceivably, for
4 example, migrate into CalRx and purchase drugs from the
5 State of California, if the generic drugs they're offering
6 are, in fact, the lowest priced drug.
7 So we -- you know, we take all of that into
8 account whenever we're making any formulary change. We
9 make formulary changes constantly over -- you know, over
10 the course of a contract. There are periods each year
11 when we review the formulary, because obviously what's --
12 the treatment protocols will change, new drugs come on the
13 market. So we're constantly looking at new ones. And
14 obviously, we take -- I shouldn't say obviously. We
15 take -- we take the pain associated with changing drugs
16 and the anxiety associated with changing drugs into
17 account.
18 Having said that, one of the goals in the longer
19 term is to transition people who are on high-cost drugs,
20 where there are lower cost alternatives that are
21 clinically equally efficacious to those drugs. The key in
22 making those transitions is communication and a robust
23 appeals structure, if members feel like, for whatever
24 reason, an alternative drug is not doing the job that it
25 used to. So that's -- that's the -- sort of basically how

1 we handle the formulary issues.
2 COMMITTEE MEMBER BROWN: I appreciate that
3 explanation. Given COVID-19 and how many of us are not
4 going to our doctors, even the online or the telehealth,
5 those changes can be complicated. So I hope we're going
6 to try to keep those --
7 CHIEF HEALTH DIRECTOR MOULDS: Yeah.
8 COMMITTEE MEMBER BROWN: -- to a minimum for our
9 members. Thank you for that explanation.
10 CHIEF HEALTH DIRECTOR MOULDS: Yes. Thank you.
11 That's a good point.
12 CHAIRPERSON FECKNER: Thank you. I have Mr.
13 Miller.
14 Mr. Miller?
15 Go, David. I think you're on.
16 COMMITTEE MEMBER MILLER: There we go. No, I had
17 no comment. I was just mentioning -- I just posted a note
18 that my video keeps freezing. And it looks like Shawnda's
19 video and a few others are freezing at my end as well.
20 And when it's frozen be, I can't speak like just happens
21 right now and has happened when I've tried to make motions
22 and stuff.
23 CHAIRPERSON FECKNER: Very good. Thank you.
24 Ms. Greene-Ross.
25 ACTING COMMITTEE MEMBER GREENE-ROSS: Just want

1 to thank Don and the team in this negotiation for the new
2 contract. Good to be in the driver's seat. Hopefully,
3 this is a trend for all purchasers of pharmaceuticals.
4 Has it been standard that most of these companies have
5 done the rebate process versus the one we're heading into,
6 which is more transparent?
7 CHIEF HEALTH DIRECTOR MOULDS: Yeah. We're -- we
8 will be on the cutting edge with this one. So the federal
9 government has acquisition-based contracts. There are a
10 few other purchasers. Nobody our size. So, you know,
11 it -- yes, the standard is -- is rebates and acquisition
12 spread as the primary mechanism for PBMs to make their
13 money. And we just think it's a lot cleaner to be paying
14 them to find the drugs and to distribute the drugs,
15 because that's -- you know, that's what we're focused on.
16 So thank you for that. And, yeah, this is -- this is
17 relatively novel.
18 ACTING COMMITTEE MEMBER GREENE-ROSS: Well,
19 that's what I wanted to -- on behalf of he Controller,
20 this is just amazing and commendable to be on the cutting
21 edge. This is the right direction that this should go.
22 So thank you very much for all that hard work and getting
23 this worked out. This is going to be great. Thank you.
24 CHIEF HEALTH DIRECTOR MOULDS: Yea. And thanks
25 to the team -- the contracts team obviously, and Marta,

1 and to the legal team that helped with all of this.
2 CHAIRPERSON FECKNER: Great. Thank you.
3 I have Mr. Rubalcava.
4 You're muted, Ramon.
5 VICE CHAIRPERSON RUBALCAVA: Sorry. Thank you.
6 CHAIRPERSON FECKNER: There you go.
7 VICE CHAIRPERSON RUBALCAVA: Thank you.
8 Thank you, Don. Thank you, Mr. Chair for the
9 comment and thank you, Don, to you and your team for this
10 new approach.
11 You mentioned earlier that this new platform will
12 facilitate going to CalRx. But also I think you mentioned
13 in your memo that it's also -- we have other innovations,
14 for example, the biosimilar first strategies and the
15 reference pricing -- reference-based pricing. So will
16 this new platform also facilitate moving to those -- those
17 -- to those initiatives?
18 CHIEF HEALTH DIRECTOR MOULDS: It will. It's
19 a -- it's a more neutral platform, so it's much easier to
20 move to those. You know, we've obviously -- to Ms.
21 Brown's point earlier, we've postponed the reference
22 pricing initiative during COVID, because we just felt that
23 it was -- there's enough transition for our members right
24 now as is and we couldn't engage in the communication
25 initiative with providers that we needed to -- both

1 providers and our members that we needed to to do it
2 without bumps. So we've -- we've postponed that. We're
3 moving forward with the biosimilars first initiative,
4 which doesn't actually -- which only affects new -- new
5 scripts going forward. We're beginning that in January.
6 So -- so, yeah it will -- it will facilitate that.
7 VICE CHAIRPERSON RUBALCAVA: And another big
8 favorable item you mentioned is that it will sort of break
9 up the black box. There will be more transparency on the
10 drug prices. What's systems in place do we have to make
11 sure we are getting the best price, and that, you know,
12 the black box keeps getting broken up, I guess.
13 CHIEF HEALTH DIRECTOR MOULDS: Yeah. So that's
14 a -- that's a great question. I mean, the --
15 VICE CHAIRPERSON RUBALCAVA: And if I could add,
16 Don -- if I could just add and you can answer them both.
17 And how do we make sure that those savings are passed on
18 to the members?
19 Thank you.
20 CHIEF HEALTH DIRECTOR MOULDS: So -- yes. Sure.
21 So, you know, the big improvement is that we will actually
22 be seeing those prices. Marta. Marta, if you have
23 anything to add there, jump in, but we are -- we're -- we
24 will be in a position to see what the acquisition price is
25 for particular drugs and -- and to verify that that's our

1 price.
2 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
3 CHIEF GREEN: Yeah. This is Marta. So previously when
4 we'd receive a claim, it would be basically a net claim.
5 So we wouldn't know truly what the acquisition price was,
6 the element of it that was a rebate, how much of it was
7 really for the PBM for the distribution and whatnot. And
8 so now, in this claim, you will actually see the
9 acquisition cost transparently for every transaction. And
10 so on the surface, we can see exactly how much the drugs
11 cost us and our members.
12 And the second question, Mr. Rubalcava, you asked
13 was how do we ensure that savings are past along to our
14 members? It -- so when our total PBM spend goes down, we
15 can reduce costs as we build it into those health plan
16 rates. And so that's how the cost reduction is felt by
17 our members.
18 VICE CHAIRPERSON RUBALCAVA: Thank you very much.
19 And again, congratulations on the good work. And unless,
20 there are any other questions, Mr. Chair, I would move the
21 recommendation.
22 CHAIRPERSON FECKNER: Thank you. There's a
23 motion. Do we have a second?
24 COMMITTEE MEMBER BROWN: Second.
25 CHAIRPERSON FECKNER: Thank you.

1 Moved by Mr. Rubalcava, seconded by Ms. Brown.
2 I do want to also thank Mr. Moulds and all the
3 staff that were involved in putting this together. It was
4 a lot of hard wok and very thoughtful work. So thank you
5 for the job well done.
6 We do have a couple requests from the public to
7 speak. Mr. Fox, I do believe you have a couple of
8 callers.
9 STAKEHOLDER RELATIONS CHIEF FOX: Yes, sir, Mr.
10 Chair. First off, we have Mr. Tim Behrens from CSR.
11 CHAIRPERSON FECKNER: Thank you.
12 MR. BEHRENS: Thank you, Chairman Feckner and
13 members of the Committee. Tim Behrens, California State
14 Retirees speaking in favor of this motion.
15 I really want to thank Don for his response to
16 the Board member's question about the formulary. That was
17 good news that you shared. I would like to say some
18 positive things about OptumRx. They actually stepped up.
19 After they started on bumpy roads, have stepped up and,
20 together with the CalPERS Health team and their
21 leadership, they have been very responsive to our
22 memberships regarding their medications and any questions
23 they might have.
24 And for the last couple years, they've been
25 sending their staff and pharmacists to all of our Board

1 meetings doing free cholesterol training and answering any
2 question anybody in the audience had about their
3 medications and cost of medications.
4 So thank you very much.
5 CHAIRPERSON FECKNER: Thank you, sir.
6 Mr. Fox.
7 STAKEHOLDER RELATIONS CHIEF FOX: Mr. Chair, the
8 next person we have to speak on this subject is Mr. Larry
9 Woodson.
10 CHAIRPERSON FECKNER: Thank you.
11 MR. WOODSON: Hi. Good morning. Larry Woodson,
12 California State Retirees. Thanks for the opportunity to
13 comment.
14 I'd like to go back and just give some thanks to
15 the Health team for -- on Item 4b, review of Committee
16 delegation. The initial draft presented awhile back on
17 that, we had problems with. Kim Malm met with us. We
18 discussed it and some of our concerns were -- most of them
19 were addressed. So I thank you for doing that.
20 CSR, as Tim said, we do support this one-year
21 extension. It makes sense for all the reasons that Don
22 articulated. We have a little concern about the
23 acquisition-based contract and I'll make the point.
24 The -- we support the principle of doing away
25 with the rebate system. Back in February, 2019, Trump's

1 Health and Human Services program proposed a rule to
2 eliminate PBM rebates nationwide. The PBM lobby strongly
3 rallied and opposed that rule. It was withdrawn. But one
4 of the PBM talking points was that rebate elimination
5 would result in higher drug prices for the consumer. And
6 my concern is, to the extent that that's accurate, is
7 there risk to CalPERS by eliminating it? I mean, I like
8 what I heard about knowing the acquisition cost. I'll
9 point out that that's different than the drug
10 manufacturing cost. And I'm not sure -- you know, it
11 really depends on how honest the PBM is in providing
12 acquisition costs, I suppose.
13 But the other -- I mean, the other thing I like
14 about it is you do have a -- with a one-year extension,
15 you can evaluate the impact on cost. So I think that's
16 good and that's why we support it.
17 One other comment when you're -- there was
18 discussion about change in formulary and Don mentioned,
19 you know, that there are adjustments to formularies
20 throughout the year and you would try to lower drug costs
21 by -- I mean, one way to lower drug costs is to go to
22 different drugs. I've had a discussion with him regarding
23 some information that's been very alarming to me regarding
24 generic drug manufacturing from India and China, and the
25 quality, and the recalls have been quite high. And I'm

1 looking into that further. But I just want to raise that
2 as something to consider as you're, you know, trying to
3 find the lowest price generic. Most of the generics now
4 come from overseas and we have less control -- FDA has
5 less control over them.
6 Thank you for your time.
7 CHAIRPERSON FECKNER: Very good. Thank you very
8 much. Seeing no other requests -- Mr. Fox, is there
9 anyone else on the line, I'm sorry?
10 STAKEHOLDER RELATIONS CHIEF FOX: No, Mr. Chair.
11 That concludes public comment on Item 6a.
12 CHAIRPERSON FECKNER: Very good. Thank you.
13 Seeing no other requests to speak. The motion
14 being before you.
15 Ms. Hopper, please call the roll.
16 COMMITTEE SECRETARY HOPPER: Margaret Brown?
17 COMMITTEE MEMBER BROWN: Aye.
18 COMMITTEE SECRETARY HOPPER: Henry Jones?
19 COMMITTEE MEMBER JONES: Aye.
20 COMMITTEE SECRETARY HOPPER: David Miller?
21 COMMITTEE MEMBER MILLER: An enthusiastic aye.
22 COMMITTEE SECRETARY HOPPER: Eraina Ortega?
23 COMMITTEE MEMBER ORTEGA: Aye.
24 COMMITTEE SECRETARY HOPPER: Ramon Rubalcava?
25 VICE CHAIRPERSON RUBALCAVA: Aye.

1 COMMITTEE SECRETARY HOPPER: Theresa Taylor?
2 COMMITTEE MEMBER TAYLOR: Aye.
3 COMMITTEE SECRETARY HOPPER: Shawnda Westly?
4 COMMITTEE MEMBER WESTLY: Aye.
5 COMMITTEE SECRETARY HOPPER: Karen Greene-Ross
6 for Betty Yee?
7 ACTING COMMITTEE MEMBER GREENE-ROSS: Aye.
8 COMMITTEE SECRETARY HOPPER: Mr. Chair, we have
9 all ayes. Ramon Rubalcava making the motion, Margaret
10 Brown seconding it.
11 CHAIRPERSON FECKNER: Motion passes. Thank you
12 very much. Thank you, Mr. Moulds.
13 That bring us to Agenda Item 7.
14 7a, Risk Mitigation Strategies, HMO and PPO
15 organizations.
16 Ms. Green.
17 (Thereupon an overhead presentation was
18 presented as follows.)
19 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
20 CHIEF GREEN: Good morning, Mr. Chair and members of the
21 Committee. Marta Green, CalPERS team member.
22 As you said this is Agenda item 7a, HMO and PPO
23 Risk Mitigation Strategies. This is an information item.
24 And it is a continuation of our earlier conversations
25 we've had regarding how risk fragmentation is creating

1 significant issues within the CalPERS portfolio.
2 During the January stakeholder forum, we spoke at
3 length with our stakeholders regarding the challenges in
4 the PPO basic portfolio. Then during the July off-site,
5 we discussed the challenges the entire CalPERS basic
6 portfolio is currently facing related to risk
7 concentrations, risk pool fragmentation, and adverse
8 selection.
9 Over the past couple months, we investigated a
10 list of potential solutions and modeled preliminary
11 premium impacts for the next few years under each
12 scenario. Today, I'm very pleased to share our modeling
13 results for those risk mitigation strategies, as well as a
14 holistic overview of how implementing the different
15 strategies would affect the portfolio of CalPERS basic
16 health plans.
17 Based on our discussion today and a stakeholder
18 process to be completed over the next two months, we will
19 bring final recommendations for your consideration and
20 action in November.
21 Next slide, please.
22 --o0o--
23 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
24 CHIEF GREEN: So I'll start today with a brief refresher
25 on the challenges our portfolio is currently facing

1 related to risk concentration and our previous approaches
2 to mitigating risk. Then we will show what the CalPERS
3 portfolio will face if no action is taken to address risk.
4 We have modeled what will happen to premiums and risk if
5 no changes are made and no risk mitigation strategy is
6 implemented.
7 We've worked hard to model all possible risk
8 mitigation interventions and we will walk you through
9 each. First, I will show you what a reinsurance or stop
10 loss approach would do to our portfolio. After that, we
11 will get into various scenarios for plan eliminations or
12 mergers and see how those would impact our program.
13 Then we will review a portfolio rating approach,
14 a concept that we first discussed in July. I will discuss
15 two approaches to portfolio rating, one for PPO and one
16 for the HMO.
17 As part of this section, I will highlight a few
18 benefit design alternatives that could be considered for
19 the PPO basic plans. Lastly, I will discuss next steps
20 for the project.
21 Next slide, please.
22 --o0o--
23 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
24 CHIEF GREEN: As you recall, CalPERS ended risk adjustment
25 in 2019 due to the complexity and lack of transparency

1 with the prior risk-adjustment model. Since then, the
2 premiums for our basic health plans have no longer been
3 priced upon the value of the benefit design network, but
4 rather on the concentration of healthy or unhealthy lives
5 in them.
6 As premiums in the high-risk plans increase,
7 members in these plans were required to either assume a
8 greater financial burden or leave their health plan. As a
9 result, a few of our plans are in what's called a death
10 spiral, a cycle in which premiums increase from one year
11 to the next, members then leave that plan because of those
12 increases, and then the premiums consequently increase
13 even more because risk is worse.
14 As we mentioned in July, currently these plans
15 are PERSCare, Anthem Traditional HMO, and Blue Shield
16 Access+. And our projections indicate that Health Net's
17 SmartCare is also on its way.
18 I just want to pause here briefly to highlight
19 how quickly adverse selection occurs. Risk adjustment was
20 removed just two years ago and three plans are already
21 nearing unsustainability. Without mitigating the impact
22 of risk concentration, health plans are forced to reduce
23 their health care costs to remain competitive in our
24 portfolio by introducing low cost and narrow network
25 alternatives to attract healthy risk, exiting high-cost

1 areas, and/or removing high-cost and high-value providers
2 from their networks.
3 In short, plans are not currently competing on
4 cost and quality, but instead on how they can attract
5 members that use little or no health care.
6 Because the HMO basic portfolio is experiencing
7 similar issues due to risk concentration as the PPO basic
8 plan, we combined our previously launched PPO assessment
9 project with a larger effort to address risk concentration
10 in the entire basic portfolio.
11 At the July off-site, we discussed the need to
12 address risk and the various approaches that could be
13 considered. Today's presentation models the various
14 options for consideration.
15 Next slide, please.
16 --o0o--
17 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
18 CHIEF GREEN: We looked at a variety of strategies to
19 manage risk in our basic portfolio. The team analyzed
20 historical member migration data and members responses to
21 premium and provider network changes. Based on that
22 study, the team modeled out premium projections for 2022
23 to 2026 for each scenario based on 2019 data. Projections
24 factor in member migration among the plans and how the
25 population risk changes in each plan over time.

1 I should note, however, that there are no
2 COVID-19 impacts assumptions included in the projections.
3 This is because there is great uncertainty over the future
4 cost of impacts of COVID-19, and those uncertainties could
5 potentially cloud the modeling.
6 The goal of risk mitigation is to remove the risk
7 component in the current premium rate, so that members can
8 enroll based on the true value of the health plans they
9 choose. We will discuss what each scenario does and how
10 it gets us closer to risk neutral premiums.
11 I also want to pause here to note that the
12 projected premiums we are sharing today are solely for the
13 purpose of our risk mitigation discussion and they are not
14 representative of final premiums, which will be
15 aggressively negotiated by the CalPERS team and approved
16 by the PHBC each summer.
17 The modeling considers average annual health care
18 unit cost increases, also known as health care inflation,
19 in making its projections. There's a couple of caveats I
20 want to share before we jump into the modeling. The first
21 is that we are using the risk scoring tool that is
22 currently embedded in our health care data warehouse for
23 modeling. It is the same risk scoring tool that we use
24 when we discuss rates with you in closed in April and in
25 open session in June and at the July off-site.

1 As we discussed previously, we are looking at
2 multiple tools to evaluate risk with the goal to use a
3 transparent, widely adopted approach. We are in active
4 conversations with our consultant actuaries, plans, and
5 colleagues from other agencies and purchasers that
6 mitigate risk to identify the best possible approach.
7 When we bring this item to you in November, it will be
8 with the best risk scoring tool for our portfolio.
9 Secondly, I'm only showing you the larger plans
10 in this presentation. Plans with small enrollment can
11 have larger year-over-year risk score fluctuations,
12 especially if the risk school -- pool is as fragmented as
13 ours is. The final modeling, which we will show in
14 November, will include the smaller regional plans as well.
15 With that being said, I'll dive into the modeling
16 results.
17 Next slide, please.
18 --o0o--
19 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
20 CHIEF GREEN: So the first thing we modeled -- or the
21 first scenario here is the status quo. If we don't manage
22 risk within our portfolio, the basic plan premiums will
23 continue to be impacted by adverse selection. As the
24 healthier members migrate to lower cost options, the broad
25 network plans retain a greater proportion of high-cost

1 members with more health care needs relative to other
2 plans.
3 While the differences in concentration of high
4 and low health risk among the plans keeps increasing, the
5 model shows an increasing disparity between premium and
6 product values.
7 So I'm going to start with these specific
8 examples. The chart to the left shows the modeling
9 results for PERS -- Basic PERSCare. As a reminder,
10 PERSCare is a broad network PPO plan with an actuarial
11 value of 93 percent. This plan has the members with the
12 highest medical needs among the entire basic portfolio.
13 The pink bars represent the published premium for
14 2021 and the projected premiums from 2022 to 2026, which
15 is pricing based on risk. The green bars represent the
16 premiums for the plans priced -- price based on the value
17 of the product. Absent intervention, by 2026, the
18 PERSCare premium is approximately 70 percent higher than
19 its value.
20 The chart to the right is PERS -- is basic PERS
21 Select. PERS Select is a slightly narrower network PPO
22 plan with an actuarial value of 86 to 88 percent depending
23 on how many of the VBID elements each member takes up,
24 which means it has a slightly higher member out-of-pocket
25 cost compared to PERSCare.

1 The PERS Select premium is currently underpriced
2 due to the concentration of healthy risk. Over time, the
3 disparity between plan premium and value continues to
4 widen.
5 Next slide, please.
6 --o0o--
7 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
8 CHIEF GREEN: In the HMO portfolio, we see the same
9 patterns as in the PPO portfolio. The chart to the left
10 is the premium projections for Anthem Select, which is a
11 narrower network HMO plan compared to other plans offered
12 by Anthem. Anthem Select is another plan that is
13 currently underpriced due to its concentration of heath
14 risk. The model also shows that the projected risk-driven
15 premiums are below the plan's value from to 2022 to 2026.
16 To the right is Anthem Traditional. Again, it
17 has a broader network compared to Anthem Select and is
18 offered in many high-cost low-competition areas of our
19 State. Opposite of Anthem Select, Anthem Traditional has
20 a concentration of unhealthy risk. Like PERSCare, the
21 high premium increases cause healthy lives to move out of
22 the plan triggering a death spiral.
23 Next slide, please.
24 --o0o--
25 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

1 CHIEF GREEN: To the left, we have Blue Shield Access+.
2 When risk adjustment ended in 2019, Blue Shield Access+
3 kept their premium rate relatively low by exiting the more
4 costly Bay Area counties. And the Board approved spending
5 $99 million to buy down the rate in 2019.
6 As one of the broad network HMO plans, Access+
7 has a concentration of unhealthy members, which drives its
8 premiums above the plan value. The disparity becomes even
9 more prominent between 2022 to 2026.
10 When Access+ exited the Bay Area to cut costs,
11 these high-cost members had to migrate to other plans,
12 most notably Health Net SmartCare. As we see in the chart
13 on the right, we project that as -- that as soon as 2023,
14 SmartCare's premium will exceed its value and the
15 disparity will worsen into 2026 as healthy lives move out
16 of the plan to avoid the higher premiums.
17 Next slide, please.
18 --o0o--
19 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
20 CHIEF GREEN: The next plan is Kaiser. As you know,
21 Kaiser is the largest plan in our portfolio and has about
22 50 percent of our basic membership. As a result of its
23 size, Kaiser's risk score is the median for the portfolio,
24 and therefore its premium is defined as risk neutral.
25 UnitedHealthcare is currently underpriced

1 relative to its value. Like PERS Select PPO, and Anthem
2 Select HMO, UnitedHealthcare is also benefited by the
3 concentration of healthy members.
4 Next slide, please.
5 --o0o--
6 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
7 CHIEF GREEN: So now I'm going to get into various
8 alternatives. As we discussed in July, reinsurance is a
9 risk mitigation typically used to protect an entire
10 portfolio of products from outlier high cost claims.
11 The Affordable Care Act used reinsurance as a
12 short-term risk mitigation strategy while the new
13 individual market plans were launched. California and the
14 federal exchange phased out reinsurance after three years.
15 Different than a traditional reinsurance
16 arrangement for this option, we used the principle of stop
17 loss reinsurance to model a premium adjustment. In this
18 scenario, we modeled a 250,000 stop loss point based on
19 per member per year total health care costs in each plan.
20 In the process, these large claim costs are taken
21 out of the plan's experience and shared by all basic
22 members. Therefore, a health plan with a concentration of
23 healthy risk will have less of these large claims, but
24 will share the cost of those claims with plans that have a
25 concentration of unhealthy lives.

1 The challenge with this methodology is it still
2 incentivizes health plans to chase healthy risk and
3 discourages plans to manage high-cost members, since their
4 claims no longer impact the premiums. To put it simply,
5 if a plan's member -- if a plan member costs exceed
6 $250,000, that member's costs are no longer the
7 responsibility of the plan to manage. These are the
8 individual cases we need -- that need the most care
9 management. And this approach incentivizes the plans to
10 focus elsewhere.
11 Let me walk you through the model results in the
12 next few slides.
13 Next slide, please.
14 --o0o--
15 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
16 CHIEF GREEN: So I'm going to walk you through some
17 individual plans and how reinsurance would impact
18 premiums. In general, some plans are partially benefited
19 and for others reinsurance actually exacerbates the
20 pricing issue and some plans have some very strange
21 results.
22 This slide shows the modeling for reinsurance
23 scenario for the two PPO plans. For PERSCare, the graphic
24 to the left, same as what we showed you in status quo.
25 The pink bars are the risk-driven premium and the green

1 bars are the premiums based on value.
2 As you can see, the reinsurance premiums, which
3 we're showing here in red, help reduce some of the risk in
4 the premiums for PERSCare, but it doesn't get you to the
5 true value of the plan, which is the green bar.
6 PERS Select, on the right, will become
7 problematic because the reinsurance pricing further
8 reduces the costs in the out-years and actually
9 exacerbates the pricing relative to value problem. Each
10 plan's members -- each plan's enrollment has a unique cost
11 distribution. And since the reinsurance approach
12 concentrates only on mitigating the highest cost claims,
13 and not average risk, PERS Select actually over-benefits
14 from this approach.
15 Next slide, please.
16 --o0o--
17 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
18 CHIEF GREEN: Similarly, reinsurance does very little to
19 address the risk-based pricing for Anthem Select. In the
20 out-years, reinsurance is actually projected to
21 overcorrect the premium issues for Anthem Traditional,
22 which would be problematic.
23 Next slide, please.
24 --o0o--
25 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

1 CHIEF GREEN: For Blue Shield Access+, reinsurance is
2 again only a partial solution. And the health care
3 SmartCare premiums are also overcorrected, such that the
4 premium is even further away from its value.
5 Next slide, please.
6 --o0o--
7 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
8 CHIEF GREEN: Next, I want to talk about an approach of
9 merging plans or simply removing plans that are currently
10 in a death spiral. We modeled two scenarios for the PPO,
11 one is removing PERSCare and the other is merging PERSCare
12 and PERS Choice.
13 For the HMO, we modeled a scenario for moving
14 Anthem Traditional and Blue Shield Access+. I want to
15 emphasize here that I -- we would not actually recommend
16 the removal of these plans from the current portfolio for
17 a couple of reasons.
18 The first is it removes HMO options for members
19 in several counties in California, as currently Anthem
20 Traditional and/or Blue Shield Access+ are the only HMO
21 options in these counties. Even in counties offering
22 other HMO options, removing these two plans causes
23 significant member disruption in ten other counties, as it
24 eliminates member's access to some of the major provider
25 groups that are not in the network for other HMOs.

1 So I would not recommend this on a policy basis,
2 but we wanted to show you that we thought through every
3 potential option to address risk.
4 In the next few slides, I'll walk you through the
5 scenarios and show you what the projected premiums would
6 look like in the next few years.
7 Next slide, please.
8 --o0o--
9 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
10 CHIEF GREEN: First, we modeled this scenario of removing
11 PERSCare in 2022. The chart to the left illustrates the
12 projected premiums for this scenario. After removing
13 PERSCare, the PERS Choice premium increased by about 13
14 percent in 2022, mainly driven by the addition of the
15 high-risk members from PERSCare.
16 After that, PERS Choice enters into the beginning
17 of a death spiral and its premiums quickly catch up to the
18 PERSCare level in a few years. At the same tame, PERS
19 Select premiums remain low and underpriced due to its
20 concentration of healthy risk.
21 To the right, we modeled a scenario in which we'd
22 create a new plan with a merged benefit design somewhere
23 between PERSCare and PERS Choice. For the sake of
24 modeling, we called it PERS Health. Very similar to
25 removing PERSCare, the projected premiums for this PERS

1 Health plan become unaffordable in a few years, as the new
2 plan quickly enters into a death spiral.
3 Next slide, please.
4 --o0o--
5 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
6 CHIEF GREEN: This next slide shows the projected premiums
7 for PERS Choice or PERS Health, because they'll be about
8 the same, and PERS Select compared to its plan value under
9 the scenario of removing PERSCare or merging PERSCare and
10 PERS Choice.
11 Since premiums are priced based on the underlying
12 health risk of the plan, PERS Choice plan premiums, or
13 PERS Health plan premiums are now above the plan value,
14 and this disparity gradually increases over time as
15 healthier members move out of the plan to lower cost
16 options. And PERS Select premiums continue to be lower
17 than its value due to the concentration of healthy risk.
18 Next slide, please.
19 --o0o--
20 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
21 CHIEF GREEN: The next option we modeled is eliminating
22 Anthem Traditional and Blue Shield Access+. These are two
23 broad network HMO products. Again, I would not recommend
24 this approach for the reasons I outlined earlier. If we
25 remove Anthem Traditional and Blue Shield Access+, the

1 chart to the left shows the projected premiums for Anthem
2 Select, with the pink bar as the risk-driven premium, and
3 the green bar is the pricing based on value.
4 This chart shows that removing two broad network
5 plans still won't close the gap. To the right is Health
6 Net SmartCare. The premiums continue to escalate and
7 eventually exceed the value of the product.
8 So, in sum, the modeling shows that merging plans
9 or eliminating plans would not move the remaining plan
10 premiums closer to plan value. It would simply remove one
11 death spiral and push risk around in the portfolio to
12 other health plans, and eventually cause those plans to
13 enter a death spiral.
14 Next slide, please.
15 --o0o--
16 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
17 CHIEF GREEN: We've just spent some time talking about a
18 variety of interventions that do not address the
19 underlying issue of adverse selection and risk pool
20 fragmentation. Now, I want to spend some time talking
21 about portfolio rating, the concept I introduced back in
22 July.
23 Portfolio rating is designed to address the
24 fundamental cause of our portfolio instability, while also
25 ensuring our plans are priced on their value, and our

1 carriers are incentivized to manage the health of our
2 members.
3 I'm going to walk through the modeling of
4 portfolio rating on the PPO including scenarios for
5 implementing portfolio rating in 2022, as well as an
6 option for two-year phase in to ease premium changes. We
7 will also show you some benefit design alternatives under
8 portfolio rating, including changing the PERS Select
9 benefits to mirror Covered California's Silver 70 plan, as
10 well as two-plan model we are calling for this
11 conversation PERS Platinum and PERS Gold. I will then
12 walk you through the portfolio rating of the HMO.
13 Next slide, please.
14 --o0o--
15 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
16 CHIEF GREEN: So the ultimate goal of portfolio rating is
17 to have the carriers in our portfolio compete based on the
18 value of their products, instead of chasing healthy lives.
19 Under portfolio rating, we have different approaches to
20 achieving value-based pricing for the HMO and the PPO.
21 On the PPO side, we can price each plan based on
22 the network and benefit differentials, while for the HMO,
23 we have to utilize a risk adjuster tool to remove the
24 underlying health risk from the pricing. This has to do
25 with what's common among the PPO plans and it's not shared

1 among the HMO plans.
2 Starting with the PPO, all of our PPO plans are
3 administered by a single third-party administrator, in our
4 case, Anthem Blue Cross, with the same business model, the
5 same care management tools and approaches, the same
6 underlying provider contracting, the same leverage and
7 provider negotiations, and the same geographic footprint,
8 which is the entire State.
9 Different among PERSCare, PERS Choice, and PERS
10 Select products are the provider network and benefit
11 designs such as deductible and coinsurance. All of these
12 have financial values associated with them. Therefore, we
13 can pool the entire PPO basic population together and
14 treat them as one health plan with tiers, then price the
15 PPO tiers based on the network and benefit differentials
16 between the plans.
17 The situation on the HMO slide -- or on the HMO
18 side is more complex. Other than the same benefit design,
19 we have a number of carriers within our HMO, and each one
20 of them have different business models, their approach to
21 care management is different, the nature of the contracts
22 are different in terms of their penetration of capitation
23 or fee-for-service arrangements. How much leverage and
24 influence a carrier has in a particular geographic
25 location as well as the varying geographic coverage and

1 provider networks.
2 From a pricing perspective, it is impossible to
3 have a standard way to measure each piece and individually
4 turn team into a value. Therefore, on the HMO side, we
5 have to remove risk from the pricing as opposed to price
6 basing on the network and benefit designs like we can on
7 the PPO.
8 As I mentioned in July, we discussed the HSS-HCC
9 Risk Adjuster Tool, which is used to risk adjust the State
10 and federal exchanges. But we are also considering other
11 tools that meet our needs, are transparent, and are widely
12 adopted. We are working on identifying and refining the
13 risk score methodology that is appropriate for the CalPERS
14 population. We used the MARA, M-a-r-a, risk score
15 methodology in the modeling for today's discussion as it
16 is readily available in our data warehouse and is the risk
17 scoring tool we use during the rate-setting process.
18 While we are focusing on the HHS-HCC risk scoring
19 tool, we will -- which will provide greater transparency
20 and is, as I said, used by the State and federal
21 exchanges, we expect very similar direction and relative
22 magnitude for modeling purposes as we see with the MARA
23 risk scoring tool.
24 Next slide.
25 --o0o--

1 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
2 CHIEF GREEN: I'm going to start naming the slides. This
3 is slide 19, so those that are on the phone can follow
4 along.
5 So again slide 19. So let's start on the PPO.
6 In this scenario, we show that the portfolio rate and
7 price the products based on value starting in 2022, there
8 is a significant change in the first year, then premiums
9 become much less volatile then they have been in recent
10 years.
11 This chart shows the 2021 risk-driven premiums
12 for the three PPO plans, and then premiums for 2022
13 through 2026 price based on the plan's value.
14 Under portfolio rating, all three PPOs have
15 stable premium increases year over year, as member
16 migration between the PPO plans are no longer impacting
17 the premiums. However, there are significant premium
18 changes in the first year of implementing portfolio
19 rating.
20 The PERSCare premium decreases by about 18
21 percent from 2021 to 2022 and PERS Select premium
22 increases by about 43 percent. Also, I'll get more into
23 this in a moment, you will see that there's very little
24 difference in the value between these three products.
25 Next slide, slide 20, please.

1 --o0o--
2 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
3 CHIEF GREEN: This is what it would look like if we phased
4 in portfolio rating over two years. As I just mentioned
5 in the previous slide, we projected significant premium
6 change in 2022 for PERSCare and PERS Select under
7 portfolio rating. In this scenario, the impact would be
8 spread over two years, 2022 and 2023. Here, you can see a
9 more gradual progression towards the risk neutral premium.
10 Another thing we can consider is to buy down the
11 PERS Select premium in 2022 using surplus in our Health
12 Care Fund. So you will have PERSCare and PERS Choice to
13 get to the risk neutral pricing in the first year. And
14 PERS Select would go halfway in 2022 and then reach risk
15 neutral pricing in 2023.
16 Next slide, slide 21, please.
17 --o0o--
18 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
19 CHIEF GREEN: The next benefit alternative for PERS Select
20 under portfolio rating. What we did here is we mirrored
21 the Covered California Silver 70 product, with 70 percent
22 actuarial value. What that means is the plan is paying
23 approximately 70 percent of the average health care cost
24 for members and members are responsible for 30 percent of
25 the cost.

1 I'm going to pause here to say that Covered
2 California's benefit design is a high deductible health
3 plan. This product is not consistent with CalPERS
4 approach to comprehensive health coverage and we will not
5 be recommending this approach in November.
6 However, we felt it important to show that it is
7 possible to create a low premium product, understanding
8 that cost sharing would be very significant. On the
9 graph, we have the purple bars representing the premium
10 projections for the PERSCare Silver 70 product and the
11 orange and green are PERSCare and PERS Choice.
12 Once again, this shows that PERSCare and PERS
13 Choice premiums and benefits are so similar when these
14 products are priced based on their value. Offering two
15 products with very similar benefit designs provides little
16 meaningful choice to CalPERS members. With that in mind,
17 the team came up with alternatives to consider.
18 Next slide, slide 22, please.
19 --o0o--
20 CHAIRPERSON FECKNER: Marta, before you move on,
21 I have a question.
22 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
23 CHIEF GREEN: Absolutely.
24 CHAIRPERSON FECKNER: Mr. Jones.
25 You're muted.

1 COMMITTEE MEMBER JONES: I could wait till she
2 finished. It's a general question. So I could wait till
3 she finished.
4 CHAIRPERSON FECKNER: Very good. Thank you.
5 Continue on, Ms. Green.
6 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
7 CHIEF GREEN: Thank you, Mr. Chair.
8 Okay. Here we are on slide 22. This chart
9 model -- this chart models replacing the current PERS PPO
10 products with two new products for which this presentation
11 were calling PERS Platinum and PERS Gold. These
12 placeholder names reflect the actuarial value middle tiers
13 used in the State and federal exchanges. With a PPO
14 lineup like this, we would have products that would have a
15 true distinction between their designs.
16 What you see on this chart is PERS Platinum, a
17 PPO plan with a 90 percent actuarial value. And PERS
18 Gold, a PPO plan with an 80 percent actuarial value.
19 Currently, PERSCare is approximately 93 percent
20 actuarial value and PERS Choice is at an 88 percent
21 actuarial value. And again, as I mentioned previously,
22 PERS Select is between 86 and 88, depending on how many
23 elements -- the VBID design elements member takes up.
24 So the PERS Platinum with a 90 percent actuarial
25 value is in between PERSCare and PERS Choice. Again, 90

1 percent actuarial value means the plan is responsible for
2 paying 90 percent of the anticipated health care costs and
3 the member is responsible for ten percent of the costs.
4 It's a very rich benefit design compared to other
5 commercial products offered in the market.
6 And then we have PERS Gold with an 80 percent
7 actuarial value, which -- with slightly higher
8 out-of-pocket costs than PERS Select. The projected
9 premium is slightly higher compared to the current Select
10 products, but you will see that it will remain over time a
11 very competitive product within the portfolio.
12 Although these actuarial values for PERS Platinum
13 and PERS Gold would be slightly different than Care,
14 Choice and Select, by working closely with our
15 stakeholders on their preferences and priorities, we can
16 ensure that the benefit designs feel similar to the
17 original product lineup.
18 With these two products, we would have a true
19 distinction and benefit in pricing under portfolio rating
20 of the PPO. We can achieve these actuarial values through
21 a variety of different benefit design options, including
22 various deductible and out-of-pocket cost options and the
23 choice of in and out-of-network benefit coverage.
24 The team is currently working on the various
25 benefit design options and we will engage stakeholders in

1 their preferences over the next two months. Then we can
2 bring options for consideration at the November PHBC.
3 Next slide, slide 23, please.
4 --o0o--
5 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
6 CHIEF GREEN: So between now and November for the PPO, we
7 well have a multi-phase stakeholder process. We will
8 model different Platinum 90/10 and Gold 80/20 benefit
9 designs, including network and cost sharing alternatives.
10 We're going to listen to our stakeholders and incorporate
11 their preferences. And our final design options will be
12 presented in November for a decision that would be
13 incorporated in the 2022 rate development cycle.
14 Next slide, slide 24, please.
15 --o0o--
16 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
17 CHIEF GREEN: Next, I'm going to talk about the HMO.
18 First, I want to step back and provide a global look at
19 what HMO pricing is doing right now and what it would do
20 under an HMO portfolio rating environment.
21 At the chart on the left, you see premium
22 projections in a line graph if we do nothing to mitigate
23 risk. As you can see, we have different products on very
24 different trajectories due to risk concentration. The
25 steeper the line means they're getting more unhealthy

1 lives. The most obvious is the red line at the top, which
2 is Anthem Traditional, which, as I said, is in a death
3 spiral.
4 The chart to the right shows premiums in a
5 portfolio-rated environment, with less volatility and
6 lower year-over-year rate increases. Also, the difference
7 between the lines reflects the value of the product
8 regardless of the risk concentration in the plan.
9 In the next few slides, we'll walk through the
10 scenarios on an individual plan basis.
11 Next slide, slide 25, please.
12 --o0o--
13 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
14 CHIEF GREEN: First, just as a reminder, that this
15 modeling is based on the MARA risk score tool, which is
16 currently embedded in our data warehouse. We're still
17 working towards identifying and refining the risk score
18 methodology that is appropriate for CalPERS. As I
19 mentioned earlier, we are considering the HHS-HCC risk
20 scoring model and other alternatives that meet our
21 objectives.
22 As a result, these premium projections are not
23 final. However, they're directionally correct. You may
24 see small movements in these projected premiums in
25 November when we use a final risk score in our model.

1 But back to graph.
2 Here's what will happen to Anthem Select and
3 Anthem Traditional under portfolio rating. Anthem Select
4 is currently benefited by the concentration of healthy
5 members. Therefore, it's pricing will go up when it's
6 reflecting the value of the product.
7 Anthem Traditional with its concentration of
8 unhealthy lives is the opposite. The premium will go down
9 to reflect its true value, once it's no longer in a death
10 spiral.
11 Next slide, slide 26, please.
12 --o0o--
13 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
14 CHIEF GREEN: Next, is Blue Shield Access+, which is in a
15 similar situation, albeit not as advanced as Anthem
16 Traditional. It is currently overpriced due to its
17 concentration of unhealthy risk, so the premiums would go
18 down with a move to portfolio rating.
19 Health Net SmartCare will likely see a slightly
20 more than normal premium increase in the first year, then
21 level off in the out-years as we prevent it from entering
22 a death spiral.
23 Next slide, slide 27, please.
24 --o0o--
25 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

1 CHIEF GREEN: For Kaiser, with 50 Percent of our basic
2 membership, the risk score wouldn't change if we portfolio
3 rate. The projected premiums for Kaiser are based on the
4 estimated unit cost increases, or health care inflation,
5 that we've seen trending in the health care market.
6 UnitedHealthcare would see a premium increase in
7 the first year, unless the plan improves efficiency or
8 makes other changes within the product to bring down the
9 premium. After the first year, the plan will level off to
10 a modest trend.
11 Next slide, slide 28, please.
12 --o0o--
13 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
14 CHIEF GREEN: For next steps. So if we are going to
15 proceed with portfolio rating in the HMO, we would need to
16 select the risk adjustment tool. As I said, our priority
17 is to select a transparent and known model. We are still
18 focusing on HHS-HCC, but will consider other tools as
19 appropriate.
20 We will then have to calibrate and normalize to
21 the CalPERS population as necessary. We would also need
22 to take a look at any year-over-year volatility in the
23 risk scores in the regional and small plan offerings, and
24 determine if any adjustments needs to be made based on
25 plan size. We then need to go through a process of

1 validating the risk scores for their carriers to make sure
2 our risk scores reflect their data regarding the
3 population in their plan.
4 Beginning with the stakeholder engagement
5 briefing last week, we will be discussing our approach
6 with our stakeholders over the coming months to get their
7 feedback. We will meet with representatives from each of
8 our distinct six stakeholder communities, including
9 employers, labor groups, retirees, and plans.
10 I truly only have two goals between now and
11 November, refining our approach and methodology with the
12 plans and spending as much time as possible understanding
13 the needs and desires of our stakeholders. Then we will
14 present a final risk mitigation strategy package and
15 modeling in November.
16 The last thing I'd like to reiterate here is that
17 if we don't mitigate risk concentration in our portfolio,
18 two things will happen. The first is that we will
19 continue to experience large member migration patterns and
20 death spirals in our various plan offerings. We are now
21 only two years out from removing risk adjustment and we
22 already have two HMOs and one PPO in a death spiral.
23 Without truly mitigating the underlying risk
24 concentration, the best we can do is close plan offerings,
25 which will just move the death spirals to other offerings.

1 This volatility puts this sustainability of our program at
2 risk.
3 This second thing I will -- that will continue to
4 happen without risk mitigation is the plans will continue
5 to compete on attracting healthy lives as opposed to
6 competing on costs and quality of care. Right now, the
7 primary way to reduce premiums for individual plans is to
8 have more healthy lives or by cutting out the high-cost
9 high-value providers.
10 This is in stark contrast to our goals of having
11 health plans do a better job negotiating with providers to
12 bring down costs and to improve the quality of the care
13 they are providing to our members, regardless of their
14 health conditions. We will not be able to achieve these
15 goals without a comprehensive risk mitigation strategy.
16 Next slide, which is the last side, slide 29.
17 --o0o--
18 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
19 CHIEF GREEN: So our overall next steps are to have our
20 robust stakeholder engagement process, refine the
21 portfolio rating methodology for both HMO and PPO,
22 determining any changes in benefit designs that we would
23 recommend, and bringing the final methodology and team's
24 recommendations for Board discussion and approval in
25 November.

1 And with that, that concludes my presentation.
2 I'm happy to take any questions.
3 CHAIRPERSON FECKNER: Thank you, Ms. Green and
4 thank you for the presentation. We certainly want to make
5 sure that our plans are viable, so this is a good
6 discussion to have. Even more importantly, we want to
7 have the least amount of impact to our members that we
8 can. So being able to work this out, I think is a great
9 job on your behalf and as well as your staff.
10 So thank you.
11 We have a couple of questions. Mr. Jones.
12 COMMITTEE MEMBER JONES: Yeah. Thank you, Mr.
13 Chair. Again, Ms. Green, thank you for an excellent
14 presentation. As usual, it's clear and easy to follow,
15 so -- and very informative.
16 I have a couple questions. One is that you made
17 reference to the reserves to buy down the premiums in 2021
18 early on. So my question is is whether or not that had
19 been removed from your projections going forward, since we
20 have no way to determine whether or not there will be
21 additional funds to buy down premiums going forward.
22 And the next question is that looking at this
23 overall health plan -- I mean, I've been on the Board now
24 12 years and I've seen significant changes where we've
25 removed risk adjustment. We've put it back. I've seen

1 the elimination of plans, and we -- expansion of plans.
2 How do we come to grips with these -- to avoid
3 these frequent major changes in our health plan
4 strategies, because it -- if our ultimate goal is to make
5 sure that our members are getting healthier and the cost
6 is affordable, how do we evaluate if every two or three
7 years we're changing some significant components of these
8 plans, so you can't get a handle on what's working and
9 what isn't working? So that's a concern I have in terms
10 of going forward.
11 And I know you mentioned that you're not
12 recommending eliminating any plans, but I mean, it's part
13 of that discussion. So I'd like to hear your vows on
14 those issues.
15 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
16 CHIEF GREEN: Absolutely. Thank you for both of those
17 questions. So the first question remind me. So we talked
18 about the elimination of plans. The first question,
19 remind me, Mr. Jones, was?
20 COMMITTEE MEMBER JONES: The buydown reserve.
21 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
22 CHIEF GREEN: They buydown. Thank you. Thank you.
23 Sorry.
24 I was paying so much attention to the second
25 question, which I find to be very intriguing that I forgot

1 the first question. So on the first question, so we
2 modeled the just one year of buydowns, because we have
3 some sense of where we may be with respect to reserves for
4 the 2022 pan year, but we cannot project where we would be
5 in 2023 and beyond.
6 COMMITTEE MEMBER JONES: Yes.
7 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
8 CHIEF GREEN: So for that projection, we simply looked at
9 2022. I cannot guarantee that we would have enough
10 reserves to do the buydown that we modeled. I think it is
11 reasonable to think that we would have that much reserves.
12 But a lot of whether or not we would have it has to do
13 with COVID and how many costs we see relative to COVID,
14 and whether or not we've got a lot of treatment costs
15 and/or vaccine-related costs that would make that buydown
16 not tenable.
17 But as of right now, I think it's reasonable to
18 assume we would have some reserves available for a buydown
19 in 2022 for PERS Select, which is specifically what we
20 modeled.
21 Okay. Our second question I agree that the
22 volatility in the portfolio is a big problem. And I think
23 that we've tried over time a number of different
24 strategies to mitigate risk. And so closing the plans or
25 trying to consolidate into single plans as we've modeled

1 here is a way that some organizations manage risk, without
2 doing portfolio rating.
3 The problem with a portfolio as big as ours and
4 as diverse as ours is to really do that well, you have to
5 go down to a single plan. And that excludes a regional
6 offering, that excludes a lot of things that are high
7 performing and are positive for our portfolio.
8 And so we can continue to do that, but it's again
9 going to just move that risk around to other products, and
10 then we will have to collapse those products. And I think
11 it's disruptive for our members, as you mentioned, and it
12 also just doesn't, at the end of the day, get to the
13 underlying issue of pricing everything relative to its
14 value or relative to risk-neutral pricing.
15 The prior risk adjustment strategy, as I
16 mentioned, had a number of issues relative to
17 transparency. It was complicated. It had four phases
18 with true-up that created unexpected results. Buy doing
19 portfolio rating, you don't have to -- you don't have
20 those complications. You don't have those issues that
21 could create the failure of the program. What we're
22 proposing here is very similar to what the State of
23 Washington does and other major purchasers, where they
24 simply rate on the front end a risk neutral premium as
25 opposed to attempting to do a lot of risk transfer

1 payments on the back end.
2 Does that address that question?
3 COMMITTEE MEMBER JONES: Yes, it does. So what's
4 the -- what's the solution then?
5 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
6 CHIEF GREEN: So my -- I believe that the solution is
7 portfolio rating, and then, as you said, stability, so
8 that we can come to a specific neutral stable platform.
9 We allow members to settle into their plans and we
10 monitoring the risk concentration and member migration
11 patterns from there.
12 Does that mean like we'd never recommend a change
13 in the future? No. But I think it's a much more stable
14 platform than the one we have today.
15 COMMITTEE MEMBER JONES: Okay. Thank you. And
16 that may have -- may go to the discussion going forward is
17 to have a discussion about a -- a no-change policy for
18 four to five years and see what the results may offer or
19 have a sunset clause or something like that.
20 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
21 CHIEF GREEN: At least a lot less change than we've been
22 seeing.
23 COMMITTEE MEMBER JONES: Yeah, right. Okay.
24 Thank you very much.
25 CHIEF HEALTH DIRECTOR MOULDS: I'll also -- I'll

1 also add just that, you know, there are a lot of other
2 large purchasers. This is the norm in the market. The
3 large purchasers like Medicare, Covered California have
4 been doing this for year and -- years, and without really
5 any drama. You know, I think -- I think we made it more
6 complicated by doing it in-house in a less transparent way
7 and ran into difficulties there.
8 But once we get this, it becomes something that's
9 knowable to the plans that they can factor into their
10 pricing decisions on a -- on an annual basis and that we
11 can make the adjustments. And the goal here is to
12 increase stability not to add instability.
13 COMMITTEE MEMBER JONES: Thank you.
14 CHAIRPERSON FECKNER: Very good. Thank you. I
15 have Ms. Taylor.
16 COMMITTEE MEMBER TAYLOR: Thank you, Mr. Chair.
17 So I have a couple of questions. You answered
18 one of my questions, which is what's the difference
19 between risk adjusting and portfolio rating. So I did get
20 that answered. Thank you very much.
21 MARA and risk scoring, which is the tool we use,
22 and that's developed by us, I take it.
23 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
24 CHIEF GREEN: No, it's not developed by us. It's just
25 naturally embedded in our data warehouse. And so there

1 are, that I'm aware of, at least six or seven well known
2 risk-adjusting tools or risk scoring tools. MARA is the
3 one that's currently embedded in the data warehouse. It
4 is a well-known tool that isn't typically used for the
5 purposes of portfolio rating. So that's why we're looking
6 at the HSS-HCC model as a risking scoring tool again. But
7 we're focusing on that model, but that isn't guaranteed
8 that that will be the best model for our population.
9 COMMITTEE MEMBER TAYLOR: And how do you
10 determine what's the best model?
11 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
12 CHIEF GREEN: So I -- there's a lot of different analysis
13 we're doing. One of the things that we do is we look at
14 the risk score outputs and compare it to claims
15 experience. So if you can look on an average per member
16 per month basis how much we are spending per person, per
17 member and seeing how that correlates with the risk score,
18 they should be longitudinally correct, right?
19 So plans with higher risk generally should see
20 higher than average claims or -- and encounters, right,
21 because some of them are embedded in the capitation. And
22 plans with lower risk scores should see lower. So you
23 should be able to see the claims volume migrating on the
24 same pattern as the risk score. So that's on.
25 We also look at pharmacy claims, so how do

1 pharmacy claims relate to the risk score, because in
2 general, people with greater health conditions or
3 co-morbidities have more pharmacy claims associated with
4 them. So you should say alignment amongst the various
5 things we can measure relative to our member's health
6 through the risk score and find the one that most closely
7 matches all of those ways in which we can measure our
8 own -- our own member's health status through their claims
9 data.
10 COMMITTEE MEMBER TAYLOR: And how long does -- do
11 you think it would take for us to determine which one fits
12 our population the best?
13 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
14 CHIEF GREEN: My goal is to have that determined in the
15 next 30 days.
16 COMMITTEE MEMBER TAYLOR: In -- Oh, wow. Okay.
17 That's pretty fast.
18 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
19 CHIEF GREEN: We've been working on this since July. So
20 we've done a fair amount of modeling. We've looked at
21 year over year. We've looked at MARA risk score outputs.
22 We've looked at pharmacy-only risk score outputs. And so
23 we're further along than I think in my presentation, which
24 I had to finish two weeks ago --
25 COMMITTEE MEMBER TAYLOR: I get it. I get it.

1 (Laughter.)
2 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
3 CHIEF GREEN: Yeah. Yeah -- than really was drafted in
4 this presentation. And we're still feeling really good
5 about the HCC model, but we want to be absolutely certain
6 before we bring the Board the recommendation.
7 COMMITTEE MEMBER TAYLOR: Now, I guess one of my
8 other questions is as we go through this are we -- like,
9 so we've got the portfolio rating. We've got the PO
10 process that we're going to go through, right, with a few
11 steps here to 90/10 and the 80//20, because we're trying
12 that out, and talking to stakeholders. And that's with a
13 two-year phase-in, right?
14 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
15 CHIEF GREEN: It -- the portfolio rating with the 90/10
16 and the 80/20 I did not model with a two-year phase-in.
17 Because they would be new products, it would be really
18 difficult to phase that in, because it would have all new
19 membership.
20 COMMITTEE MEMBER TAYLOR: Okay.
21 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
22 CHIEF GREEN: So if we were with the existing products, it
23 would be much easier to do a two-year phase-in, because
24 you already have a known population in each product and
25 you're just adjusting for the people that move.

1 COMMITTEE MEMBER TAYLOR: Okay.
2 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
3 CHIEF GREEN: But with two new products, we would not
4 necessarily be recommending a two-year phase-in on the
5 PPO. But if we stay with the current lineup, the
6 PERSCare, PERS Choice, and PERS Select, two-year phase-in
7 could be a recommendation.
8 COMMITTEE MEMBER TAYLOR: Okay. And then -- and
9 so as you roll this out to the stakeholders, do you
10 foresee a problem with going to the two programs rather
11 than the three. Do you I think that that's going to cause
12 some contention with our stakeholders and does it
13 reduce -- and here's a concern of mine. One other
14 question. Does it reduce the ability of our rural folks
15 to be able to access health care.
16 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
17 CHIEF GREEN: That's an excellent question. So I'm going
18 to take that one first and then I'm going to go back to
19 how we're managing the stakeholders.
20 I actually think it improves choice for the rural
21 membership, because right now if you want a broad network
22 plan with a rich benefit design, your only option is
23 PERSCare. And as I've modeled here, PERSCare is
24 incredibly expensive in compared to its value. So going
25 to a portfolio rating or risk neutral PERS Platinum and

1 PERS Gold model would reduce costs for those rural members
2 that would still have access to that broad network PPO,
3 that PERS Platinum product.
4 And as I said, we can actually calibrate each
5 piece of the benefit design to get us close to the
6 existing products as possible, meaning try to tailor the
7 cost sharing to -- as close as possible. They will be
8 some differences, because PERSCare is 93 percent. So if
9 we're going to compare PERSCare to PERS Platinum, PERSCare
10 is 93 percent, PERS Platinum is 90 percent. There will be
11 a little bit of change, but we can try to get as close as
12 possible. So from a member experience standpoint, it
13 feels a lot like PERSCare.
14 With PERS Select, it's a little bit different.
15 So I think the reason that we are modeling the 80/20
16 benefit design -- as I said in the presentation, so
17 there's a real difference between the two products,
18 because the other plans are so similar that there's not a
19 whole lot of difference or real choice. But also, we've
20 heard from our employer stakeholder community that it's
21 very important to have a lower premium PPO product for
22 some of their members, especially in the areas that don't
23 have HMO offerings.
24 And so this is going to create a product that is
25 going to look a lot like PERS Select with a slightly

1 higher premium once it's based on value. So we hope that
2 that meets the needs of our employer community as well.
3 So that's why we want to meet with each of the
4 distinct communities and ensure that what we're proposing
5 to you is the best lineup that we can, that solves as many
6 of their needs as possible.
7 COMMITTEE MEMBER TAYLOR: Well, this is a big
8 undertaking, and I really appreciate you working so hard
9 to get everything under control. I know it's not going to
10 control our medical costs. But to the degree that we can
11 help our members afford this, I really appreciate the work
12 you guys are doing. Thank you.
13 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
14 CHIEF GREEN: Well, and I believe that the stable
15 portfolio will give us greater opportunity to actually do
16 meaningful work on health care costs, because we will
17 have -- we will no longer be having health plans chasing
18 healthy lives, but instead will be truly incentivized to
19 manage per unit costs. And so that's where the
20 competition study and some of our other important work
21 comes in. And I think this portfolio is the right
22 platform to implement some of those solutions as well.
23 COMMITTEE MEMBER TAYLOR: Well, I appreciate
24 that. And I get Henry's point on change. And certainly
25 I've been -- I've only been here since 2014. I don't

1 remember now. But I've seen a lot of change. And I
2 remember asking the questions as to why we were dropping
3 the risk adjustment. I didn't realize it went -- lacked
4 transparency and that it really wasn't based on normal
5 risk adjustments that are done.
6 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
7 CHIEF GREEN: I've heard from many of our carriers as I
8 came on board that, you know, they would have risk scores
9 that would come out the other end that they didn't
10 understand. They didn't understand. Didn't seem to track
11 with their data and then they would have unexpected
12 results. And so we've been meeting with our carriers,
13 both as a group, as well as individually, and we have
14 committed to them that we would be providing transparency
15 to what the risk score looks like. We'd be validating it
16 with the carriers, so there would not be any unexpected
17 results.
18 COMMITTEE MEMBER TAYLOR: Awesome. Again, thank
19 you very much for the work.
20 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
21 CHIEF GREEN: Thank you.
22 CHAIRPERSON FECKNER: Thank you.
23 Ms. Middleton.
24 BOARD MEMBER MIDDLETON: Thank you, Mr. Chair.
25 And first, I want to thank Marta and all of her

1 team and Don for an incredible amount of work. I am just
2 wonderfully impressed with what you have done.
3 It's a very small thing, but a rich compliment
4 for the name change to PERS Platinum and PERS Gold. As a
5 36-year member who has had to check the difference between
6 Select, Care, and -- I don't know how many times to figure
7 out which one was the better program. I think I actually
8 will understand Platinum.
9 (Laughter.)
10 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
11 CHIEF GREEN: Well, thank you so much. It is a
12 placeholder name. And it's the pleasure of the Board if
13 that's -- if that's what you choose to adopt. But I think
14 it is clear and transparent what those products are if you
15 name them by their metal tiers.
16 BOARD MEMBER MIDDLETON: Thank you.
17 CHAIRPERSON FECKNER: Totally agree. Thank you,
18 Ms. Middleton.
19 Ms. Brown.
20 COMMITTEE MEMBER BROWN: Thank you, Mr. Chair. I
21 do agree with Ms. Middleton. I am always looking up the
22 difference between the different PERSCare, PERS Select.
23 So Marta, I want to make sure I understand what we're --
24 what we're sort of recommending. I think it's page 22 of
25 29. I mean, we're not recommending. It's just a

1 discussion.
2 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
3 CHIEF GREEN: Um-hmm.
4 COMMITTEE MEMBER BROWN: Going to the portfolio
5 rating PERS Platinum and PERS Gold, is that correct, what
6 we're aiming at?
7 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
8 CHIEF GREEN: Yes. So -- so --
9 COMMITTEE MEMBER BROWN: Recommending we aim for,
10 correct?
11 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
12 CHIEF GREEN: What I'm -- what I would like to bring to
13 you in November is a portfolio rating approach that has an
14 HMO element and a PPO element. And that on the PPO side,
15 I would like to model and present to you for consideration
16 a new product lineup that has distinction between the
17 products, so that's the PERS Platinum and PERS Gold. So
18 it's a little bit of a two-phaser, right?
19 So the first piece of it is the portfolio rating
20 piece, which has two elements, right, HMO and PPO. And
21 then also potentially a new lineup within the PPO. We
22 don't have to do both. We could simply do portfolio
23 rating and leave the PPO as it is. I believe that the
24 two-plan lineup will make more sense in a portfolio
25 environment.

1 COMMITTEE MEMBER BROWN: Great. And then we
2 would still have 90/10 and an 80/20, right, the Gold is
3 80/20, the Platinum is 90/10. Okay. Good.
4 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
5 CHIEF GREEN: Yep.
6 COMMITTEE MEMBER BROWN: So you talk about
7 calibrate to make it feel the same. And so just give me
8 some ideas of what you think about in terms of
9 calibration?
10 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
11 CHIEF GREEN: Okay. So the -- when I talked about
12 calibration, a lot of that is taking the risk-adjustment
13 tool and ensuring that all -- so HCC in the
14 risk-adjustment tool that we're focusing on stands for
15 health care condition. And what it does is it scores
16 different health care conditions based on the claims that
17 are fed into it.
18 And so there are times at which some health care
19 conditions are more prevalent in one population versus
20 another. And so we need to make sure that in -- and this
21 is part of the normalization process, so thinking about
22 our risk scores versus what's the plan's claim experience.
23 Some of that modeling I was talking about just a few
24 questions ago. That calibration is do we have to change
25 the weighting between any of the risk -- any of the health

1 care conditions because they're more or less prevalent
2 within our population than they are on say the federal
3 exchange.
4 My desire is to not have to do that, not have to
5 change any of the weighting, but we have to see the full
6 results and make sure that everything makes sense before
7 we determine whether or not any calibration of the HCC
8 model is required.
9 But I think your question was more designed
10 towards the benefit design structure and how we can make
11 the benefit designs feel to the member more like the
12 benefit designs in their existing products, so the
13 PERSCare, PERS Choice, and PERS Select. So the way in
14 which we do that is you have a whole menu of different
15 options you can use to get to a 90 percent or an 80
16 percent actuarial value. There are choices like is your
17 copay X or Y, you know, $10 or $20, $20 or $40 dollars?
18 Is it a coinsurance, is it ten percent, 20 percent, 15
19 percent? What are those different amounts? What is the
20 out-of-network benefit look like? Do you have a limited
21 out-of-network benefit? Do you not have an out-of-network
22 benefit?
23 All of those things roll up into an actuarial
24 value to get you to the 90/10, and so the -- or the 80/20.
25 So the point of the stakeholder process is to maybe model

1 four different options or ten different options for each
2 product, so the 90/10 and the 80/20, and try to get one of
3 them as close to the existing PERSCare/PERS Choice product
4 design for the 90/10 and the PERS Select product design
5 for the 80/20, and see if there's any preferences that the
6 stakeholder community has for a little bit more here, a
7 little bit less there, a little bit more generous, a
8 little bit less generous based on their desires for their
9 health care product.
10 And then we can bring a 90/10 and 80/20 product
11 to the Committee for consideration that reflects the
12 stakeholder desires and is as close to the existing
13 product lineup as possible.
14 Does that help?
15 COMMITTEE MEMBER BROWN: It does, because I
16 had -- when you said calibrate, but I had also write down
17 -- wrote coinsurance/copay, so --
18 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
19 CHIEF GREEN: Yeah. Yeah.
20 COMMITTEE MEMBER BROWN: -- the same thing.
21 And again, I remember I think I was just on the
22 Board when we increased the copays and it was a very
23 unhappy time for our members.
24 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
25 CHIEF GREEN: Yep.

1 COMMITTEE MEMBER BROWN: And so I don't think
2 they are going to be happy, but -- especially with the --
3 our lower cost PPO going up, it looks like 527 to maybe
4 606 under this current what you're looking at.
5 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
6 CHIEF GREEN: Um-hmm. It would be --
7 COMMITTEE MEMBER BROWN: Yeah, and that's a
8 big -- and that's a big jump already. But I do appreciate
9 this and will look to see what the stakeholders will say.
10 Thank you.
11 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
12 CHIEF GREEN: Thank you.
13 CHAIRPERSON FECKNER: Thank you.
14 Mr. Rubalcava.
15 VICE CHAIRPERSON RUBALCAVA: Thank you, Mr.
16 Chair. Thank you, Don. Thank you, Marta. This is
17 amazing. I just want to start -- I have a couple
18 questions, but I want to start by framing by I think our
19 Committee Chair started correctly, we're -- we want viable
20 plans, but we also want to be mindful of the impact to the
21 members.
22 And so I'll start with the second part first, our
23 members. One thing that always seems to go counter to our
24 best plan designs, our best science, whatever, is that not
25 everybody plays with those rules. There's so many

1 provide -- there's so many -- there's the hospital,
2 there's the insurance company, and the medical groups.
3 And they have conflicts of interest. And I'm worried
4 about the member. So sometimes we -- I like what you said
5 that they shouldn't be trying to chase the best risk and
6 they should try to have -- I mean, they're in this
7 business -- I mean, the medical groups are in the business
8 to try to care -- take care of our members. And that's
9 what I want to see that there's an incentive for outcomes,
10 that if they're -- that they have chronic illness, we
11 should treat that chronic illness. If they're
12 pre-diabetic, they should keep them -- make sure they
13 don't go to the diabetic stage.
14 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
15 CHIEF GREEN: Um-hmm.
16 VICE CHAIRPERSON RUBALCAVA: And that's what I
17 want to make sure that we have incentives. And somehow --
18 sometimes I think we don't allow that to happen, because
19 there's -- so that's -- so that's my concern is that
20 there's always going to be people who are going to try to
21 game the system.
22 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
23 CHIEF GREEN: Yep.
24 VICE CHAIRPERSON RUBALCAVA: For example, I'm
25 worried about -- our members really have loyalty to their

1 doctors, but sometimes they're not sure or they don't know
2 whether that doctor is -- has the best clinical practices.
3 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
4 CHIEF GREEN: Um-hmm.
5 VICE CHAIRPERSON RUBALCAVA: Are they maintaining
6 them? Are they improving their health? Are they trying
7 to improve their health? And it's -- and that's something
8 I wish we had a way to gauge.
9 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
10 CHIEF GREEN: Yep.
11 VICE CHAIRPERSON RUBALCAVA: And so that goes to
12 my first question. I was going to start with a -- the
13 member impact, but let me go through this whole thing. I
14 know that, at least what I read about, the science about
15 this -- that these quality narrow networks are designed
16 because they have proven medical groups that can focus
17 on -- I hate the word "managed care", but they focus on
18 making sure that they engage with the members, and they're
19 taking their numbers, and they're improving those numbers,
20 medical groups.
21 And so how -- where is there a row for those --
22 is there a -- how does this -- how -- can you explain to
23 me how this profile rating, how would that impact with the
24 plan design when some groups may have more than one ACO,
25 or they have different quality networks, and they're

1 contracting is all over place or -- you know, their
2 variance between fee-for-service versus con -- concen --
3 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
4 CHIEF GREEN: Capitation.
5 VICE CHAIRPERSON RUBALCAVA: -- capitation?
6 Thank you.
7 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
8 CHIEF GREEN: Yep. Yep.
9 VICE CHAIRPERSON RUBALCAVA: Yes. Yes. That
10 one. How have we done with that? That's the first
11 question. Then I have two more. Thank you.
12 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
13 CHIEF GREEN: Okay. So I'll start --
14 VICE CHAIRPERSON RUBALCAVA: Sorry for all the
15 preamble. Sorry.
16 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
17 CHIEF GREEN: No, you're fine. Absolutely great.
18 So I'll start with the quality of care that is
19 provided to the members. This is the managing of the
20 chronic condition. This is ensuring that members are --
21 remain healthy throughout the course of their lives. And
22 so in addition to incentivizing with pricing to be aligned
23 with care management, which is what portfolio rating does,
24 the other thing that we do have, and we're continuing to
25 improve on, is the performance measurement in our

1 contracts.
2 VICE CHAIRPERSON RUBALCAVA: Okay.
3 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
4 CHIEF GREEN: And so we have a variety of things that we
5 measure health plan performance. And a percentage of
6 their administrative service fee is at risk based on their
7 performance against those measurements. And we're focused
8 on some of the key chronic conditions including diabetes
9 that you mentioned, as a measurement of performance.
10 And so all of our health plans are currently
11 required to be active participants in their member's care
12 management, some to more effect than to others. But the
13 complication of the existing scenarios on top of that, so,
14 you know, they have to do it or they could lose some
15 administrative services fees, which is true.
16 But then also they're advantaged in the market --
17 in the CalPERS market by getting rid of some of those
18 lives, which is not what we'd want them to do. So what we
19 want them to do is be incentivized to keep those lives and
20 manage the care, so they'd do -- their members are taken
21 care of, but also so that they perform well against their
22 performance measurement.
23 So I'll just pause to say that I don't think that
24 our existing performance measurement scheme, although it's
25 robust, it is not perfect. And we are thinking about ways

1 that we can align those performance measurement with other
2 major public purchasers, like the Department of Health
3 Care Services, which purchases on behalf of Medi-Cal and
4 Covered California.
5 Because if you think about if we all pooled our
6 resources together, so the 13 million in Medi-Cal, the 1.5
7 in Covered, and our 1.5 all together, that's a lot of
8 Californians that are pushing the health plans all in the
9 same direction. So we think that we can do some pretty
10 cool stuff by aligning on certain determinants.
11 But to your second questions, I think it's
12 actually a great question, that ACO question. So that's
13 what Trio is, as an example. Trio is an accountable care
14 organization product and it was developed and designed to
15 do specifically the thing that you are talking about,
16 which is really pushing a lot of the care management
17 responsibility to the high-functioning medical groups that
18 need to coordinate closely with their members to help them
19 manage their chronic conditions.
20 And that -- we want to encourage those in the
21 network, but we don't want to encourage those in the
22 network just for the purpose of attracting healthy lives
23 that don't need that care management. We want those in
24 the network to actually also deal with the chronic
25 conditions. And so part of that is this risk-neutral

1 pricing. So when members make their selection, they pick
2 the product that best meets their needs, as opposed to
3 just the one that's either cheaper or maybe because their
4 employer covers it 100 percent, they just pick the
5 expensive one because they think it's the best, when it's
6 not actually priced on its value.
7 So I'm hoping over time that we will see more of
8 our carriers integrate accountable care organization type
9 contracting models within their existing arrangements.
10 VICE CHAIRPERSON RUBALCAVA: Thank you.
11 And my second question relates to the second --
12 thank you for those. Excellent. Performance metrics. I
13 knew that. Thank you. I forgot.
14 Mercer helped you do the new medication strategy,
15 but there were also doing some study or you guys were
16 working on some sort of what is the right mix. Is this
17 part of that study or is that a separate study that we're
18 still expecting?
19 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
20 CHIEF GREEN: That's the competition study, which we will
21 have --
22 VICE CHAIRPERSON RUBALCAVA: Competition study,
23 right.
24 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
25 CHIEF GREEN: And that's with -- not with Mercer, but

1 that's with Bates White and includes --
2 VICE CHAIRPERSON RUBALCAVA: Okay.
3 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
4 CHIEF GREEN: -- Leemore Dafny, the professor from
5 Harvard --
6 VICE CHAIRPERSON RUBALCAVA: That's right.
7 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
8 CHIEF GREEN: -- that joined us at the July off-site.
9 Yep.
10 VICE CHAIRPERSON RUBALCAVA: And where is that
11 at, the competition study?
12 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
13 CHIEF GREEN: We'll have -- I'm hoping to have some
14 preliminary information by November, but we will have full
15 results by the end of the year.
16 VICE CHAIRPERSON RUBALCAVA: Thank you.
17 And my last question is a lot of my colleagues
18 talked about the impact on the stakeholders. And I'm glad
19 you're going to engage with them and what have you. But I
20 think one thing that would be helpful for them to
21 understand is you mentioned a lot how death spiral and
22 people basically vote with their feet. They walk to --
23 the people who are sick stay with the doctor. The people
24 who are healthy walk.
25 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

1 CHIEF GREEN: Yep.
2 VICE CHAIRPERSON RUBALCAVA: It would be helpful,
3 I think, if you share the -- the enrollment numbers and
4 see -- so they can see the trends how they have changed.
5 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
6 CHIEF GREEN: Yep.
7 VICE CHAIRPERSON RUBALCAVA: Because you
8 mentioned it, you know, how some plans are impacted
9 because they leave an area and then other people had to
10 pick them up. But if you could show the numbers, I think
11 that would be helpful. I mean --
12 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
13 CHIEF GREEN: Yes, we can --
14 VICE CHAIRPERSON RUBALCAVA: Like what was
15 occurring -- you know, like who's growing at the expense
16 of what, you know, for example. I think that would be
17 helpful, I think.
18 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
19 CHIEF GREEN: Yeah, absolutely. We can show enrollment
20 over time. That's an easy add. And what we will intend
21 to do is a shorter version of this presentation to begin
22 those conversations. And then -- and we can include all
23 of the enrollment information as you suggest. And then
24 we'll talk about different benefit design alternatives and
25 get their feedback.

1 VICE CHAIRPERSON RUBALCAVA: Thank you for doing
2 that. And again, I compliment you and all the work you
3 guys are doing. Don, you have a good shop there.
4 Thank you, Marta. Appreciate it.
5 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
6 CHIEF GREEN: Thank you.
7 VICE CHAIRPERSON RUBALCAVA: Thank you, Mr.
8 Chair.
9 CHAIRPERSON FECKNER: Thank you.
10 Ms. Olivares.
11 BOARD MEMBER OLIVARES: Thank you, Mr. Chair.
12 Ms. Green, would it be possible to get a list of
13 the chronic conditions that outcomes are managed for?
14 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
15 CHIEF GREEN: In the performance guarantees in the
16 contract?
17 BOARD MEMBER OLIVARES: Yes.
18 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
19 CHIEF GREEN: Yeah, I can send that. I can get that to
20 you. I don't have it off the top of my head, but I can.
21 BOARD MEMBER OLIVARES: How do we ensure equity
22 when it comes to looking at chronic conditions?
23 So chronic conditions can vary by race and
24 gender.
25 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

1 CHIEF GREEN: Yeah. Yeah, that's an excellent question.
2 So I think we've discussed here in this Committee, but I
3 welcome Don to jump in, that CalPERS does not currently
4 collect race and ethnicity data. And that is a project
5 that we're undertaking, so race, ethnicity, gender
6 identity. So we're -- the full, what they call the SOGI,
7 information. We are going to start to collect that. And
8 then we are gong to design performance incentives that are
9 specific to the disparities in health care delivery by
10 those different categories that we do not currently do.
11 So currently, health plans only are reporting on
12 the aggregate irrespective of race, ethnicity, gender,
13 gender identity, except for those conditions, of course,
14 that only impact one gender.
15 But in sum, they're not differentiating between
16 the different categories. But it is a strong goal of mine
17 personally, as well as the health team broadly, to be able
18 to measure those on all of those important elements,
19 because we all know that health outcomes vary distinctly
20 on those categories.
21 CHIEF HEALTH DIRECTOR MOULDS: Yeah, so just --
22 just --
23 BOARD MEMBER OLIVARES: What's the approximate --
24 CHIEF HEALTH DIRECTOR MOULDS: Sorry. Go ahead.
25 BOARD MEMBER OLIVARES: What's the approximate

1 timeline on that?

2 CHIEF HEALTH DIRECTOR MOULDS: So we have -- so
3 let me -- let me back up for one second. So we don't
4 collect the race and ethnicity data in myCalPERS. We
5 collect it -- we've started collecting it on -- in our
6 surveys, but we have not been -- we have not been
7 stratifying it, which means that we haven't been using it,
8 and essentially using the data to look at any
9 discrepancies in quality, or access, and so forth.

10 So we're going to be collecting it across the
11 board, so that we can know the difference between the
12 experience with respects to grievances and outcomes of
13 those grievances on the CalPERS side, and then we're going
14 to be stratifying it in our surveys, so we'll have a
15 better sense of everything from access to outcomes.

16 The technical work that's going on on the CalPERS
17 side is going on now and we expect it to be completed in
18 January. So there's quite a lot of programming that goes
19 into this. The initial timeline was out well into the
20 spring. We've pushed it working with our IT folks back to
21 as soon as we can. The -- the stratification work on the
22 surveys is going to begin with the -- with the next survey
23 that comes in, which -- which is the 2021 survey. And I
24 think that comes in the fall. Dr. Logan is, I know,
25 available if I've messed up that date, but I think that's

1 right.
2 But so we've -- the other thing that I'll add
3 we've been doing, this is something that -- that, as I
4 think you know, enterprise-wide has been a priority is
5 we've been out talking with Medi-Cal, and particularly
6 with Covered California about what they do and other
7 initiatives that we can undertake together to make a
8 difference in this space.
9 It is -- the entire health leadership team, this
10 is something that is a top priority for us. It's
11 something where we feel like we really want to make a
12 difference. And frankly, we do not have -- right now, we
13 haven't historically had the picture into any disparities
14 that -- that exist. And knowing what we know about the
15 health care system in the United States, it's likely that
16 some of those exist in our membership as well. The first
17 step is really understanding and getting a clearer picture
18 of what's going on here. The next step are initiatives.
19 BOARD MEMBER OLIVARES: Thank you. So that's the
20 output process, right, in terms of collecting that data on
21 any disparities. But on the input, how do we select our
22 current list of chronic conditions?
23 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
24 CHIEF GREEN: Oh, for performance measurement?
25 BOARD MEMBER OLIVARES: Yes.

1 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
2 CHIEF GREEN: So we look at a couple of things, just --
3 literature on what are the chronic conditions that most
4 impact a member's well-being, as well as most impact cost
5 to the system. So that's one tool that we use. And also
6 our claims data, so what chronic conditions are the most
7 prevalent in our data set. Those are kind of the two
8 things that we look at. And then third, we're work --
9 we're working to align with the Covered California and
10 DHCS on similar performance measurement, so that we can
11 act as one voice and try to place as much pressure on the
12 health care delivery system to do a better job of managing
13 those chronic conditions. So those are -- that's kind of
14 the different elements in phases that we look at.
15 CHIEF HEALTH DIRECTOR MOULDS: And most -- most
16 of those.
17 BOARD MEMBER OLIVARES: Do we --
18 CHIEF HEALTH DIRECTOR MOULDS: Sorry, I did it
19 again. Sorry.
20 (Laughter.)
21 BOARD MEMBER OLIVARES: I wanted to know how we
22 look at managing maternal fetal outcomes.
23 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
24 CHIEF GREEN: I don't have that off the top of my head,
25 but I'm happy to pose that question to Dr. Logan and get

1 you a response.
2 BOARD MEMBER OLIVARES: Thank you. There tend to
3 be very extreme racial and ethnic disparities.
4 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
5 CHIEF GREEN: Yes.
6 CHIEF HEALTH DIRECTOR MOULDS: Yes.
7 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
8 CHIEF GREEN: Yes, there absolutely are. And for me
9 personally having a 17-month old and a seven year old,
10 this is a of keen interest to me.
11 BOARD MEMBER OLIVARES: As it is me. So many
12 women of color end up experiencing undiagnosed
13 preeclampsia and suffering eclampsia, which means having a
14 stroke or seizure during child birth.
15 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
16 CHIEF GREEN: Yep.
17 BOARD MEMBER OLIVARES: It's ex -- yes, so I
18 would like us to look at that outcome.
19 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
20 CHIEF GREEN: Yeah, it's terrifying and I agree.
21 BOARD MEMBER OLIVARES: Um-hmm.
22 CHIEF HEALTH DIRECTOR MOULDS: Yes. The other --
23 the other thing that's really interesting on that data is
24 that the literature says that, you know, for a long time
25 it was assumed it was -- it was correlating just to

1 poverty. It's not.
2 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
3 CHIEF GREEN: No.
4 BOARD MEMBER OLIVARES: No.
5 CHIEF HEALTH DIRECTOR MOULDS: It correlates to
6 race, irrespective of poverty. It's quite problematic.
7 BOARD MEMBER OLIVARES: Yes.
8 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
9 CHIEF GREEN: Which is why I think the data that we
10 collect and the information we have relative to our claims
11 data could be really informative on the notion of what --
12 of further advancing the thinking on that it is not
13 poverty related.
14 BOARD MEMBER OLIVARES: Um-hmm. Thank you.
15 CHIEF HEALTH DIRECTOR MOULDS: Not just poverty
16 related.
17 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
18 CHIEF GREEN: Yeah, there you go. Thank you.
19 CHAIRPERSON FECKNER: Anything else, Ms.
20 Olivares?
21 BOARD MEMBER OLIVARES: No, thank you.
22 CHAIRPERSON FECKNER: Thank you.
23 Mr. Rubalcava again.
24 VICE CHAIRPERSON RUBALCAVA: Thank you. Sorry,
25 one more question. Ms. Olivares reminded me and some

1 other people. I know that, at least with other employers,
2 the insurance carriers provide like dashboards and
3 utilization reports that show like how -- you know, the
4 trends in inpatient care versus outpatient, particular
5 disease states, or, you know, number of instances of
6 prenatal care, things like -- premature birth, things like
7 that.
8 Maybe -- and I'm sure you guys study them and
9 everything. So maybe at some training session you can do
10 like a -- like a profile for demographics and what are
11 the -- the trends, and, you know -- and who -- what plans
12 have been more successful at say tackling what -- or
13 what -- because I know they have apps and tools for like
14 prenatal care, for example --
15 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
16 CHIEF GREEN: Right.
17 VICE CHAIRPERSON RUBALCAVA: -- or for
18 controlling your weight. Maybe you can give some
19 education on that at some point and what tools are you
20 using, what engagement are you doing with the carriers to
21 make sure they're engaging with their covered population.
22 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
23 CHIEF GREEN: Yep, absolutely.
24 VICE CHAIRPERSON RUBALCAVA: Thank you. It's a
25 suggestion. Thank you.

1 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
2 CHIEF GREEN: I think that sounds like a great idea and we
3 can definitely do some of that. Thank you.
4 VICE CHAIRPERSON RUBALCAVA: Thank you.
5 CHAIRPERSON FECKNER: Very good. Thank you.
6 I have no other requests to speak, no other
7 questions. Anything else, Ms. Green?
8 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
9 CHIEF GREEN: Nothing more from me.
10 CHAIRPERSON FECKNER: Mr. Moulds, anything else
11 on this topic?
12 CHIEF HEALTH DIRECTOR MOULDS: Not from me, no.
13 Just my --
14 CHAIRPERSON FECKNER: Very good. Thank yo.
15 CHIEF HEALTH DIRECTOR MOULDS: -- my gratitude to
16 Ms. Green and her team for terrific work on this. Thank
17 you.
18 CHAIRPERSON FECKNER: Absolutely. We all share
19 in that. So thank you, Ms. Green.
20 Item 7b, Long-Term Care Program competitive
21 strategy. Mr. Moulds.
22 CHIEF HEALTH DIRECTOR MOULDS: Great. So this --
23 so good afternoon. Don Moulds, CalPERS team.
24 This is the second of two discussions about
25 mitigating potential long-term care rate increases.

1 Yesterday, you heard from the Investment team about their
2 efforts to explore changes to the Long-Term Care Fund
3 asset allocation as a way of potentially decreasing the
4 side of the needed premium increases.
5 Right now, I'm going to talk about the second way
6 of mitigating rate increases, which is through benefit
7 design changes. By way of reminder, we're contractually
8 obligated to provide the benefits our members select when
9 they enroll in the Long-Term Care Program, unless they
10 voluntarily agree to different benefits.
11 So any benefit design changes that are adopted by
12 the Board would be optional for our program enrollees. It
13 would ultimately be up to them whether they take them up.
14 The goal of the benefit design changes we're
15 going to talk about here would be to offer our
16 policyholders benefit modifications, potentially available
17 on their own or in combination that would decrease the
18 expected liabilities for those policies.
19 These options would be made available to program
20 beneficiaries seeking to forego some or all of a potential
21 premium increase. The CalPERS team has modeled changes to
22 current benefit designs with the goal of reducing their
23 expect liabilities. Some of these include modifying the
24 duration of elimination periods, instituting annual
25 deductible or other cost sharing, differentiating

1 reimbursement by level of disability and decreasing the
2 daily benefit and policy duration.
3 The modeling we've conducted takes the most
4 common benefit designs in each block of the LTC Program
5 and then projects the decrease in expected liabilities
6 that would be realized by changing them.
7 So, for example, transitioning from a 90-day
8 elimination period to a 180-day elimination period would
9 decrease the expected liabilities of a typical plan in the
10 largest LTC blocks by about 17 percent. Because we're
11 able to reserve less money to pay future claims on a
12 policy that includes that benefit change, the 17 percent
13 decrease would translate to a corresponding decrease in
14 rates.
15 For planning purposes, we're assuming that some
16 rates increase will be necessary. So our actuaries have
17 been modeling packages of benefit design modifications to
18 make available to members who want to buy down the
19 expected liabilities of their plan in order to forego
20 premium increases.
21 I wish I could offer you details about what that
22 reduced package would look like, but it obviously depends
23 on the size of the premium increase we may need. The
24 extent to which these options are employed and the number
25 of options that need to be employed will depend on the

1 analysis and final determination of the premium increase
2 that is necessary.
3 Our goal though will be to offer a package that
4 would negate a proposed rate increase for most program
5 enrollees.
6 In November, the final proposed premium increases
7 required for each block will be presented in PHBC for
8 adoption. The recommended mitigation options for
9 policyholders will also be presented for adoption.
10 If adopted, any premium increase would go into
11 effect no earlier than July of 2021.
12 Most of the benefit design modifications we've
13 modeled increase the cost exposure for Long-Term Care
14 Program beneficiaries. That is most of them increase cost
15 sharing or increase limitations on coverage. We don't
16 like them and our policyholders wouldn't naturally choose
17 them, save for the fact that they may be more palatable
18 than a rate increase.
19 We continue to pursue other options that would
20 bring down the costs associated with long-term care by
21 doing what we know both policyholders want and what is in
22 the best interests of the CalPERS Long-Term Care Fund,
23 supporting our policyholders in their home, so that they
24 can live longer lives with fewer disabilities outside of
25 institutional setting. I look forward to those

1 conversations in the near future.
2 So that is -- those are my remarks and I'm happy
3 to answer any questions.
4 CHAIRPERSON FECKNER: Okay. Thank you.
5 Let me see. Ms. Greene-Ross, please.
6 ACTING COMMITTEE MEMBER GREENE-ROSS: Mr. Moulds,
7 just wanted to say, you know, we're -- this is much
8 appreciated, all the effort that you're putting in to
9 trying to resolve this complicated situation with no good
10 options. So I just wanted to thank you and say how much
11 we appreciate all your -- all the different ideas you're
12 pursuing in efforts to try to keep the program going and
13 keep the cost down.
14 So thank you.
15 CHAIRPERSON FECKNER: Thank you.
16 Any -- I don't see any other comments or
17 questions on this item.
18 MS. SWEDENSKY: Rob, excuse me.
19 Rob?
20 CHAIRPERSON FECKNER: Hello.
21 MS. SWEDENSKY: We had public comment on 7a.
22 CHAIRPERSON FECKNER: All right. I thought that
23 was for 7b. That was my original note, but I will -- as
24 soon as we finish this, we'll go back to 7a for comment.
25 Anybody else for comment on 7b?

1 Seeing none.
2 Anything else on this item, Mr. Moulds?
3 CHIEF HEALTH DIRECTOR MOULDS: No, that -- that's
4 it. Thank you.
5 CHAIRPERSON FECKNER: Okay. I hope Marta is
6 still here. We're going back to 7a for public comment.
7 Mr. Fox.
8 STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair.
9 We have comments for 7a and 7b. We'll begin with 7a. Our
10 first caller is Deborah Berger.
11 MS. BERGER: Yes. Hi. I just want to make sure
12 you can hear me.
13 CHAIRPERSON FECKNER: Yes, ma'am.
14 MR. BERGER: Can you hear me?
15 Okay. Thank you.
16 CHAIRPERSON FECKNER: Yes, ma'am.
17 MS. BERGER: Yes. My name is Deb Berger and I
18 want to comment, of course, on this portfolio rating risk
19 adjustment. Marta Green made it clear that in November
20 that the CalPERS staff is going to ask the Pension Health
21 Benefits Committee to adopt this form of risk adjustment
22 called portfolio rating.
23 And it was stated in her presentation that the
24 Board ended risk adjustment a few years ago because it was
25 complex. But what the presentation didn't make clear is

1 whether portfolio rating is going to be less complex than
2 what was implemented in the past. And I would hope that
3 this would be addressed.
4 What we did learn about portfolio rating from
5 this presentation, for the CalPERS HMO plans, is that it's
6 probably going to ask CalPERS to make a very significant
7 tradeoff, and that it's going to drastically have less
8 competition for pricing based on value.
9 And the issue of value can be very subjective.
10 So if you look at slide 24, it shows that CalPERS has
11 three plans, Anthem Select, Kaiser, and UnitedHealth. And
12 they have similar coverage areas. And it appears that
13 they also have very -- or rather strong competition
14 amongst them.
15 However, if portfolio rating is implemented, the
16 slide shows that Kaiser isn't going to have any
17 competition from a plan with comparable service area
18 coverage. Not only that, Kaiser is going to have the
19 lowest rate among the plans listed on the slide.
20 So also, Anthem Select would become almost as
21 expensive as Anthem Traditional, which is the other Anthem
22 plan. Now, it was made clear in the presentation that
23 back in July, there was a presentation before the Board
24 about a health plan competition study. And this is going
25 to help determine if CalPERS has the right mix of plans

1 for optimal competition. So the question that I have that
2 I'm respectfully asking the Board to consider and its
3 stakeholders is that shouldn't they see the results of
4 this competition study before they implement any form of
5 risk adjustment? Isn't it important that the members and
6 the stakeholders and the Board be able to know this
7 information?
8 Now many of us are still waiting to find out if
9 the Board already followed through with talks to Kaiser
10 pertaining this issue. Other CalPERS health HMO plans
11 voluntarily lowered their 2021 rates and they did this in
12 response, of course, to the State and local government
13 budget deficits --
14 CHAIRPERSON FECKNER: I'm sorry, Ms. Berger,
15 you've run out time.
16 MS. BERGER: -- that were -- may I finish with a
17 question? There's a question of competition.
18 CHAIRPERSON FECKNER: As long as you make -- as
19 long as you make it quick.
20 MR. BERGER: I will. Covered California got
21 Kaiser to agree to a less than one percent increase in
22 rates. Why isn't CalPERS pressing this? And it appears
23 from the presentation that Kaiser will benefit because of
24 a lack of competition.
25 CHAIRPERSON FECKNER: Thank you for your

1 comments.
2 MR. BERGER: Thank you.
3 CHAIRPERSON FECKNER: Mr. Fox.
4 STAKEHOLDER RELATIONS CHIEF FOX: Mr. Chair, we
5 have Joanne Hollender from RPEA.
6 CHAIRPERSON FECKNER: Thank you.
7 MS. HOLLENDER: Yes. This is Joanne Hollender,
8 RPEA. Welcome and hello to the Board and Rob Feckner as
9 the Chair -- to the Committee, excuse me.
10 CHAIRPERSON FECKNER: Good morning.
11 MS. HOLLENDER: Good morning.
12 I'm a little confused by the charts. I guess I
13 don't quite get it as well as Henry. But one of the
14 things I noticed that on the status quo, the premium
15 projections for PPO basic plans, I sort of would like to
16 have seen PERS Choice laid out similar to page five of the
17 charts, so that you could see what was projected if
18 nothing was changed among the three different plans of
19 Care, Choice and Select. And that would be really
20 helpful, so that way I could compare it with some of the
21 other models that you're projecting and talking about.
22 Looking at the removal of PERSCare and then the
23 merge of PERSCare with PERS Choice, there isn't much
24 difference between the premiums between the two. So those
25 are kind of -- I don't see a big change there. So

1 actually merging might be the two -- might be the best way
2 over the two, as opposed to just removing PERSCare.
3 On the portfolio rating, I'm not sure what
4 portfolio rating means exactly. It looks like on page 22
5 you have aqua blue chart, or column -- you don't have it
6 identified, but I assume that's PERS Select and then it
7 goes to PERS Platinum and Gold the rest of the years after
8 that, 2021.
9 And I'm assuming you're getting rid of PERS
10 Select, but it doesn't really say that here. And I kind
11 of thought I heard that. So this is a little unclear to
12 me and I'm not sure what the make-up design would be to
13 make this work between eliminating PERS Choice or
14 combining it with PERSCare -- I mean, PERS Choice -- PERS
15 Select, excuse me. I'm getting so confused.
16 I've been really studying this material and, I'm
17 sorry, it just doesn't come to me clearly. But I think
18 that's an idea that should be pursued. I think the plan
19 design is very, very important and haven't heard anything
20 about any ideas on that.
21 I do want to avoid buydowns and taking money from
22 other funds to pay for PERSCare. We've got to deal with
23 this mitigation. It is just kicking the can down the
24 road, as they always say. I think it needs to be dealt
25 with. I think staff is really trying to make an attempt.

1 I know we haven't talked about this at all, except at
2 stakeholder meetings. So I'm hoping that some of us will
3 have a chance to hear more details on this, so we can
4 participate.
5 I think it's really important to get the
6 feedback. But I think your -- you came up with an idea on
7 this. I think the PERS Select 70 -- I know you were --
8 you're not for that at all from what I heard. I'm trying
9 to listen closely.
10 But I think there's a lot of things that need to
11 be sorted out here, so it's simpler to review this. It is
12 very, very complicated. And then you have the HMOs, which
13 is a whole nother thing. It looks like Anthem
14 Tradition -- Traditional is going to be on the chopping
15 block from what I'm seeing on your charts.
16 But it needs be --
17 CHAIRPERSON FECKNER: Ms. Hollender, your time
18 has expired.
19 MS. HOLLENDER: Okay. Thank you. That's it. I
20 appreciate it. Look forward to working with you.
21 CHAIRPERSON FECKNER: Very good. Thank you very
22 much.
23 Mr. Fox.
24 STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair.
25 Now, we have Mr. Larry Woodson.

1 CHAIRPERSON FECKNER: Thank you.
2 MR. WOODSON: Good morning again. Larry Woodson,
3 California State Retirees. As I said in our -- our
4 stakeholder meeting, as well as the off-site, CSR really
5 appreciates the work of Marta and her team on this issue
6 and we support your work towards the goals that you've
7 identified.
8 I am confused at the difference in your
9 presentation from the July meeting and today. In July, at
10 the off-site, there was -- a lot of the presentation
11 talked about risk pooling, talking about Social Security,
12 Medicare, Medicaid, Covered California, all having risk
13 pools that -- and you talked about single risk pools and
14 how the advantages of using a single risk pool versus what
15 the old risk adjustment model was that CalPERS used
16 previously. And yet, there was no mention of that risk
17 pooling in today's presentation.
18 Back in July, there was no mention of portfolio
19 rating. So I -- I followed the portfolio rating
20 discussion. I mean, it seems to, you know, hopefully end
21 up in the same place with your graphs using the various
22 modeling. It did seem to level cost spread. And that was
23 encouraging.
24 And so I -- I don't -- I know that -- and in
25 stakeholders you indicated that -- or there was a

1 commitment to meet with stakeholder groups hopefully in
2 the near future to discuss some of these questions that
3 have been raised.
4 And also another concern I have is, you know,
5 shifting -- modifying benefit design is a concern, because
6 that could be -- could have major impacts on our members
7 or relatively mild.
8 So anyway, I'll leave it at that and thank you
9 for the work you're doing.
10 CHAIRPERSON FECKNER: Thank you for your
11 comments.
12 Mr. Fox.
13 STAKEHOLDER RELATIONS CHIEF FOX: Thank you, Mr.
14 Chair. You have one more commenter on 7a. J.J. Jelincic.
15 MR. JELINCIC: J.J. Jelincic, RPEA.
16 Risk mitigation sounds good. In fact, risk
17 mitigation by definition is as good as motherhood and
18 gluten free apple pie. But the real question is what is
19 the problem you're trying to solve? It sounds like you're
20 trying to salvage PERSCare and Anthem Traditional. If you
21 don't identify the problem accurately, you don't reach a
22 good solution.
23 The problem really is that you have different
24 plans that offer different coverage at a different price
25 point. And when you look at the things that they say,

1 well, causing the shift in risk. Every singled one of the
2 examples they use relates to those plan differences, the
3 doctor network, the facilities, the areas. So really,
4 what is it you're trying to solve?
5 The complaint has been made that the members are
6 not choosing based on value. They're not -- but I will
7 point out that objecting to the coverage and price
8 trade-offs that the members make really is not
9 particularly helpful. I will point out that in the case
10 of the PPO, PERS controls the premiums, the benefits, the
11 doctors, the facilities, the areas, and yet there's a big
12 risk disparity there. So it's really not clear what the
13 problem is.
14 And I would also like to point out that for the
15 long-term care swapping lower benefits for a lower premium
16 seems to not only be acceptable, but desirable. And yet,
17 when we get to health care, that same tradeoff is terrible
18 and we need to mitigate it away.
19 So I really ask you to really give some thought
20 to what is the problem you are trying to solve. If you
21 don't identify the problem correctly, you don't reach a
22 good solution.
23 Thank you.
24 CHAIRPERSON FECKNER: Thank you.
25 Anyone else, Mr. Fox?

1 STAKEHOLDER RELATIONS CHIEF FOX: Mr. Chair,
2 include -- concludes comments on 7a, but we do --
3 CHAIRPERSON FECKNER: Very good.
4 STAKEHOLDER RELATIONS CHIEF FOX: -- we do have
5 comments -- we have comments on 7b.
6 CHAIRPERSON FECKNER: Very good. I'll be back to
7 you in a moment. Ms. Green, anything you wanted to
8 comment on or shall we wait until November when you come
9 back?
10 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
11 CHIEF GREEN: Oh, I don't remember every single question
12 that was posed, but I would just say --
13 CHAIRPERSON FECKNER: I'm sure not.
14 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
15 CHIEF GREEN: But I would just say that I'm looking
16 forward to talking with the stakeholder community to both
17 clarify their understanding of the issue that we're trying
18 to resolve, as well as provide any clarity about the
19 specific modeling. Also, happy to show additional charts
20 that show the progression of other plans as they continue
21 to suffer the effects of adverse selection.
22 The one thing I do remember, and it's probably
23 because Larry is near and dear to my heart, is he drew the
24 distinction between portfolio rating and single risk pool.
25 So the portfolio rating would create the single risk pool.

1 So I use slightly different terminology because
2 we have to use a different approach between the HMO and
3 the PPO, but it would create that single risk pool like
4 Social Security and Medicare that we discussed in July.
5 CHAIRPERSON FECKNER: Very good. Thank you.
6 So now back to 7b. We just finished that agenda
7 item. Mr. Fox, any callers for 7b, please.
8 STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair.
9 First we have Mr. Tim Behrens, CSR.
10 CHAIRPERSON FECKNER: Thank you.
11 MR. BEHRENS: Thank you, Mr. Chairman and members
12 of the Committee. I continue to be disappointed in this
13 long-term care product. I was hoping after yesterday's
14 discussion that the Investment team does actually ramp-up
15 and try to keep us from having those options that Don
16 alluded to. Well, the options seem pretty
17 straightforward. If you happen to be somebody that's had
18 this product for several years and spent several thousand
19 dollars on it, and then you're given an option to pay even
20 more money for it or reduce, and so then you don't get the
21 same bang for the product that you purchased, it's tough
22 option to make.
23 Having said that, I want to jump back to Item B,
24 because I wasn't down to speak on that initially, until I
25 heard Don talk about CalPERS staff reaching out to the

1 stakeholders affected by the California fires. That is
2 great. That's what you did last year. One of the things
3 I did not hear you talk about was whether or not you also
4 are going to provide staff a centralized area to continue
5 the medications coming, and cooperation between pharmacies
6 up there that will take all of our products, even though
7 they may not be originally what we purchased.
8 I really thank you and the CalPERS team for
9 reaching out. I hope you will publish some kind of a
10 document with phone numbers, and contacts, and email
11 addresses. I'd like to reproduce that and put it on our
12 paper so we can reach out to as many stakeholders as
13 possible.
14 Thank you.
15 CHAIRPERSON FECKNER: Great. Thank you.
16 Mr. Fox.
17 STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair.
18 We have Mr. Larry Woodson on 7b.
19 CHAIRPERSON FECKNER: Thank you.
20 MR. WOODSON: Good morning again. Larry Woodson.
21 Thanks for the opportunity to comment. Representing CSR.
22 So the long-term care valuation issues on three
23 different committee agendas. I commented yesterday in
24 yesterday's meeting, I -- the -- the -- the reduction --
25 the proposed reduction in discount rate from 5.25 to 4

1 percent makes sense. If, you know, your actual
2 projections are going to be 4 percent, the discount rate
3 ought to reflect that, and that's more transparent. Of
4 course, the downside is that it has the effect of
5 increasing premiums, which are already high.
6 In the analysis it seems like in your -- in
7 developing that kind of a recommendation, you would have
8 also determined what the actual rate increase would be
9 before applying any modifications of the benefit design.
10 And I'm just wondering why that wasn't included, and if
11 you know it, what it was?
12 Otherwise, I mean, generally, we support your
13 efforts. It's just -- and I -- you know, it's difficult,
14 as Tim said, to support more benefit design changes when
15 it means less service and more premium. But I understand
16 the options are limited.
17 So anyway, my main point is, you know, can you --
18 can you report out what the -- the kind of altered premium
19 would be based strictly on the lowering of the discount
20 rate.
21 Thank you.
22 CHAIRPERSON FECKNER: Thank you.
23 Mr. Moulds, do you want to add into that?
24 CHIEF HEALTH DIRECTOR MOULDS: You know, the only
25 thing I will -- I'll say there is that -- is that we have

1 not -- we're not asking you today to alter the discount
2 rate. One of the things that we're trying to do that I
3 think we made pretty clear during the INVO conversation
4 yesterday is improve that situation. So typically,
5 premium increases are attached to a rate increase -- or a
6 discount rate that you adopt. So we wouldn't send out a
7 speculative rate increase. That just doesn't make sense
8 to us.
9 Obviously, when we come back to you in November
10 with asset allocation change proposals. And just to kind
11 of follow up on some of the questions yesterday, we're not
12 proposing that you change your authority to approve asset
13 allocation. You retain authority to improve -- to approve
14 asset allocation. But when you do that, we will be
15 landing on a discount rate at that time, and that will be
16 associated with particular premium increase.
17 CHAIRPERSON FECKNER: Very good. Thank you.
18 Anyone else, Mr. Fox?
19 STAKEHOLDER RELATIONS CHIEF FOX: No, Mr. Chair.
20 That concludes comments on 7b. You'll have one more
21 commenter at the end under 7d.
22 CHAIRPERSON FECKNER: Thank you very much.
23 So it takes us to Agenda Item 7c, summary of
24 Committee direction. Mr. Moulds.
25 CHIEF HEALTH DIRECTOR MOULDS: Thanks. So I

1 have -- I have two -- two items. One is share a list of
2 chronic conditions we use in our performance measures with
3 the Board, which we're happy to do. Second was to cue up
4 a discussion of chronic conditions by -- among CalPERS
5 members by type and for discussion at a future Board
6 meeting.
7 I'll also add just that we're happy to provide
8 the pharmacy information targeted at fire victims on our
9 website, so that that's available for everybody to see.
10 It's an important -- important thing to be doing.
11 CHAIRPERSON FECKNER: Very good. Thank you very
12 much. Seeing no other requests, it moves us to 7d, public
13 comment.
14 Mr. Fox.
15 STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair.
16 We have Al Darby, RPEA.
17 CHAIRPERSON FECKNER: Thank you.
18 MR. DARBY: Good morning, Mr. Chair and Committee
19 members.
20 CHAIRPERSON FECKNER: Good morning.
21 MR. DARBY: Hello. Can you hear me?
22 CHAIRPERSON FECKNER: We can hear you.
23 MR. DARBY: Okay. My comment relates to drug
24 acquisition, the proposed new program to acquire drugs.
25 In a recent congressional investigation, it was determined

1 that a U.S. drug manufacturer was selling to pharmacy
2 benefit managers in the U.S. a product at $150. The same
3 product was found to be available in Europe at under
4 $100 -- well under $100 in several countries and amazingly
5 at $35 in Germany.
6 So my question is will you add the dimension of
7 looking beyond the shores of the U.S. to see what drug
8 pricing is in other countries, as well as using what you
9 find from other countries as leverage to further bring
10 down the cost of drugs.
11 That's my comment. Thank you.
12 CHAIRPERSON FECKNER: Thank you.
13 VICE CHAIRPERSON RUBALCAVA: Thank you. I just
14 want to remind Don that one other request was that the
15 plan enrollment figures and trends also be shared with the
16 stakeholders when they're presenting -- explaining the new
17 rating methodology.
18 Thank you.
19 CHIEF HEALTH DIRECTOR MOULDS: Yeah. Thank you.
20 CHAIRPERSON FECKNER: Very good. Thank you, Mr.
21 Rubalcava.
22 All right. Seeing no other requests to speak,
23 we're going to adjourn this meeting. The Finance
24 Committee, since we are ahead of schedule, Finance
25 Committee will begin at 11:20, 15 minutes from now. So

1 with that, we are going to adjourn the PHBC meeting.
2 Thank you all for being here. And we'll see those of you
3 that chose -- choose to go to Finance there in 15 minutes.
4 This meeting is adjourned.
5 (Thereupon California Public Employees'
6 Retirement System, Pension and Health Benefits
7 Committee open session meeting adjourned
8 at 11:06 p.m.)
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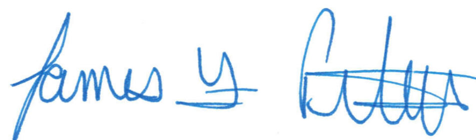
C E R T I F I C A T E OF R E P O R T E R

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 and Health Benefits Committee open session meeting was reported in shorthand by me, James F. Peters, a Certified Shorthand Reporter of the State of California, 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 September, 2020.



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