VIDEOCONFERENCE MEETING

STATE OF CALIFORNIA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

BOARD OF ADMINISTRATION

PENSION & HEALTH BENEFITS COMMITTEE

OPEN SESSION

WEBEX VIRTUAL MEETING

TUESDAY, NOVEMBER 17, 2020

9:32 A.M.

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

APPEARANCES

COMMITTEE MEMBERS:

Ms. Rob Feckner, Chairperson

Mr. Ramon Rubalcava, Vice Chairperson

Ms. Margaret Brown

Mr. Henry Jones

Mr. David Miller

Ms. Eraina Ortega

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

Mr. Kelly Fox, Chief, Stakeholder Relations

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

APPEARANCES CONTINUED

STAFF:

Ms. Pam Hopper, Committee Secretary

Ms. Julia Logan, Chief Medical Officer

ALSO PRESENT:

Mr. Tim Behrens, California State Retirees

Mr. Terry Brennand, Service Employees International Union

Ms. Nicole Casey, Town of Truckee

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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PROCEEDINGS

CHAIRPERSON FECKNER: We'll just start all over. So let's give another minute or two and see if everybody gets here and then we'll start all over with call to order and roll call.

COMMITTEE SECRETARY HOPPER: Okay. Thank you. Good morning, Mr. Chair.

Rob Feckner?

CHAIRPERSON FECKNER: Good morning.

COMMITTEE SECRETARY HOPPER: Margaret Brown?

COMMITTEE MEMBER BROWN: Good morning.

COMMITTEE SECRETARY HOPPER: Henry Jones?

COMMITTEE MEMBER JONES: Here.

COMMITTEE SECRETARY HOPPER: David Miller?

COMMITTEE MEMBER MILLER: Here.

COMMITTEE SECRETARY HOPPER: Eraina Ortega?

COMMITTEE MEMBER ORTEGA: Here.

COMMITTEE SECRETARY HOPPER: Ramon Rubalcava?

VICE CHAIRPERSON RUBALCAVA: Present. Here.

COMMITTEE SECRETARY HOPPER: Theresa Taylor?

CHAIRPERSON FECKNER: She's excused.

COMMITTEE MEMBER JONES: Excused.

COMMITTEE SECRETARY HOPPER: Honda -- Shawnda Westly?

COMMITTEE MEMBER WESTLY: Present.

COMMITTEE SECRETARY HOPPER: Karen Greene-Ross for Betty Yee?

Mr. Chair, I do not show Karen Greene-Ross as of yet for Betty Yee.

CHAIRPERSON FECKNER: That's fine. We will keep an eye out and see if she comes in. It might be helpful if everyone, if you're speaking, to turn off your video. It might help with the bandwidth today. This is going to be a tough day we can tell already.

Item 2 is the approval of the November 17th timed agenda. Do we have a motion to approve?

COMMITTEE MEMBER MILLER: So moved.

COMMITTEE MEMBER JONES: Move approval.

CHAIRPERSON FECKNER: Moved by Mr. Miller.

Who was the second?

COMMITTEE MEMBER BROWN: Mr. Jones.

CHAIRPERSON FECKNER: Mr. Jones?

COMMITTEE MEMBER JONES: Yes.

CHAIRPERSON FECKNER: Thank you.

Any discussion on the motion?

Seeing none.

Ms. Hopper, please call the roll.

COMMITTEE SECRETARY HOPPER: Margaret Brown?

COMMITTEE MEMBER BROWN: Aye.

COMMITTEE SECRETARY HOPPER: Henry Jones?

COMMITTEE MEMBER JONES: Aye.
COMMITTEE SECRETARY HOPPER: David Miller?
COMMITTEE MEMBER MILLER: Aye.
COMMITTEE SECRETARY HOPPER: Eraina Ortega?
COMMITTEE MEMBER ORTEGA: Aye.
COMMITTEE SECRETARY HOPPER: Ramon Rubalcava?
VICE CHAIRPERSON RUBALCAVA: Aye.
COMMITTEE SECRETARY HOPPER: Shawnda Westly?
COMMITTEE MEMBER WESTLY: Aye.
COMMITTEE SECRETARY HOPPER: Karen Greene-Ross for Betty Yee?
ACTING COMMITTEE MEMBER GREENE-ROSS: Aye.
COMMITTEE SECRETARY HOPPER: And, Karen, I'll go ahead and mark you in attendance as well.
ACTING COMMITTEE MEMBER GREENE-ROSS: Thank you.
COMMITTEE SECRETARY HOPPER: Mr. Chair, I have David Miller making the motion, Henry Jones seconding it on the approval of the timed agenda.
CHAIRPERSON FECKNER: Thank you.
Item 3 is the Executive Report. First, we're going to call on Mr. Suine.
DEPUTY EXECUTIVE OFFICER SUINE: Thank you, Mr. Chair. Good morning, members of the Committee. I'm Anthony Suine, CalPERS team member. I'm grateful for the opportunity to be with you again this month. My opening

comment has never been more appropriate. While 2020 has been difficult, I do have good news. There's only six Mondays left in this year. So have something to look forward to.

And while this year has been a struggle, our teams have continued to perform exceptionally well in the remote environment. And I have a lot of news to share about activities and trends in customer service and in education since we last spoke.

Our contact center team just wrapped up a very busy open enrollment season. And they've been working extremely hard to manage the increase in our call volumes. Recently, we've had some challenges with extended call wait times. Call volumes can vary for a variety reasons, particularly during peak times liken open enrollment.

In addition, we've seen an overall 30 percent increase in call volumes over the past two years. And as you know, this can create customer service issues for our members and burnout or morale issues for our team. As a result, we're working diligently to mitigate both of these concerns. We are redirecting workload from our contact center to program areas, therefore freeing up more agents to take phone calls.

We're also adding permanent positions from the enterprise vacancy pool to increase the number of our call

agents. We're also securing additional resources to assist during peak times as needed on an ongoing basis.

While it will be some time before all these new resources are fully trained, our shifting workload and utilizing resources throughout our Customer Services and Support Branch will provide immediate short-term relief. We continue to monitor workload and trends on a daily basis to identify and incorporate new strategies. In September, I updated you that overall retirements are on the decline. Over the course of the calendar year, we do continue to see an overall decrease in retirements. However, the amount of the decrease has been narrowing, as we've seen slight increases in retirements more recently.

We continue to see increases in State member retirements, offsetting the decrease in schools and public agencies. We have seen the school member retirements kick up recently and we anticipate additional increases in retirements going forward.

Thankfully, as I mentioned before, online usage of our member self-service is on the rise, including nearly 70 percent of all retirement applications, which is nearly double the percentage from pre-COVID times. This helps mitigate the impact on our team members who process paper transactions.

We continue to add member self-service

functionality. And this year for the first time, our 1099s are not only available online, but retirees also have the option of opting out of the paper mailing process. Opting out of paper helps us reduce the administrative costs of this program and helps us reduce our carbon footprint.

As you know, our team continues to monitor the impacts of natural disasters in California and across the world to ensure our retirees are -- who are still receiving paper retirement checks have access to their funds.

Besides these natural disasters, the pandemic has also impacted mail delivery in some instances. I wanted to share a personal story from the team on the global front about one member in particular.

We were connected with her through social media. She's based in the Philippines and is a surviving spouse of a CalPERS retiree. She could not get access to her paper warrants due to the cessation of U.S. mail delivery because of the pandemic in the Philippines. By the time, we heard from her and were able to connect, she had not received several retirement checks and she was struggling to provide for herself. Our team was able to make contact with her, provide her resources, and assist her with transitioning her payment method from paper to direct

deposit and immediately reissued the funds into her account.

The member was very appreciative of the assistance provided and I really want to thank our teams in Retirement Benefits Services and Public Affairs for their compassion, collaboration, and exceptional customer service. I'm grateful to be part of this team that provides that level of service with extraordinary care for the struggles our members face and the level of commitment that's consistently demonstrated throughout the entire organization.

Lastly, we're gearing up for our next CalPERS Benefit Education Week to be held in just two weeks from now, November 30th through December 4th. So far, we have nearly 20,000 registrants over 23 classes we'll be offering, which is just under 65 percent of the capacity we have for that week. For comparison purposes, the last event we held in July had at about 6,000 class registrations. So we've already more than tripled that number and we're still two weeks from the event.

I'm also Happy to share we've made many improvements based on member feedback from the first event. We've expanded the schedule of live instructor-led classes, including adding evening offerings, as well as an additional day of instructor led classes, increasing

offerings of our most highly attended classes. And in addition to classes provided by us and the Social Security Info -- Administration, we have partnered with CalHR and Nationwide to add three deferred compensation classes. We've improved the -- improved the registration process as well, which has likely led to our increased numbers.

Overall, the week will offer 23 live classes taught by our CalPERS program area experts, along with our other partners. We're looking forward to another opportunity to virtually deliver exceptional education that our members are accustomed to receiving and our team members are proud to deliver in spite of the closure of our regional offices and many other locations where we typically deliver these in-person offerings.

In conclusion, I remain extremely proud of our team for managing the current environment and delivering on our mission of serving our members and employers. I wish to thank the Board for your continued support as we work through the challenges of 2020.

Since I won't have the opportunity to meet with you all before the end of the year, I want to wish you all a safe and Happy Holiday season.

This concludes my comments and I'm happy to take any questions.

CHAIRPERSON FECKNER: It's always great to hear

when members get the satisfaction that they have come to expect. So thank you and your team for all the good work and please pass that on for me.

Let's see, anybody --

DEPUTY EXECUTIVE OFFICER SUINE: Will do.

CHAIRPERSON FECKNER: -- with any questions?

I don't see any, so thank you, Mr. Suine, you too, you and your family have a good holiday. We're going move on to Mr. Moulds portion.

Mr. Moulds, please.

CHIEF HEALTH DIRECTOR MOULDS: Great. Good morning, Mr. Chair, members of the Committee. Don Moulds CalPERS team.

We have several very substantive items on the agenda today. I have three short updates for the Committee. And then I'd like to leave time for Julia Logan, our Chief Medical Officer, to provide you with an update on COVID-19, since there's much happening right now.

First, for my update, we published our health benefits annual report for the 2019 plan year and delivered it to the Legislature and the Director of Finance as required by statute. The report is Item 5 on your agenda and it's also available on the CalPERS website.

It provides information about our programs, plans and financials. You may notice that it has fewer pages, as we leaned out the report to focus on the most important information and to improve our reader's experience. I'd like to thank the many CalPERS team members across the enterprise who contributed to the development and delivery of the report. We hope you find it informative and a good resource.

Next, I want to let the Committee know that our 2021 health plan member survey will kick off on January 11th, 2021. This is our annual survey that asks members to rate their experience with their plan and their pharmacy benefits during the 2020 plan year. We worked with an independent firm and survey roughly 26,000 randomly selected members across the plan.

This year we strengthened the survey and included questions on behavioral health and more complete demographic information, including race, ethnicity, sexual orientation and gender identity. These details will help provide a fuller picture of our membership and its health status. We'll also use the survey results to measure outcomes and trends, members' care experiences, and access to care. We would ask all members who receive a survey to respond. It goes a long way in helping make the health plan better for everyone.

And last, but not least, I want to let you know that last week Marta Green was appointed to the Board of Directors of the Public Sector HealthCare Roundtable. The Healthcare Roundtable is a non-partisan member-directed coalition that exists to give public sector health care purchasers and state and local health plan administrators a voice in the design, development, and implementation of national health care policy. The Roundtable does this by providing in-depth policy analysis and a forum to collectively engage with key decision makers in Washington D.C.

Additionally, this month, Marta continued to represent CalPERS members' interests in congressional office briefings, albeit virtually these days, to support a federal prohibition on surprise balance billing. Talks between Congressional offices have begun anew and there appears to be some momentum towards finding a solution to this vital consumer protection issues. She will continue her virtual Hill visits over the coming weeks.

I'm going to stop there, so there's time for Julia. After, if you have any questions for either us, we'd be happy to take them.

CHAIRPERSON FECKNER: Thank you.

Good morning, Ms. Logan

CHIEF MEDICAL OFFICER LOGAN: Good morning.

Julia Logan, CalPERS Chief Medical Officer. I will be giving you a brief update on COVID-19 treatment and vaccine updates and how our health plans are working to serve our members during this pandemic. I'm sure you are aware that nationwide we are experiencing the dreaded fall and winter surge. The U.S. surpassed 11 million cases on Sunday. And the latest 1 million cases were added in just seven days. The daily average of new cases is up by 80 percent from two weeks ago.

For a time, it looked like California was bucking the nationwide trend, but sadly our state is now experiencing the fastest increase in Coronavirus cases since the beginning of the pandemic.

Over a seven-day period beginning November 1st, this state saw a more than 50 percent increase in cases and our Governor announced yesterday afternoon that 94 percent of our state, so 41 counties, will revert back to the most restrictive purple tier effective today.

The Governor is also considering the possibility of instituting a statewide curfew, though his office is still reviewing the data from other states and countries that have already implemented curfews.

Against this dire backdrop, there is some incredibly bright and hopeful spots around treatment and prevention that are important to highlight. Treatment of

COVID has certainly improved dramatically since the early days of the pandemic. As we learn more and more about this virus, doctors and nurses just keep getting better at treating the disease. They know what works, what doesn't work.

Experience has taught doctors more about whether to put people on ventilators, how much oxygen to provide, and how to prevent some of the worst effects of the disease, before our immune systems have had a chance to react significantly.

And most significant of all right now is the news last week from Pfizer and just yesterday from Moderna that their vaccine candidates are 90 percent and almost 95 percent effective respectively in preventing the disease among volunteers who had no prior infection.

We have learned that these two vaccines are quite similar in efficacy, because they both use the same basic vaccine design. But they do have some distinct differences. One major difference is how the vaccines need to be stored. Moderna's vaccine can be stored in a normal refrigerator for up to 30 days. By contrast, the Pfizer vaccine has to be kept at minus 70 degrees Celsius.

This feature may make mass distribution of the Moderna vaccine much less challenging. Both these high efficacy vaccine, however, will be necessary to adequately

vaccinate our population.

And there are some things we still need to learn about both vaccines. We don't know how long protection will last, if they will give short-term immunity like a flu vaccine or longer protection like some of the childhood vaccines.

And we don't know yet if the vaccines work in certain groups better than others. While neither trial uncovered any serious side effects, we will not know the long-term safety profile of -- these vaccines for some time. In terms of timeline of when these vaccines will be approved and available, we don't know exactly when, but they may be available for limited distribution to health care workers and those at increased risk for severe disease as early as the end of the year and widely available to the public by mid-2021.

We will be following COVID vaccine distribution closely and we continue to work with the plans on all issues related to COVID, and, in fact, just completed our quarterly business reviews with each of the plans, where we discussed at length our COVID response and looking to the future regarding vaccine availability and readiness. Some of the trends we noted previously with you, such as telehealth utilization and mail order uptake of medications continue to be high. And we anticipate that

these will be long-lasting impacts of COVID-19.

We continue to track grievances and appeals as they relate to COVID. And I'm pleased to say that it's been very quiet on that front. And the concerns that members had earlier in the summer around testing availability do not appear to be an issue now. And I believe that that has to do with the massive effort on the part of our health plans and the State to increase and maintain testing capacity. Testing plays a major role in fighting COVID-19. And we have been keeping close tabs on the availability for our members.

Finally, as we look forward to the holidays, it's never been more important for us all to take action against the pandemic. Isolate as much as possible, wear masks, avoid indoor groups and all the stuff that we already know about, but that we are all understandably growing weary and fatigued. We're not going to be doing all this forever. I really think that the vaccine results may be the light at the end of the tunnel. Please hang on and stay safe.

I appreciate your attention and time and I'm happy to take questions.

CHAIRPERSON FECKNER: Thank you, Dr. Logan. Very sobering but informing comments. So thank you very much.

I do have a question from Mr. Miller.

COMMITTEE MEMBER MILLER: Thank you, Dr. Logan. This question is for you or for anyone else who wants to weigh in. One of the things I've been concerned is I've heard a number of experts express concerns about not just the logistics of deployment, but the success of the deployment in terms of public acceptance and participation, you know, absent any kind of a mandate for vaccinations. And some of the polling that I saw was showing, you know, nearly half of the country saying they would not accept or would not have a vaccine imposed on them. And so I was wondering if you'd heard anymore, have anymore current or authoritative information on those possibilities, and what kind of plans are in place to try to counter that, and finally what we can do to urge our members to get vaccinated when it's available.

CHIEF MEDICAL OFFICER LOGAN: Yes, that is an excellent point and an ongoing concern. Public acceptance of the vaccine is crucial to get to where we need to go to get to herd immunity. I know that the State and the Department of Public Health are doing all that they can to be as transparent as possible. The Governor has also instituted a COVID Vaccine Task Force to address those very issues and to vet the vaccine scientifically separate from the nationwide and the federal response.

I have every confidence in the process. The

process that is being undertaken right now being led by the NIH is rigorous and follows the process that has been followed for vaccines in the past. And so those -- it's a -- it's a rigorous process and it goes through several independent agencies and experts. And so I feel like it's something that we as a nation need to start to trust and to understand.

And I think we haven't been exposed to that sort of -- to this level of news about vaccines and about how vaccines are developed. So I think it's new to people. And so getting to understand how it really works is very important. But, yes, I appreciate your concern, because it -- I share it as well.

COMMITTEE MEMBER MILLER: Thank you.

CHAIRPERSON FECKNER: Thank you.

I see no other requests to speak, so thank you Dr. Logan. Anything else, Mr. Moulds?

CHIEF HEALTH DIRECTOR MOULDS: No. Thank you.

CHAIRPERSON FECKNER: All right. That moves us to us Agenda Item 4, the action consent items, the approval of the September 15th Pension and Health Committee Meeting Minutes. What's the pleasure of the Committee?

COMMITTEE MEMBER MILLER: So moved.

VICE CHAIRPERSON RUBALCAVA: I will second.

CHAIRPERSON FECKNER: Moved by Mr. Miller.
VICE CHAIRPERSON RUBALCAVA: Ramon Rubalcava seconds, Mr. Feckner.
CHAIRPERSON FECKNER: Thank you. Seconded by Mr. Rubalcava.
Any discussion on the motion?
Seeing none.
Ms. Hopper, please.
COMMITTEE SECRETARY HOPPER: Margaret Brown?
COMMITTEE MEMBER BROWN: Aye.
COMMITTEE SECRETARY HOPPER: Henry Jones?
Henry Jones?
COMMITTEE MEMBER JONES: Aye.
COMMITTEE SECRETARY HOPPER: David Miller?
COMMITTEE MEMBER MILLER: Aye.
COMMITTEE SECRETARY HOPPER: Eraina Ortega?
COMMITTEE MEMBER ORTEGA: Aye.
COMMITTEE SECRETARY HOPPER: Ramon Rubalcava?
VICE CHAIRPERSON RUBALCAVA: Aye.
COMMITTEE SECRETARY HOPPER: Theresa Taylor?
CHAIRPERSON FECKNER: Excused.
COMMITTEE SECRETARY HOPPER: Shawnda Westly?
COMMITTEE MEMBER WESTLY: Aye.
COMMITTEE SECRETARY HOPPER: Karen Greene-Ross for Betty Yee?

ACTING COMMITTEE MEMBER GREENE-ROSS: Aye.

COMMITTEE SECRETARY HOPPER: Mr. Chair, I have David Miller making the motion, Ramon Rubalcava seconding it for agenda item the approval of the Pension and Health Benefits Committee meeting minutes.

CHAIRPERSON FECKNER: Thank you. Moves us to Agenda Item 5, the information consent items. I do have a request to take Item 5c separately. So we have again no other requests. So let's move to Item 5c. I have Ms. Greene-Ross that had a question.

ACTING COMMITTEE MEMBER GREENE-ROSS: Thank you, Mr. Feckner. My question is about the employee survey. In August of last year, we -- in September, we had hearings on mental health access and parity and we were going to include that in the survey. And when I look at the -- page 15, which sort of briefly summarizes the survey results of our beneficiaries, I just wanted to know if that was incorporated or that's being done separately?

CHIEF HEALTH DIRECTOR MOULDS: Yes, I appreciate your question Ms. Greene-Ross. So we -- we made a call about three weeks ago as we were looking at the cumulative amount of material for this Board meeting and the need to really dive in on the behavioral health issue. We've heard that it's a critical issue for you, as a Board, and rightly so for us as well. So what we decided to do was

to move that entire agenda item to the January off-site and give it more time than we would have been able to give it today. So we have a full presentation that will be -- and discussion that will be led by Dr. Logan that's queued up for the January off-site.

ACTING COMMITTEE MEMBER GREENE-ROSS: And did we survey employees or we're still working on how to incorporate a survey of that of the beneficiaries?

CHIEF HEALTH DIRECTOR MOULDS: Dr. Logan can speak to the specifics of the -- of the survey.

CHIEF MEDICAL OFFICER LOGAN: Yes. So this is Julia Logan. We have a health plan member survey, where we did add specific behavioral health questions around access and member experience. So we can talk more about that at a January off-site.

ACTING COMMITTEE MEMBER GREENE-ROSS: Right. I just was trying to understand in the context of this report that we sent to the Legislature. There was no mention of that.

CHIEF HEALTH DIRECTOR MOULDS: That was the 2019 report, so that dates back a full year.

ACTING COMMITTEE MEMBER GREENE-ROSS: Ahh. Okay. Appreciate that then. Thank you very much. I'll forward to the January off-site, where we can discuss it more.

Thank you.

CHIEF HEALTH DIRECTOR MOULDS: Yep.

CHAIRPERSON FECKNER: Thank you. Seeing no other requests.

We move to Item 6, the action agenda items. 6a is the approval of new health plans, benefit designs, and services area changes.

Mr. Moulds.

CHIEF HEALTH DIRECTOR MOULDS: I'm going to turn it over to Marta Green.

CHAIRPERSON FECKNER: Very good. Good morning, Ms. Green

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Good morning, Mr. Chair and members of the Pension and Health Benefits Committee. Marta Green, CalPERS team member.

(Thereupon a slide presentation.)

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: This is Agenda Item 6a, approval of new benefit -- excuse me, approval of new health plans, benefit designs, and service area change. This is an action item.

For the agenda -- next slide, please.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: For the agenda, we'll go through the

timeline, plan proposals for 2020 due by carrier, and then discuss next steps.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: So here's our timeline. In August, CalPERS asked the HMO health plans to submit proposals for any changes to their existing plan products or to add plan products for CalPERS consideration. In September, Anthem Blue Cross, Blue Shield of California, UnitedHealthcare and Western Health Advantage submitted proposals for consideration.

The submissions included applicable pricing, provider network and coverage area, benefit -- and benefit design information. The CalPERS team conducted an extensive analysis to determine any added value these proposals will bring to the CalPERS Health Benefits Program. The analysis consisted of the network coverage areas, numbers of providers, coverage overlaps, projected administrative services fees and medical costs. I'm going to walk through each plan proposal separately and provide the team's recommendation based on our analysis.

Any approved plan proposals will be incorporated into the 2022 rate development process beginning early next year.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Anthem Blue Cross Medicare Advantage Plan is currently offered in 37 counties ni California. This proposal would expand their Medicare Advantage Plan into 21 additional counties, converting it into a statewide option. This service area expansion provides members, particularly in rural counties, with more choices. The projected increase for the expansion of premium is $4.73, or a little over one percent increase. The proposed benefit design aligns with CalPERS standard Medicare Advantage benefit design. And the team does recommend approval of this proposal.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: In addition, Anthem is offering two new benefits for the Medicare Advantage plan, Healthy Pantry and non-emergency transportation. Healthy Pantry offers 12 telephonic nutritional counseling sessions plus a monthly shipment of non-perishable items. Non-emergency transportation offers 12 one-way trips up to 60 miles to approved locations. The addition of these two new benefits will add $2.86 cents or a 0.75 percent increase

in the premium.

These proposed benefits are consistent with the additional supplemental benefits in the CHRONIC Care Act and meet our stakeholder expectations by adding Medicare Advantage benefits where appropriate and cost effective to help keep our members healthy and provide additional access to care options. As a reminder, Kaiser and UnitedHealthcare offered similar benefit changes approved for the 2021 plan year. The team recommends approval of this proposal.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Blue Shield of California is proposing to reenter Access+ into eight of the nine Bay Area counties it exited in 2019, all of the counties it exited, except for Napa. This proposal is contingent upon Board approval of the risk mitigation strategy for 2022. As background, the elimination of risk adjustment for the 2019 plan year would have resulted in a significant increase to the Access+ premium. To partially mitigate, Blue Shield exited out of nine higher cost Bay Area counties. Blue Shield projects a 1.6 percent increase to the current Access+ pricing and there are no benefit changes associated with this proposal.

This is the first of a few proposals that we are going to recommend approval contingent on the results of our basic plan competition study. As we've discussed with you previously, we've engaged a team of economists to study the right mix and concentration of plans in each of our distinct geographies to inform the footprints of the plans in our portfolio. The results of this study are expected cin January.

So for a few of these proposals, we are recommending that the Board approve the continued development of the proposal and rates pending the outcome of the competition study. We plan to bring you the results of those -- of that study in March, which will include the counties appropriate for expansion.

So the CalPERS team recommends approval with the understanding that the proposal is contingent on Board approval of the risk mitigation strategy, and the results of the competition study.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Blue Shield is also proposing to expand its Access+ EPO product into two rural counties, Lassen and Shasta, contingent upon DMHC regulatory approval and Board approval of the risk mitigation strategy for 2022. The

Access+ EPO plan is currently offered in Colusa, Mendocino and Sierra counties. By adding Lassen and Shasta, rural county members will have more choice as they are often limited to only the PERS PPO plans. Blue Shield projects small financial impact of 0.15 percent increase to the current Access+ pricing and there are no benefit design changes associated with this proposal. The CalPERS team recommends approval with the acknowledgement that this proposal is contingent upon DMHC regulatory approval and CalPERS Board approval the risk mitigation strategy.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Blue Shield is also proposing to expand its Trio plan into four counties, Monterey, Santa Cruz, Orange, and Stanislaus. Of those counties proposed, Monterey is the only county that does not currently have a low cost HMO option as three other counties have varying level of plan concentration. Monterey county is contingent upon successful provider negotiation and DMHC regulatory approval.

Blue Shield anticipates no financial impact for expanding the Trio service area and there are no benefit design changes associated with this proposal. The CalPERS team recommends approval of the expansion into Monterey

with acknowledgement that it is contingent upon successful provider negotiation and DMHC approval.

Additionally, the team recommends approval of the remaining three counties, Santa Cruz, Stanislaus, Orange, if the competition study indicates these counties are appropriate for additional plan offerings. The team will provide an update at the March PHBC meeting contin -- including whether these counties should be included in the expansion.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Blue Shield is proposing two options, a 58 county and a 41 county for a new Medicare Advantage Plan that would include prescription drug coverage. The 41-county proposal matches Blue Shield's proposed Access+ and Trio service areas for 2022 and the 58-county is a statewide option.

This proposal would allow members to remain with the same carrier as they age into Medicare. The proposed benefit design aligns with CalPERS standard Medicare Advantage benefit design, but includes some other benefits as well, a $80 quarterly over-the-counter drug benefit, personal emergency response system, post-discharge meals, and 24 non-emergency one-way trips for transportation. It

also includes an option for dental and vision benefits for contracting public agency members.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: The projected single-party premium for the 58-county option is $346.87. The 41-county option is slightly lower at $346.83. There is no significant single-party premium difference between the two options. And the 58-county option provides statewide service area coverage for Blue Shield's Medicare Advantage members. The CalPERS team recommends approval of the 58-county option.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: UnitedHealthcare is proposing a nationwide Medicare Advantage Plan, in which prescription drug coverage would be carved out and provided by OptumRx under our direct contract. This plan is being offered in addition to UnitedHealthcare's current Medicare Advantage product that has an integrated pharmacy benefit.

The proposed benefit design reduces member cost sharing to zero for most services, similar to CalPERS self-funded Medicare supplement PPO plans. Due to the

reduction in cost sharing, UnitedHealthcare projects a higher medical cost compared to the current United Medicare Advantage product. The overall projected 2022 premium is in between the current Anthem and Kaiser Medicare Advantage Plan premiums.

The CalPERS team recommends approval of this proposal. If approved, CalPERS will allow other carriers offering Medicare Advantage plans to propose to reduce member cost sharing as part of the 2022 rate development process.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: UnitedHealthcare is also proposing its SignatureValue Harmony Basic HMO narrow network plan in five Southern California counties, Los Angeles, Orange, Riverside, San Bernardino and San Diego. The number of HMO offerings in these service areas ranges from seven to eight plans. This new plan is projected to be either the second or third lowest HMO premium in the five counties. The proposed benefit design aligns with CalPERS standard basic plan benefit design with a focus on physician-patient relationships. The CalPERS team recommends approval of this new plan, if the competition study indicates that these counties are appropriate for

additional plan offerings. The team will provide an update at the March PHBC meeting to confirm whether this new plan should included and in which counties.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: UnitedHealthcare is also proposing to introduce its self-funded Doctors EPO plan into nine Bay Area counties. And this is in partnership with Canopy Health. This a self-funded plan proposal and UnitedHealthcare would act as third-party administrator. The CalPERS team recommends not accepting this proposal until such time that the self-funded PPO procurement is conducted and the current self-funded PPO contract expires in 2024.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Western Health Advantage is proposing a new MyCare Medicare Advantage plan, in which prescription drug coverage would provided by OptumRx. The 2022 premium projected is $359.62. The proposed benefit design aligns with CalPERS standard Medicare Advantage benefit design. This plan would allow members enrolled in Western Health Advantage basic plan to remain with the same carrier as

they age into Medicare. The CalPERS team recommends approval of this proposal.

Before I move on to the summary for today's proposals, I'd like to share another exciting potential development for Western Health Advantage. They recently filed for regulatory approval of an expansion into Humboldt County and hope to offer this product to CalPERS for the 2022 plan year. This county currently does not have a low-cost HMO option and has a concentration of public employees as there is a large State prison in the county. Western Health Advantage intends to submit this expansion for consideration and we plan to bring the recommendation to the PHBC in March.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: So this table summarizes the plan proposals. You'll see we have the various proposals that we would recommend approval, those that we would recommend approval pending the outcome of the competition study, and one that we recommend disapproval.

Now, I'll talk about next steps.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Any approved plan proposals will be

incorporated in the 2022 rate development process. The CalPERS team will continue to work with each carrier on their approved proposals. Once the results of the competition study are received, we will confirm which counties for each plan are appropriate for expansion at the March PHBC meeting. The team will present preliminary and final rates in summer of 2021 for the 2022 plan year.

The concludes my presentation and I'm happy to take any questions.

CHAIRPERSON FECKNER: Thank you, Ms. Green, for a very succinct report. I do have a couple of questions pending. I have Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you, Mr. Chair and thank you, Ms. Green, for again an excellent presentation as usual. Couple of questions. One is that I noticed that there are three items that are pending -- approval pending based on additional study research. So why are we asking to approve those now when we'll have to revisit them when you complete your work or study?

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: That's a great question. Thank you, Mr. Jones. So really what we want to know is if any of these should be disapproved by the Board, we will stop development of those before we move into the next cycle. But if the Board is comfortable with these moving forward,

pending the outcome of the competition study, we would come back in March for final approval of those. So this is an early indication of whether or not the Board is interested in some or all of these.

Those that the Board may not be interested in, we would not move forward with continued development. Those that the Board is interested in, we would continue to develop and confirm specifically which counties in March.

COMMITTEE MEMBER JONES: Okay. Thank you.

And my next question is I think it's on the iPad page 74, I think that's the page -- let me see if I can go back to it. Seventy-four. Yeah, 74 and Anthem Blue Cross, the non-emergency medical transportation now has a projected premium impact of $2.86 and it includes SilverSneakers. Now, I thought that that was a complimentary benefit in the past, so why now are they including it as a charge?

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Thanks. Great question. So SilverSneakers itself is complimentary. It's the transportation to and from a SilverSneakers location that is incorporated in the non-emergency transportation.

COMMITTEE MEMBER JONES: Okay. Okay. Thank you very much.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

CHIEF GREEN: You're welcome.

CHAIRPERSON FECKNER: Thank you.

Ms. Brown.

COMMITTEE MEMBER BROWN: Thank you, Mr. Chair. Marta, that's a very fast and detailed presentation. Thank you. I was very happy to hear about Western Health Advantage coming up with a plan as people age into Medicare. That's exciting. And also, more importantly, the potential HMO for Humboldt County, that is so exciting. You know, it's interesting as the State plans prisons in these rural counties, they actually don't plan for services for all the State employees. And so this is very exciting that Western Health is going to do this. So what's the likelihood that they'll get approval to do that? I mean, is it more likely or less likely?

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: They're feeling very confident about the expansion and it has already been filed for regulatory approval. And so that's -- that happens pretty late in the development. There's never a 100 percent guarantee, but I'm feeling pretty confident.

COMMITTEE MEMBER BROWN: Well, this is -- I'm so excited for our State employees or retirees out in Humboldt County. This could be a real money saver for them.

Thank you.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Great.

CHAIRPERSON FECKNER: Thank you.

Mr. Rubalcava.

VICE CHAIRPERSON RUBALCAVA: Thank you, Mr. Feckner, Chair. Thank you, Marta, for an excellent presentation and congratulation on being appointed to the Public Sector Roundtable.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Thank you.

VICE CHAIRPERSON RUBALCAVA: And it's good to hear that our insurance carriers are proposing new plans and expansion of service area. My question is more, I understand that we have to wait for -- some of them are contingent the risk mitigation adjustment and others are based on the competition study, because we want to make sure that we have the right mix of plans in any one area, especially Southern California or in areas where there's a lot of competition already.

So my question is through the rate development proposal, even though we're trying to, through these new studies, through these new approaches the risk mitigation and the competition, trying to make sure that the people are competing based on quality of care in their primary

care physician networks and stuff and not necessarily trying to get out the risk pool.

So obvious the carriers will have to weigh in whether -- say in Southern California whether there's, you know, new -- a new narrow network or quality of network, what have you, or new expansion. So does the time frame allow for them to get a sense of who's the competition, so to speak, before they submit rates or will they be -- have to submit rates and then there's an opportunity for them to adjust based on who's -- who's in the pool with them? So I'm trying to understand how that timeline works.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: That's a great -- that's a great question. Thank you for that question. So part of the reason we're bringing this to you now with the way we've constructed our approval, it's so that all of the carriers see what all of the carriers have proposed.

Now, they will have to develop rates and submit rates before we confirm the final county lineup. And we will make any adjustments based on the final county lineup that we bring to the Board at the March PHBC. However, they are at least aware of what's proposed and what's possible.

In the previous years, if you recall, or at least in recent years, those proposals have been part of the

confidential rates process, and so plans didn't know what the other carriers were doing until we got to preliminary rates in May. And that's what caused a lot of the lack of transparency and misunderstanding of what the market was doing.

But by doing it this way, we have transparency. All of the carriers know what is being further developed. They can take that into consideration when developing rates. And depending on the final lineup of both plans and service areas, they can adjust their proposed rates accordingly.

VICE CHAIRPERSON RUBALCAVA: Thank you for explaining that and I really appreciate the report.

Thank you very much.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Thank you.

CHIEF HEALTH DIRECTOR MOULDS: And this is Don. I'll just add in that -- that this two-step process that Marta described, where we come back to you with the final results of the competition study, that's this year only. Going forward, we'll have that fully in place. It will be something knowing to us, to the carriers, to you, and so we'll be able to do this in November with full information.

CHAIRPERSON FECKNER: Great. Thank you and thank

you both. Thank you for the explanation, Ms. Green. It would be nice to not have to play the, "I-got-you-what-if" game every year. So this is good to put it out front.

I have Mr. Miller with a comment.

COMMITTEE MEMBER MILLER: Yeah, two -- two kind of comments. Well, actually three. First is thanks for the really nice, concise, illuminating presentation. I really appreciated it. Really on target. So I have no real questions about it.

I do really look forward to December, and particularly the information on the -- those that are kind of pending further information. And I -- before I've mentioned I still have concerns and really want to hear in December about, for example, you know, Trio. This move toward these lower cost higher deductible, the kind of potential adverse selection competitive issues with that. They certainly concern me and a lot of our members and stakeholders.

And the second thing is I'll be curious to see if -- you know, we're probably just starting to give some thought to this, but it kind of relates to Director Brown's comment about how nice it is to see, you know, how -- you know, an HMO in Humboldt, because I think not just Humboldt, but a lot of our rural locales are going to see, at least from State employees, a lot more people

residing there, a lot more of the time. We've learned with the distance and teleworking, that we don't really need to have the concentrations of employees physically in, you know, a 25-story building in Sacramento, for example, that people can do a lot of their work -- and I think the new normal after we get to it is we'll see a lot more people be able to enjoy rural living if -- if they so choose, which may impact the pattern of kind of the needs assessment of our membership out there. So I'll be interested to see as we go along how that dynamic develops.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Thank you, Mr. Miller

COMMITTEE MEMBER MILLER: Thank you.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Thank you. I agree. Expanding rural access is a top priority for both, Mr. Moulds and me. One thing I want to clarify about Trio is it actually doesn't have any higher cost sharing than our other HMOs. All of our HMOs have exactly the same benefit design, no higher deductibles.

The difference is it's a narrower network. So Blue Shield Access+ in contrast is considered a broad network HMO and the Trio is a tailored network. But the cost sharing, the out-of-pocket cost, the out-of-pocket

exposure is identical.

COMMITTEE MEMBER MILLER: Yeah. Thanks for that clarification.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: You're welcome.

CHAIRPERSON FECKNER: Very good. Thank you.

Mr. Rubalcava.

VICE CHAIRPERSON RUBALCAVA: Thank you, again, both Don and Marta for a great presentation. And given the presentation, I think it's appropriate to have a motion to approve the recommendation -- the staff recommendations and -- so of approval contingent on the competition study results, and I will so move.

COMMITTEE MEMBER WESTLY: Second.

COMMITTEE MEMBER MILLER: I'll second that. This is David Miller.

CHAIRPERSON FECKNER: Mr. Miller seconding.

Any discussion on the motion?

Seeing none.

Before we vote, we do have a couple of members from the audience that would like to make comments. Mr. Fox, I believe we have Mr. Behrens and Mr. Jelincic on the line. Can you please invite Mr. Behrens to make his comments.

STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair.

We have three callers in total on 6a.

First, we'll have Mr. Tim Behrens.

MR. BEHRENS: Thank you, Kelly. Chairman Feckner, members of the Committee, members of the Board. CSR is speaking in complete support of the staff recommendations. I want to thank Marta, and Don, and your health team for a great presentation. I really like that our members are going to have more choices, that there's been more additional rural areas added, at a minimal cost and increase in cost, and they will continue to provide quality medical services. So we speak in support of the recommended action.

Thank you much. Have a good day.

CHAIRPERSON FECKNER: Thank you very much.

Mr. Fox.

STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair. Next up, Mr. J.J. Jelincic.

MR. JELINCIC: Hi. J.J. Jelincic, beneficiary. I'm not going to advocate a position. I do want to make an observation and point out something the Board needs to consider. The agenda item proposes new benefits and expansion into new geographic areas. All things being equal, more is better. However, the agenda points to one of the most consistent things about insurance, the greater the benefits, the greater the premium. As trustees, the

Board gets to exercise its expert prudent opinion as to whether the increased benefits are worth the increased costs.

On the question of expansion into new geographic areas by several of the plans, several have indicated an increased cost related to the expansion. Most are dependent on CalPERS agreeing to subsidize the expansion into areas where they cannot compete on their own.

Again, as trustees and expert prudent persons, the Board gets to exercise its judgments.

Thank you for your consideration.

CHAIRPERSON FECKNER: Thank you.

Mr. Fox.

STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair. The last speaker on Item 6a is Mr. Larry Woodson from CSR.

MR. WOODSON: Good morning. Can you hear me okay?

CHAIRPERSON FECKNER: We can hear you just fine, sir.

MR. WOODSON: Okay. Larry Woodson, CSR. Thank you, Mr. Feckner -- Chairman Feckner and Committee members for the opportunity to comment.

First of all, I'd like to also add congratulations to Marta Green for her appointment to the California Healthcare Roundtable. This really just marks

a continuance of CalPERS involvement in that forum. And I've been to several of the meetings over the years and it's a really good opportunity to --

MR. BEHRENS: Hello.

MR. WOODSON: Can you hear me?

I'm getting feedback.

Hello?

CHAIRPERSON FECKNER: Hello.

MR. WOODSON: Okay. I'll continue. Anyway, congratulations to Marta.

We've -- as Tim said, we reviewed the proposal, the changes, the additions, consider them all very positive for our members. They'll increase choice, expand geographic access. I also like the addition of supplemental benefits. That's been incremental. We've been urging that over a couple of years now. It's also especially good to see Blue Shield Access+ proposing to return to the Bay Area, which they exited and caused a lot of disruption to our members a few years ago when CalPERS left the -- or abandoned the risk adjustment policy, the old one, so -- and I don't think the increases in prices that Mr. Jelincic cited are a major concern. At least what was cited by Marta seemed to be very minimal.

I commend staff on their good work on this and in releasing it early, rather than dumping it all on members

at the same time of the rate development. So appreciate the work and we urge Board approval of all the proposals. Thank you.

CHAIRPERSON FECKNER: Thank you.

Anybody else, Mr. Fox?

CHIEF HEALTH DIRECTOR MOULDS: Mr. Feckner, can I speak to the cost issue for one second?

CHAIRPERSON FECKNER: As soon as we find out if there's any other callers. Mr. Fox.

STAKEHOLDER RELATIONS CHIEF FOX: Yeah. No more callers, Mr. Chairman, on Item 6a.

CHAIRPERSON FECKNER: Great. Thank you.

Mr. Moulds, please.

CHIEF HEALTH DIRECTOR MOULDS: Thanks. So I certainly appreciate Mr. Jelincic's concern about keeping premiums as low as possible and the relation between increased benefits and increased premiums. In this particular instance, the CHRONIC Act that was passed federally was passed on a bipartisan basis with the theory, borne out by experience, that investments in these kind of non-medical health options can actually, over the long term, significantly reduce cost. So a lot of them are directed at the goal -- the overarching goal of keeping people out of hospitals, which is where the costs really lie. So we will see in our own experience over a

year -- over years, as we -- as we adopt some of these in our plans, but in other places, you see these being cost effective for that reason in particular.

CHAIRPERSON FECKNER: Very good. Thank you.

I have Mr. Jones with a comment before we vote.

COMMITTEE MEMBER JONES: Yeah. Thank you, Mr. Chair. Yeah, just a technical, I heard Mr. Miller indicate that we would be reviewing these in December. And I just wanted to, for our viewing public, to note that our revised schedule shows that this is coming back in November. That's all. Thank you.

CHAIRPERSON FECKNER: Very good. Thank you. Seeing no other requests to speak, a motion being before you, Mrs. Hopper please call the roll.

COMMITTEE SECRETARY HOPPER: Margaret Brown?

COMMITTEE MEMBER BROWN: Aye.

COMMITTEE SECRETARY HOPPER: Henry Jones?

COMMITTEE MEMBER JONES: Aye.

COMMITTEE SECRETARY HOPPER: David Miller?

COMMITTEE MEMBER MILLER: Aye.

COMMITTEE SECRETARY HOPPER: Eraina Ortega?

COMMITTEE MEMBER ORTEGA: Aye.

COMMITTEE SECRETARY HOPPER: Ramon Rubalcava?

VICE CHAIRPERSON RUBALCAVA. Aye.

COMMITTEE SECRETARY HOPPER: Theresa Taylor?

CHAIRPERSON FECKNER: Excused.

COMMITTEE SECRETARY HOPPER: Shawnda Westly?

COMMITTEE MEMBER WESTLY: Aye.

COMMITTEE SECRETARY HOPPER: Karen Greene-Ross for Betty Yee?

ACTING COMMITTEE MEMBER GREENE-ROSS: Aye.

COMMITTEE SECRETARY HOPPER: Mr. Chair, I have all ayes. And I believe I have Ramon Rubalcava making the motion and David Miller seconding.

CHAIRPERSON FECKNER: You are correct.

Thank you very much. Thank you, Ms. Green. And again, I also, on behalf of myself and the Committee, want to congratulate you on your new appointment. Obviously, they recognize talent. So thank you for representing us there.

That brings us to Item 6b, Risk Mitigation Strategies. Mr. Moulds.

CHIEF HEALTH DIRECTOR MOULDS: Thank you, Mr. Chair. I'll be turning it over to Ms. Green one more time.

CHAIRPERSON FECKNER: Very good.

CHIEF HEALTH DIRECTOR MOULDS: Actually, two more times.

(Laughter.)

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

CHIEF GREEN: Thank you, Mr. Moulds and Mr. Chair. Again, Marta Green, CalPERS team member.

(Thereupon a slide presentation.)

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

CHIEF GREEN: I'm here with my second agenda item, 6b, HMO and PPO risk mitigation strategies. This is an action item. This is the culmination of multiple conversations we've had regarding how risk fragmentation is creating adverse selection and instability in the CalPERS portfolio. Over the past several months, we've focused on refining the risk mitigation approach and engaged in multiple stakeholder discussions. Today, I'm excited to share our final modeling results and provide our recommendations for a comprehensive approach to risk mitigation in the CalPERS basic portfolio.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

CHIEF GREEN: I'll start with a refresher on the challenges our portfolio faces related to risk concentration as well as a brief history of CalPERS risk mitigation strategies. I'll discuss our analysis for portfolio rating and the final methodology. Then we will dive into our updated modeling results for the proposed methodology for the HMO and PPO basic portfolio, including

replacing our current three basic PPO plans with a proposed PERS Platinum and PERS Gold plans. Finally, we'll provide the team's recommendation for your approval.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: I'll start with a review of the challenges we face in the basic portfolio. Since the removal of risk adjustment just two years ago, a significant disparity in the premiums for our basic health plans has arisen. This is because premiums are no longer priced based on their value, but rather on the concentration of healthy or unhealthy lives in each plan.

Without mitigating the impact of risk concentration, health plans are forced to reduce their health care costs, to remain competitive by introducing network alternatives that only attract healthy risk, exiting high-cost areas, and/or removing providers that do an exceptional job of treating high-cost conditions.

In short, plans are not competing on cost and quality, but instead on how they can attract members that use little or no health care.

We've spoken at length about the instability that this causes in the portfolio. If we don't mitigate the risk concentration in our basic portfolio, two things will

happen. The first is that we will continue to experience large member migration patterns and various plan offerings will be unsustainable. We are now only two years out after removing risk adjustment and we already have two HMOs and one PPO plan in a death spiral. This volatility is not only hard on our members, it puts sustainability of our program at risk.

The second thing that will continue to happen without risk mitigation is that plans will continue to compete on attracting healthy lives as opposed to competing on cost and quality of care. This is in stark contrast to our goals of having health plans do a better job negotiating with providers to bring costs down and to improve the quality of care provided to our members regardless of their health conditions.

We will not be able to achieve these goals without a comprehensive risk mitigation strategy. With a comprehensive risk mitigation strategy, instead of focusing on mitigating adverse selection, we can appropriately focus our time and energy on innovative cost-saving and quality-improvement programs, bringing the right kind of plan competition into each geography of our state and encouraging the right provider partnerships to deliver care in a low-cost, high-quality setting.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Let me give you a quick recap of what led to this conversation today. The previous risk adjustment program in started in 2014 and lasted until 2018. It was terminated beginning in the 2019 plan year due to the complexity and lack of transparency with the prior risk adjustment model.

Since then, premium changes have triggered large member migration patterns between the plans and unhealthy concentration of risk in certain products. The Committee and stakeholders shared concerns regarding the premium volatility and stability in the basic portfolio.

Following the -- focusing first on the PPO portfolio, the CalPERS team launched the PPO assessment in October of 2019 to understand the cause of the premium disparities between the PPO basic plans and to help inform proposed changes to the program.

In January, stakeholder and member input was collected through the stakeholder forum discussion on risk concentration and through surveys that went out to PPO basic members. Through the PPO assessment, we identified that risk concentration and adverse selection are the key issues facing the PPO program.

At the July off-site, we expanded the PPO

assessment to look at instability and adverse selection n the entire basic portfolio. We investigated a list Of potential solutions and modeled premium impacts for the next several years under each scenario.

The preliminary results from the modeling of risk mitigation for the HMO and PPO basic plans were shared at the September PHBC meeting. And we are here today with refined results and to provide our final recommendations for CalPERS risk mitigation strategies and ask the Committee for approval.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: So in September, we discussed several potential risk mitigation approaches. We discussed and modeled a reinsurance approach. The challenge of this methodology is it still incentivizes health plans to chase health risk. And the modeling shows this approach would only partially mitigate the risk and the resulting premiums would not reflect the plan's value.

We also discussed the approach merging plans or simply removing plans that are currently unsustainable. Unfortunately, this approach would also not move the remaining plans' premiums closer to their value.

Finally, we introduced the approach of portfolio

rating. It is a risk mitigation methodology designed to address the fundamental cause of our portfolio instability by ensuring our plans are priced based on their value and incentivizing our carriers to manage the health of our members.

Portfolio rating is a front-end pricing model, where we would continue to aggressively negotiate rates with our carriers as we always have. What's different is when the premiums are published for our members, the risk component would be removed from the rate. All products would be priced risk neutrally.

I would like to emphasize how transparent this approach would be. CalPERS would routinely publish each plan's risk score before, during and after rate negotiations. That information would be available to the public on our website, so anyone could review it.

Portfolio rating is an approach similar to the one used in most of the large group commercial market and by some states.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: So what's the difference between the old risk adjustment methodology implemented in 2014 and this proposed portfolio rating approach?

First, the previous risk adjustment method involved a lengthy four-stage process, including complex back-end tran -- fund transfers between health plan sub-accounts in our Health Care Fund. One risk adjustment cycle from phase one premium setting to phase five -- four, final reconciliation would take an entire two-year period to complete.

Secondly, the previous risk adjustment process lacked transparency, which caused challenges in projecting health care costs for premium setting. The overly complex process, combined with a lack of transparency, caused significant administrative burden and premium volatility.

Based on the lessons we learned from the previous risk-adjustment program, we are now proposing a simplified approach, which would have only a single step to set premiums at the front end. We will use a broadly accepted risk scoring model and be transparent with our process.

Finally, premiums will be set in a revenue neutral manner for the entire basic portfolio to ensure total premium collected will be sufficient to pay for the member's health care costs and administrative fees, therefore no back-end money transfers and reconciliations are needed under this approach.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

CHIEF GREEN: So let's discuss the details of the portfolio rating methodology. First, we are using the Milliman Advanced Risk Adjusters, or MARA, prospective as the risk scoring tool. In the past couple of months, the team analyzed three risk score models, MARA Concurrent, MARA Prospective, and the health -- Department of Health and Human Services Hierarchical Condition Category, also known as the HSS-HCC.

We compared each plan's risk score with claims, premiums and pharmacy costs. We surveyed the market to learn which risk scoring tools are used by other organizations and consulted with actuaries that support other states and large group purchasers. We also discussed the various risk scoring tools with the health plans. Based on our analysis and the feedback we received, we learned that the MARA Prospective would be the best fit for the CalPERS population and the portfolio rating approach.

It is specifically designed to predict health care costs in the upcoming year as opposed to MARA Concurrent or the HHS-HCC model which are designed to predict costs in the current year. The MARA Prospective is the risk scoring tool used by the State of Washington in their current risk adjustment process for the portfolio

of products they offer to their public employees.

Secondly, we address the issue of volatility in risk scores for plans with relatively small populations. The risk score for each individual health plan will be credibility-adjusted based on the plan size. And I'll talk a little bit more about credibility adjustment on the next slide.

We are also recommending a two-year phase-in approach. Upon implementation of portfolio rating, there could be some changes in the first-year premiums for some plans. In order to reduce volatility and smooth premiums, a two-year phase-in is recommended to split the portfolio rating impacts between year one and year two, meaning that part of the change would occur in 2022 and full implementation would take place in 2023.

The phase-in approach also includes having HMO and PPO rating as two separate risk pools and ultimately moving the entire basic program toward a single risk pool in the future.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: As I mentioned, the risk score for individual health plans will be credibility adjusted based on the plan size. Credibility adjustment is a

standardized actuarial approach when calculating risk scores, medical loss ratio and other financial measures in small plan sizes. It is used in both Medicare and Medicaid programs, as well as by State insurance regulators.

Generally speaking, risk score is a measure of how costly an -- individuals are based on their medical needs compared to the average. A CalPERS member with a risk score of 1.00 means that that person's medical costs are the average of the CalPERS basic program. Similarly, a risk score lower or higher than 1.00 means the person's medical costs are lover or higher than average.

At a high level, the risk-neutral premiums for each health plan is set by removing the average risk score from the medical and pharmacy costs for members who are enrolled in the plan. This means that the accuracy of the risk score is very important Based on a 2012 actuarial -- Society of Actuaries' study, after a plan gets to 25,000 members, the accuracy of the risk score is not increased significantly when adding additional members. Therefore, in our analysis, we assumed the plan-specific risk score is considered 100 percent credible or accurate when enrollment sizes is of 25,000 or larger. Credibility adjustment applies to risk scores with plans of enrollments of sizes of less than 25,000 based on that

standard actuarial credibility calculation.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Next, let's took at the updated modeling results for the HMO based on the final proposed portfolio rating approach. The modeling results include five-year premium projections using the MARA Prospective risk scoring tool in a two-year phase-in. Again, a credibility adjustment is applied to health plans with risk scores -- with health plan risk scores for health plans with enrollment less than 25,000. HMO plans subject to this adjustment are Anthem Traditional, Blue Shield Trio, Health Net SmartCare, Sharp and Western Health Advantage.

One exception is Health Net Salud y Más. It is a cross-border health plan with very unique demographics. Currently, there are also reporting issues related to the health care claims incurred in Mexico. The team is investigating the potential treatment for Salud y Más and will report back to the Committee with our final recommendation in March. It may be appropriate to exclude the plan from portfolio rating for the first year, while we refine the most appropriate approach for this very unique offering.

Please note that these are just projected

premiums that we are sharing today and solely for the purposes of the risk mitigation discussion. And they are not representative of final premiums, which will be aggressively negotiated by the CalPERS team and approved by the PHBC each summer. The modeling considers average annual health care unit cost increases in making its projections.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Before going into the modeling for individual HMO basic plans, I want to give you a global look of what's happening now in the HMO portfolio and how it would look in a portfolio rating environment. If we don't manage the risk within our portfolio, the basic plan premiums will continue to be impacted by adverse selection. As the healthier members migrate to lower cost options, the broad network plans retain a greater proportion of high-cost members with more health care needs relative to other plans.

While differences in the concentration of high and low health risk among the plans keeps increasing, the model shows and increasing disparity between premiums and product values. This is an updated slide compared to the one we showed you in September. We now included all basic

HMO plans, except for Health Net Salud y Más.

On the left here you will see the projection for single-party premiums for the next five years, if we do nothing to mitigate risk. As you can see, we have different products on very different trajectories due to risk concentration. A steeper line means they're getting more unhealthy lives or healthy lives keep moving out of the plan over time. Anthem traditional is the most significant as this product is currently being heavily selected against and Blue Shield Access+ and Health Net SmartCare are close behind.

On the right is the five-year single party premium projection if portfolio rating is implemented in 2022. This is without a two-year phase-in. As you can see, this is in a much more stable environment with much more regular in anticipated premium changes year over year. The differences between the lines reflect the value of the product regardless of the risk concentration in each plan.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: This slide is similar to the last one with the status quo on the left, but of the right is the five-year single-party premium projection for risk

mitigation with a two-year phase-in. In this scenario, we split portfolio rating impacts between year one and year two, meaning that part of the change would occur in 2022 and full implementation would take place in 2023, which allows members to adjust to the changes with a portfolio rating.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Let's look more specifically at each health plan and compare the premium projections under current pricing versus the premium projections under portfolio rating with a two-year phase-in.

On the left is Anthem Select. The pink bars represent the projected premiums for 2022 to 2026 which is pricing based on risk. The green bars represent the premiums for the plans priced risk neutrally with a two-year phase-in. As a reminder, Anthem Select is currently underpriced due to the concentration of healthy risk. As you can see, the portfolio rated premium for 2022 is similar to the current pricing due to the phase-in and then premiums are fully reflecting plan values starting in 2023 and beyond.

On the right is Anthem Traditional. It is offered in many higher-cost lower-competition areas of our

State. Unlike Anthem Select, Anthem Traditional has a concentration of unhealthy risk. The projected premiums under portfolio rating are priced based on the plan's value and are much more stable year over year.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: On this slide, to the left is Blue Shield Access+, which displays a similar pattern as I just described for Anthem Traditional with more stable premium increases under portfolio rating than under the current pricing.

On the right is Blue Shield Trio. It's the new ACO HMO plan available in six counties started in the 2020 plan year and expanded to nine in 2021. The premiums under portfolio rating are credibility adjusted. As you can see, after portfolio rating, the rates are slightly above the current pricing.

Next, we have Health Net Smart -- next slide, please.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Next, we have Health Net SmartCare and Kaiser. Health Net SmartCare on the left sees a similar pattern to Anthem Traditional and Blue Shield Access+ with

more stable year-over-year premium increases and lower overall projected premiums under the portfolio rating environment.

Kaiser has similar results under both scenarios. This is because Kaiser has the largest population of the entire HMO basic portfolio, nearly half of all of its members. And as a result, Kaiser's risk score is very close to that. It's just slightly below.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Here, we have Sharp and UnitedHealthcare. Similar to Anthem Select, both Sharp and UnitedHealthcare are currently underpriced due to the concentration of healthy risk. The projected premiums under portfolio rating are higher compared to the current pricing, which better reflect the value of the product. Sharp's premiums are credibility adjusted due to the low plan size.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Lastly, we have Western Health Advantage. It has similar premium projections for both scenarios. This is because the average risk score for Western Health Advantage's population is similar to that of the overall

HMO basic program. Its risk score is also credibility adjusted due to low enrollment.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Next, we will discuss the updated results from the modeling of portfolio rating for the PPO basic health plans based on the final proposed methodology, including replacing current PERS Basic PPO plans with the proposed PERS Platinum and PERS Gold. Similar to the HMO plans, we will show you the projected premiums under the current pricing, if we don't mitigate risk and what it would do under the portfolio rating environment.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Before I dive into modeling results, I want to emphasize the different portfolio rating approach for PPO compared to HMO. As we discussed in September, our PPO plans are administered by a single third-party administrator, currently Anthem Blue Cross, with the same business model, same care management tools and approaches, same underlying provider contracting, same leverage and provider negotiations, and the same geographic footprint which is the whole state.

We will able -- we are able to price each PPO plan based on the network and benefit differentials, while for the HMO, we have to utilize risk scoring tool to remove the underlying health risk from pricing.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: First, we will show you what will happen if we don't manage risk within our PPO portfolio. On the graph, the orange bars represent the five-year premium projections for PERSCare, the green bars in the middle are the premium projections for PERS Choice and the blue bars are PERS Select.

Just as a reminder, PERSCare is a broad provider network PPO plan, with a richer benefit design and an actuarial value of 92 percent. PERS Choice is the same provider network as PERSCare, but leaner benefit designs with an actuarial value of 87 percent. PERS Select is the lowest plan value compared to the other two PPO plans with a slightly narrower network and has the same benefits as PERS Choice with the addition of some value-based insurance designs.

Similar to the PPO portfolio, if we take no action, the basic portfolio -- PPO portfolio will continue to be impacted by adverse selection. PERSCare will see

about 10 percent annual premium increases from 2022 to 2026, as the healthier members continue to exit out of the plan because of their inflated premiums and move to lower valued plans. By 2026, PERSCare will lose 60 percent of its membership.

As we've discussed, the PERS Select premium is currently underpriced due to the concentration of healthy risk. Over time, as healthier members continue to move to lower option plans from PERSCare to PERS Choice, from PERS Choice to PERS Select, the premium disparity continues to worsen in the PPO basic program.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: These are the five-year premium projections if we portfolio rate and price the three PPO products based on the plan's value starting in 2022.

Under portfolio rating, all three PPO plans have stable premium increases year over year. As a member of migrations between PPO plans are no longer impacting the premiums. However, the premium will be brought much closer together, because there's very little difference in the plan value between these products. This does not provide meaningful choice to CalPERS members. With that in mind, as discussed in September, next I will show you

the updated projections for replacing the current three PPO options with PERS Platinum and PERS Gold.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: In this scenario portfolio rating is implemented in 2022 and the three PPO basic plans are converted to two plans, PERS Platinum and PERS Gold.

In this new two-plan design PERS Platinum would remain the same broader provider network and richer benefits as today's PERSCare with a 92 percent actuarial value. PERS Gold would be similar to today's PERS Select with the same narrow provider network, but with reduced benefits at 80 percent actuarial value, rather than 87 percent, meaning it would be less rich benefit design than the PERS Select plans. With these two products, we would have a true distinction in benefits and pricing under portfolio rating for the PPO.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: These are the premium projections with a two-year phase-in approach. In this scenario, we split the premium impacts of implementing portfolio rating between year one and year two, meaning that part of the

change would occur in 2022 and full implementation would take place in 2023.

Following the September Board meeting, we began discussing potential benefit designs options for PERS Gold with our stakeholder communities. Each organization expressed a desire to gather additional feedback from their various members to better weigh in on the options to reduce the actuarial value of PERS Gold.

As a result, we are recommending including the benefit design changes to PERS Gold as part of the second year of the two-year phase-in. Therefore, for the first year and 2022, we recommend replacing the current three PPO plans with PERS Platinum and PERS Gold, with PERS Platinum being the same as the current PERSCare and PERS Gold being the same as the current PERS Select.

As the next step of the phase-inn approach, we would continue to discuss with stakeholders about the potential benefit design changes for PERS Gold to move towards a benefit design more similar to a standard 80 percent actuarial value gold level plan. We would bring those proposed changes to the Committee in November of 2021 for recommendation to implement in 2023.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

CHIEF GREEN: With that, I'd like to provide our recommendation.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

CHIEF GREEN: For the entire basic portfolio, the team recommends adopting portfolio rating with a two-year phase-in. For the PPO basic portfolio, the team recommends replacing the current PPO basic plans with the proposed PERS Platinum and PERS Gold with the specific benefit designs for those new plans to be considered and adopted next November and the final benefit designs in place for the 2023 plan year.

This concludes my presentation and I'm happy to take questions.

CHAIRPERSON FECKNER: Thank you, Ms. Green for a great presentation. I do have a couple of questions. I have Ms. Greene-Ross.

ACTING COMMITTEE MEMBER GREENE-ROSS: Thank you, Marta. That was very, very interesting and very helpful. I just sort of have big picture questions about the impact of this transparency long term. And so, first, it's -- I'm curious if we can apply or will apply this model to the other plans. And then if so, you know, how -- that will become more public. And I'm just curious about

making all this information more public, claims experience, and the impact on our negotiations with these providers and whether you know how the state's other purchasers are applying this and being transparent about that as well, because I think that information also is the more -- the more transparency overall, would help all of us public health purchasers.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Great questions. Thank you, Ms. Greene-Ross. So the pieces that we're proposing to make entirely public are each plan's risk score, so you understand kind of how the proposed premiums would be adjusted.

We are also engaged in a whole lot of price transparency initiatives that are not directly related to this, but I think get to specifically your comment. So recently, we participated with Rand on a hospital price transparency study, where we provided our entire claims experience over a five-year period, in order to calculate the average percentage of Medicare for a wide variety of procedures, both inpatient and outpatient at each hospital in California to really articulate and understand the performance of each hospital on the metric of pricing in our portfolio.

And these sorts of initiatives not advanced the

public conversation, which I think is what your addressing. So how do we all understand how health care unit costs are impacting all of us as health care purchasers and health care users, but also specifically to CalPERS how is each facility performing in our portfolio and how do we use that in negotiations moving forward?

On the issue of transparency in the portfolio rating process? The State of Washington, which is one that I referenced in the presentation, they also publish health plan risk scores on a routine basis. So it helps build trust and transparency in the whole process.

ACTING COMMITTEE MEMBER GREENE-ROSS: Yeah, that's great. I think it would help long term on all of that. So thank you.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Thank you.

CHAIRPERSON FECKNER: Thank you. I have Ms. Westly.

COMMITTEE MEMBER WESTLY: Thank you. This is really a comment not a question. And, first of all, I wanted to thank Ms. Green and Mr. Moulds for their presentation. And you make this stuff very easy to digest. And I very much appreciate it, being new to the CalPERS Board and the Health Committee over the last, you know, year.

As we move forward, I think it's really important that we, as a Committee, and we, as the CalPERS Board, really focus on how we can help to influence bringing down some of these health care costs, because this is the end result of a system that just simply doesn't work for the benefit of patients. There have been anti-competitive practices in Northern California. Those are now headed into San Diego and other Southern California areas. Large health care mergers always end up with patients paying more and receiving less care.

And our Attorney General Becerra had an initiative -- a measure, and the Legislature -- next year, SB 977 by now termed-out Senator Bill Monning which dealt with reviews of these health transactions. And I really think that this is something that we as health care committee members should start focusing on in ways that we can help support a way to have more say over these exploitative costs to patients. For instance, a C-section in Sacramento is 13,000 more than in LA County. A knee replacement is 15,000 more in Sacramento then it is in LA County. And last time I checked, LA County has a higher cost of living.

So it's nothing that we can solve here today on this call. But in order for us to enjoy more appropriate health care premiums that only starts when we start having

the hard conversation about how we deliver better price regulation in someway to bad actors in California. And that may indeed include allowing the Attorney General in the future to be able to review health transactions for all health care mergers, not just nonprofits, which he already does.

That was my comment. Thank you so much.

CHAIRPERSON FECKNER: Thank you.

I have Ms. Brown.

COMMITTEE MEMBER BROWN: Thank you, Mr. Chair. Thank you, Marta, for the information.

I want to go to page 22 of the presentation. It's the two-year phasing -- phase in of the new benefits, if we approve. It's the PERS Platinum and the PERS Gold. So -- so basically, Marta, what you're saying is the people who are currently in PERSCare are overpaying for the services they're receiving -- for their benefit design, is that correct?

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: That's correct.

COMMITTEE MEMBER BROWN: And how many of those are there in PERSCare, just roughly?

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: You know, I don't recall off the top of my head, but I can certainly get the enrollment figures for

all of the plans.

COMMITTEE MEMBER BROWN: Okay. So -- yeah, so I'm going to request that information and then -- and then so the people who are currently in PERS Select and the other PERS, what's it called?

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Choice.

COMMITTEE MEMBER BROWN: Choice, they're underpaying for their benefit design, is what you're saying?

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: So PERS Choice is a little bit closer to a risk-neutral premium.

COMMITTEE MEMBER BROWN: Okay.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: It's -- but PERS Select is significantly under what a risk neutral premium would be.

COMMITTEE MEMBER BROWN: Okay. So what I want to see is not only what people are -- how many people are in each plans, I'd like to see a dot plot of where they are, because my guess is, is that a majority of the PERS Platinum who are overpaying are in rural areas, because they don't have access to HMO. I don't know that, but I'm sure you could just give me a little GIS plot of where these people are.

You know, my concern is -- I mean, do we have three times as many people paying for PERS Choice and PERS Select as we do in PERSCare? I mean, what's the ratio 3 to 1?

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: It could be about that. But again, PERS Choice is somewhat similar to a risk-neutral premium. PERS Select is the one that's -- that's significantly underpriced.

COMMITTEE MEMBER BROWN: You know, my concern is that if it's 2 to 1 or 3 to 1 that basically, you know, 75 percent or 50 percent of the population is going to be paying to help bring down the benefits for our least healthy population. And I don't know that we should be doing that, because when I look at -- when I look at on page 22 the $824 in year career 2026, I know that's -- that's an estimate, but I can't -- I mean, it would have been like $683 if we left it the same.

And so that's a -- that's a huge increase we're asking for a lot of people to pay. And I want to know what that number is before I vote on this, because I just want to see how many people are going to have to pay a lot more for their health care. I mean, right now people are struggling, and I have serious concerns about this plan.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

CHIEF GREEN: I'll be happy to get those figures for you.

COMMITTEE MEMBER BROWN: Thanks.

CHAIRPERSON FECKNER: Thank you.

I have Mr. Miller.

COMMITTEE MEMBER MILLER: Yes. Thank you again for a really clear and understandable presentation. The kind of piggybacking on Director Brown's point, when -- the pain point for folks who are in the PERS Select over the coming years is really, I think, going to be a hardship for a lot of people. I think it was pretty predictable, and we've had these discussions when these things were being developed, that it looked like we were really trying to, more or less, kill off the top tier PPOs and push people to move into PERS Select. And we were really eager to push people to choose that option, because of some of the new features of that option. It was more HMO like in some respects.

People were reluctant that the cost was such a big driver and that it almost, I think for some stakeholders that I've talked to, they feel it feels like kind of a loss bait-and-switch to get them to abandon the more -- you know, the luxurious, as some people viewed it, PPOs or higher costs than go into that, because they simply couldn't afford to stay, and the price differential was so attractive.

And now it feels to them like now we've got you, so now we'll raise the prices. We'll restructure and you will no longer even have the option of, you know, the top tier PPO plans and that they're just, you know, pushing the whole thing that direction.

And I don't know how we overcome those perceptions or deal with that, but it -- over the past few years, it seems kind of a predictable outcome that is where we end up in terms of the migration patterns from these plans. And it just worries me that the size of the impact on some of our members who are the least, in some cases, able to afford, because of their -- the acuity of their illnesses has forced them to make these kind of choices.

So I just, you know, raise that as a comment. I think I still don't see a better path forward for us, but it's a painful road to be walking.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Yes, Mr. Miller. I would just add that that's part of the reason why in September we discussed that there are ways to offer lower premium options, but the cost sharing associated with those lower premiums option is quite high. And so it is a very difficult conversation, the tradeoff between premium and cost sharing, which is why we've struck a middle approach of

the PERS Gold.

CHAIRPERSON FECKNER: Thank you. I have Mr. Rubalcava.

VICE CHAIRPERSON RUBALCAVA: Thank you, Mr. Chair. Thank you, again, Marta and Don, for the presentation.

In one of the -- I'm not sure if it was your memo or Don's memo, but one of the earlier memos that's I read, it very succinctly met -- stated what our goal is, which is to provide affordable, sustainable quality health care. I thought that was very well stated.

And I think this approach is trying to get the insurance companies and the medical network to provide -- to manage care, meaning if people are chronically ill, their acuity, like Mr. Miller mentioned, that they deal with that, that they try to stabilize them and improve their health, if they can, for example pre-diabetics. And at the same tme, we have to acknowledge that there are geographical access issues, as Ms. Brown mentioned.

So I do want to comment and applaud the effort you guys are doing. I came on this Board after the decision had been made to get rid of risk adjustment. And so we saw the fluctuation in the rates as everybody was trying to figure out what they would do.

But I think this is an effort going back to get

them to do what they're supposed to do, promote the best care methods, right, the best practices, and create those networks that would have the best cost efficiency, because they do bring in their patients and try to make sure there's -- they meet the primary care physician, what have you. So we're trying to do this and I applaud you.

So my question is I had a question you raised -- answered it already. Somebody asked on the risk scores, they'll be public.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Yes.

VICE CHAIRPERSON RUBALCAVA: So I guess it fits to my early question about the timetable on the rating -- on the rate development. The risk scores that come out of this MARA -- MARA, the Milliman.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: MARA, yes. Yep.

VICE CHAIRPERSON RUBALCAVA: So is it -- I know under State law, the actuarial results are the actuarial results. You can't negotiate them. You can't argue them. Are the risk scores in the same situation where can -- can the carriers try to fight, push back, or something like that or they're -- they're -- explain how that's going to be, once we publish them or release them.

Thank you.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Thank you. That's a great question. So risk -- the risk scores are the risk scores. So they will -- each member in the CalPERS portfolio, you -- if you receive CalPERS coverage, I receive CalPERS coverage. I have a risk score associated with me and my children have a risk score associated with them. And so what a plan's risk score is the cumulation of all the risk scores of the members enrolled in the plan.

So there is no argument over what the risk score of the plan is at the time in which its run. The only conversation that pertains to the rate development process, which is the same conversation we have today, is what is the next open enrollment period going to do to member migration? So how many healthier or unhealthy members do we predict are going to move in and out of the plan in order to predict the upcoming health care costs? That's the central conversation that takes place in rate negotiation.

And what's happening right now is because we have adverse selection and we have these volatile member migration patterns, people are moving more quickly. And so the carriers are incentivized to then build in more reserves in their product to potentially absorb those more unhealthy members for those plans that are being selected

against.

With a portfolio rating environment where we see much more stable member migration patterns and much more stable risk scores, those margins shrink significantly because we can better anticipate how many members are going to move in and out of each plan, because the pricing is no longer driving unhealthy risk in one direction and healthy risk in another direction.

So the only part of the negotiation relative to the risk score is what we think the upcoming open enrollment period will do, so how many people are coming in and out of, say, Access+ or in and out of SmartCare, or in and out of Trio, and then what is the predicted risk score once the plan year actually begins?

But for the risk score today, I could publish every plan's risk score today. I could do it again next week. I could do it in January. And that will be a snapshot in time based on the enrollment of that plan today.

VICE CHAIRPERSON RUBALCAVA: Thank you. That's good to know. Appreciate that. Mr. Feckner --

CHAIRPERSON FECKNER: Very good.

VICE CHAIRPERSON RUBALCAVA: Mr. Feckner, unless there's other comments, I would move that we adopt staff recommendations to start the implementation process.

CHAIRPERSON FECKNER: Thank you for the motion.

Is there a second?

COMMITTEE MEMBER WESTLY: This is Westly, I'll second.

COMMITTEE MEMBER MILLER: I'll second it.

CHAIRPERSON FECKNER: Was that -- was that Ms. Westly seconding?

COMMITTEE MEMBER WESTLY: Yes.

CHAIRPERSON FECKNER: Thank you.

All right. Motion being before.

We do have some requests to speak from the audience. I believe we have up to five folks that wish to speak. Mr. Fox.

STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair. First off, we have from RPEA Joanne Hollender.

MS. HOLLENDER: RPEA. Can you hear me?

CHAIRPERSON FECKNER: We can.

MS. HOLLENDER: Thank you for listening to me and giving me an audience. Thank you, Board. You're doing a great job in making a very tough decision. And the staff, you're working very hard. I represent a lot of people in RPEA. About 60 percent of our members are in public agencies and schools. The rest are State employees. So there are some concerns about the cost to the employees and to the agencies having to bear the cost of these

increases and changes in the PPO plans in particular.

And I did a little analysis -- it -- based on some discussion we had back in October 9th, it was a risk mitigation meeting with the staff. And we talked about, you know, options -- design options. And they said, okay, here's the one that we ended up hearing about on November 12th. But there was going to be some other options, such as a 25/75 for the Select Plan, which would be Gold. And the PERSCare plan, which would be Platinum, would have been possibly looked at as the 85/15.

But when the November 12th meeting came up, there was no option discussed with this. We were told it's just going to be the PERSCare current rate under Platinum and PERS Select under Gold. And that was it. There was no discussion. We weren't given an option to discuss it or ask about it. And that's one of the problems with this death spiral with the PERSCare plan because you're really not addressing the fact that the 90/10 plan is just too rich. It's expensive.

And I did a comparison between page 19 and 22, the current rates. And I'm not saying we want to keep those. I'm not suggesting that. But with what is finally being proposed, the PERS Select folks, as Ms. Brown said, they're taking a huge hit. They're going to be taking a 16.8 percent increase for the next -- the next year 2021.

And the following year, they're going to be taking a 10.7 percent increase.

And now the Choice folks are going to be take -- if they go into the Platinum only talking about a 5.8 percent increase next year. However, if you look at the Care, Platinum, they're going to be taking a 24.4 percent decrease. So you have the other PPO plans, or the Select plan, basically subsidizing them. Now, this is crazy. You're not really addressing the PERSCare issue, which is now Platinum. You did suggest these other options. We never got a response. We were just said this is what it's going to be, period. Marta told us that.

And I think that's very unfair to the stakeholders who really put a lot of time into this. And it isn't fair to the employers or the employees that do have to fork up that money out of their pension to pay for these health benefits. And I know I've been talking about this for a couple years with you folks, but no one is really listening.

And I'm just really, really --

CHAIRPERSON FECKNER: Ms. Hollender, your time has expired.

MS. HOLLENDER: Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Fox.

STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair. Next up, we have Mr. Tim Behrens, California State Retirees.

MR. BEHRENS: Thank you, Kelly. Committee members, Board members, CSR supports the Gold/Platinum plan. For our members, there's significant -- no significant increase in cost and no significant loss in our health plans. So we support the plan to move in 2022 to the Gold/Platinum health benefits.

Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Fox.

STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair. Next up, we have from the town of Truckee Nicole Casey.

MS. CASEY: -- letting us comment -- hi, there. Thank you for letting us comment on this item. We just wanted to point out that in the town of Truckee, we aren't being given access to any additional plans. So we're basically being asked to take on the risk of other areas and higher cost plans that we don't even have access to. It's -- it feels pretty unfair when we're asking our members, who don't have access to great care. Already, I have employees who are driving an hour down to Nevada to try and get access to a doctor. And we're asking them to take on additional cost for this program without even

giving them access to additional plans and programs, especially since just a couple years ago we were asked to take on the risk for the Bay Area, which increased our rates as well.

So as you're designing these plans, please keep in mind that you have specific areas which are not being given access to the supposed -- I think your words were price and quality options, that you're giving access to everyone else in the state.

So thank you for the opportunity to comment and we hope that you consider us. And we'd be happy to participate in any stakeholder groups that you have still running on this.

CHAIRPERSON FECKNER: Very good. Thank you for your comments.

Mr. Fox.

STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair. Next up we have from CSR, Larry Woodson.

MR. WOODSON: Hello. Can you hear me?

CHAIRPERSON FECKNER: We can hear you.

MR. WOODSON: Okay. Thank you for the opportunity to comment. Just amplifying a little bit on Mr. Behrens CSR's support for this. We -- we do thank the staff for all their hard work, also, for all the transparency. I think there's been a lot of discussion.

And unlike one of the previous commenters, I think we -- even though there was comments given about the increase in the lower price, it -- the current proposal considers that by doing a two-year phase-in, which makes the first year increase less. So I think that does address some of the concern.

Clearly, the value-based approach does result in an increase in premiums on the lower plans. And I -- we recognize that, but it significantly lowers and stabilizes the higher cost death spiral plan, was populated by a lot of our older, sicker members and those -- you know, the values of those plans is not commensurate with the cost.

And so the other thing is that, you know, I had asked -- I asked and received a new estimate on the monthly contributions, because that's part of the equation that, you know, members need to be considering when they're considering this approach. And the good news is that the monthly contribution actually goes up over the current contribution with this new strategy. It goes up to $840 a month for a single ratepayer. And that means for retirees that are fully vested, that more than covers any increase in the lower cost plans, if they're in Select.

So I think, you know, some actives would be paying more, but if you're in SEIU, what they contribute,

they've negotiated, along with the lawyers, better contribution rates, which would more than cover the increases.

So I think it's better not to kick this thing down the road, again, if it didn't pass. And we agree with the Platinum/Gold. Most of the Choice members would migrate to Platinum, because the cost would come down considerably and be affordable to them. And we are concerned about benefit design changes in the second year, but we have an opportunity to input then.

So thank you for the opportunity to comment and that's all.

CHAIRPERSON FECKNER: Thank you.

Mr. Fox.

STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair. Next up, we have from RPEA Mr. J.J. Jelincic.

MR. JELINCIC: J.J. Jelincic, Director of Health Benefits for RPEA. RPEA is not taking an organizational position on this issue. We did not have enough information to make a reasonable evaluation. We do not know what information staff has told the Board in closed session that has not been shared with the constituents.

This project is designed not to protect the health risks of members, but the financial risks of the health plans. We are not convinced that protecting

PERSCare is in the best interests of the majority of the members. If members do not value Care enough to pay for it, it is not clear that the members who accept lower insurance protection offered by PERS Choice and their narrower network of PERS Select should be asked to subsidize the richer plan.

It is also unclear that protecting those HMOs with the highest costs by asking other members to subsidize the costs serves the members as a whole. If plans could not compete, there is little reason to keep the zombies alive.

It's hard to believe that a plan that increases the cost of 80 percent of the members to lower the cost of 20 percent of the members is justified. The staff has said that the issue is health care risk. But when you look at the HMO data, it appears to be a back-door rural subsidy. Staff has said that geography and cost are not connected -- are not considered in the migration. However, the Milliman Advance Risk Adjusters, which are you going to use, provides and uses both provider costs and geography. It's just a coincidence that the higher the rural exposure, the higher the subsidy.

The plan is not to adjust the premiums between regions 1 and 3, because that is just cost not health differences. You can't have it both ways. Either costs

and geography matter or they don't. If you want a conversation about rural subsidy and subsidizing the sickest, we are willing to have that discussion, but it should be direct and not back-door.

Also, I hope that the subsidies and surcharges will be made explicit when the rates are set. On the other hand, that would involve transparency, so I'm not really expecting to see it, despite what staff has said.

Thank you.

CHAIRPERSON FECKNER: Mr. Fox, please.

STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair. The last caller on Item 6b is Terry Brennand.

CHAIRPERSON FECKNER: Mr. Brennand, are you there?

MR. BRENNAND: Oh, shoot, yeah. I'm here now. Sorry.

(Laughter.)

MR. BRENNAND: When I put it to my ear, I put it on mute.

First, let me start by thanking Don and the whole health care team for reaching out and explaining to stakeholders what can be a very complex issue. And I appreciate all the work they've put into it. I think it's clear that this is an effort to avoid disastrous consequences of the status quo. If we do nothing, the

consequences are fairly dire, and this is an effort to avoid that.

In terms of disruption, we've gone -- we need to look back at history. We've done this before. There was disruption in the rates when we made the transition. And there was significantly more disruption when we eliminated it.

So I think our concern is making sure we're more strategic and surgical with this risk mitigation than the blunt instrument used last time that caused significantly more disruption and premium changes going forward.

Thirdly, there -- members have expressed an interest in innovation and attacking cost drivers. There's no better way than to price these plans actuarially to encourage folks to attack the costs of health care and be rewarded, you know, commensurately with their innovation

And then in terms of the plan option, I mean, this is kind of like we're playing with Jenga game here. And you don't want to pull out two boards at once. The idea of rolling the premium impact over two years is very smart. But the idea of adding on top of that an additional plan option really complicates the impact of one over the other, and you could make that assessment somewhere later down the road.

For that reason, SEIU is in support of the motion before you and we urge you to support it as well.

Thank you.

CHAIRPERSON FECKNER: Thank you.

Anyone else, Mr. Fox?

STAKEHOLDER RELATIONS CHIEF FOX: Mr. Chair, that concludes public comment on Item 6b.

CHAIRPERSON FECKNER: Thank you very much. Before I go back to comments, Ms. Green or Ms. Moulds, do either one of you have any rebuttal to the comments from the callers?

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: The one that sticks out to me is Ms. Hollender. So the conversation that we're going to have relative to the final benefits design for PERS Platinum and PERS Gold will continue. We did introduce some concepts. She did reference our October meeting, which we did introduce some concepts at that meeting. That conversation isn't done. That conversation is just going to extend over the next year. And we'll bring to the Board final recommendations for the designs for PERS Platinum and PERS Gold. It's just, as Mr. Brennand just indicated, doing both of those things at the same time was not enough time for stakeholders to give full-throated and meaningful impact. So we do intend to extend that

conversation. And I apologize if that was not clear.

CHAIRPERSON FECKNER: Very good. I appreciate the explanation.

I have Ms. Brown.

COMMITTEE MEMBER BROWN: Thank you.

Marta or Don, how do these changes impact what the State pays for health care or does it impact them at all and do they have a comment on this?

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: So the risk mitigation, the portfolio rating has a very, very minor impact on the contribution. But the change from two PPOs to a single PPO will impact the State contribution, because right now what happened is the State contribution went down significantly in the most recent plan year, because PERS Select in the calculation overtook PERS Choice, because they use a very specific calculation of just subscribers in State employment. And so that subgroup of folks became more insured than the PERS Choice group of folks. So the State contribution actually dropped about $50 a month. And so when we go to two-plan options, that will change the calculation. And so that would increase the State contribution.

COMMITTEE MEMBER BROWN: All right. Thank you.

And then, you know, I -- I, too, have -- like I expressed earlier, I have concerns about the -- the

PERS -- God, the PERS Gold not only increasing dramatically, but what those benefit design changes are. And I recall when we last talked about this in a public meeting or maybe the time before, you talked about how we would make changes, so they would feel the same, but not that they would be the same.

And so my concern is that we don't know what those -- those benefit design changes are. But, I mean, if we're talking about increasing copays or increasing deductibles, I -- so we've increased their premium and we're going to increase their, more than likely, out-of-pocket. And I -- you know, I would not be able to support that.

I think, for me, it's premature to vote on this plan. I'll be voting no if we end up going forward at this point, because I need more information.

Thank you.

CHAIRPERSON FECKNER: Thank you.

We now -- seeing no other requests to speak. We have a motion before us.

Ms. Hopper, please call the roll.

COMMITTEE SECRETARY HOPPER: Margaret Brown?

COMMITTEE MEMBER BROWN: No.

COMMITTEE SECRETARY HOPPER: Henry Jones?

COMMITTEE MEMBER JONES: Aye.

COMMITTEE SECRETARY HOPPER: David Miller?
COMMITTEE MEMBER MILLER: Aye.
COMMITTEE SECRETARY HOPPER: Eraina Ortega?
COMMITTEE MEMBER ORTEGA: Aye.
COMMITTEE SECRETARY HOPPER: Ramon Rubalcava?
VICE CHAIRPERSON RUBALCAVA: Aye.
COMMITTEE SECRETARY HOPPER: Theresa Taylor?
Shawnda Westly?
COMMITTEE MEMBER WESTLY: Aye.
COMMITTEE SECRETARY HOPPER: Karen Greene-Ross for Betty Yee?
ACTING COMMITTEE MEMBER GREENE-ROSS: Aye.
COMMITTEE SECRETARY HOPPER: Mr. Chair, I have six ayes, one no made by Margaret Brown. Motion was made by Ramon Rubalcava, seconded by Shawnda Westly for agenda Item 6b, risk mitigation strategies.
CHAIRPERSON FECKNER: Thank you very much.
So before we go to Item 6c, we are going to take a 10-minute comfort break. So everyone can turn off their cameras if they'd like for a moment. When we come back our IT staff is confident that WebEx may have fixed their problems for the day. So if you want to turn your cameras back on, we'll see how that works.
So again, we're going to take a 10-minute break. We'll reconvene at 11:40.

(Off record: 11:30 a.m.)

(Thereupon a recess was taken.)

(On record: 11:41 a.m.)

CHAIRPERSON FECKNER: Call the meeting back to order. And we're going to move to Agenda Item 6c, Minimum Standards for Health Benefits Plans.

Ms. Green, whenever you're ready.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: Thanks again, Mr. Chair and members of the Pension and Health Benefits Committee. Marta Green for the third time and the last time today.

(Laughter.)

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF GREEN: This is Agenda Item 6c, which is an action item requesting your approval to pursue proposed amendments to existing regulations regarding risk adjustment to ensure our regulations are consistent with the just approved risk mitigation strategy. These are found in the section of our regulations that pertain to minimum standards for CalPERS health benefit plans.

There are -- there are -- the existing regulation is obsolete and outdated. And we're proposing changes that fall into two basic categories. So there's the revise category and the removed category. Here are the sections that we're proposing to revise. California Code

of Regulations section 599.500(x). So the purpose of this update is to update the definition of risk adjustment to reflect current actuarial science. This amendment is a non-substantive technical change.

California Code of Regulations Section 599.508(a)(8). The purpose of this amendment is to make non-substantive technical changes. This amendment is necessary to provide greater system flexibility in managing health risk by deleting outdated references.

California Code of Regulations section 599.508(a)(9). The purpose of this amendment is to delete an outdated monetary reserve requirement for CalPERS health benefit plans. This is actually not directly related to the risk mitigation strategy. However, it is found in the same general section of our regulations as the risk adjustment provisions.

And since, we're reopening this regulation for the new risk mitigation strategy, it is timely to fix this outdated language that has is been in our regulations since the 1970s. This change has no impact on our current Health Care Fund Reserve policy.

The section we are proposing to remove are California Code of Regulations Section 599.508(a)(8)(A) through (8)(E). So this will remove obsolete processes used to administer the previous risk adjustment. So it

articulated all the ways in which the old risk adjustment program was administered, while still requiring health plans to participate in any risk adjustment methodology as chosen by the CalPERS Board.

If the Committee approves these changes, we'll submit our public notice package to the Office of Administrative Law for processing and we'll return to the Committee in the coming months to request approval of the final rulemaking file. So this is just to begin the rulemaking process.

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

CHAIRPERSON FECKNER: Thank you. So far I'm seeing no requests to speak.

This s an action item. What's the pleasure of the Committee?

COMMITTEE MEMBER MILLER: Move approval.

MS. SWEDENSKY: There is public comment.

CHAIRPERSON FECKNER: A motion by Mr. Rubalcava Is there a second?

MS. SWEDENSKY: Rob.

VICE CHAIRPERSON RUBALCAVA: Mr. Miller moved it, I think.

CHAIRPERSON FECKNER: What was that?

VICE CHAIRPERSON RUBALCAVA: Mr. Miller moved --

I'll second the motion.

CHAIRPERSON FECKNER: Oh, I'm sorry. Thank you.

VICE CHAIRPERSON RUBALCAVA: But I'll second the motion.

CHAIRPERSON FECKNER: Very good. Mr. Miller makes the motion, Mr. Rubalcava seconds the motion.

Any discussion on the motion?

MS. SWEDENSKY: Rob, this is Cheree.

CHAIRPERSON FECKNER: Yes.

MS. SWEDENSKY: There is public comment on this one.

CHAIRPERSON FECKNER: I see that. I was just seeing if there was anybody else before we move forward.

MS. SWEDENSKY: Oh, sorry. Okay.

CHAIRPERSON FECKNER: All right.

Seeing no one else wishing to speak.

Mr. Fox.

STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair. We have one speakER on Item 6c. J.J. Jelincic.

MR. JELINCIC: Hello. I was not on 6c. I was on 6d as in David.

CHAIRPERSON FECKNER: Very good. We'll get back to you then, sir.

MR. JELINCIC: Thank you.

CHAIRPERSON FECKNER: All right. Seeing no one

else on Item 6c. The motion being before you.

Ms. Hopper, please call the roll.

COMMITTEE SECRETARY HOPPER: Margaret Brown?

COMMITTEE MEMBER BROWN: Aye.

COMMITTEE SECRETARY HOPPER: Henry Jones?

COMMITTEE MEMBER JONES: Aye.

COMMITTEE SECRETARY HOPPER: David Miller?

COMMITTEE MEMBER MILLER: Aye.

COMMITTEE SECRETARY HOPPER: Eraina Ortega?

COMMITTEE MEMBER ORTEGA: Aye.

COMMITTEE SECRETARY HOPPER: Ramond Rubalcava?

VICE CHAIRPERSON RUBALCAVA: Aye.

COMMITTEE SECRETARY HOPPER: Theresa Taylor?

Excused.

COMMITTEE SECRETARY HOPPER: Shawnda Westly?

COMMITTEE MEMBER WESTLY: Aye.

COMMITTEE SECRETARY HOPPER: Karen Greene-Ross for Betty Yee.

ACTING COMMITTEE MEMBER GREENE-ROSS: Aye.

COMMITTEE SECRETARY HOPPER: Mr. Chair, I have all ayes. David Miller making the motion, Ramon Rubalcava seconding on Agenda Item 6c.

CHAIRPERSON FECKNER: Thank you very much. Thank you, Ms. Green.

Moving on to 6d, Long-Term Care Optional Benefit

Design and Premium Changes. Mr. Moulds.

You're muted, Don.

CHIEF HEALTH DIRECTOR MOULDS: Sorry about that.

CHAIRPERSON FECKNER: There you go.

CHIEF HEALTH DIRECTOR MOULDS: Is that better?

CHAIRPERSON FECKNER: It is.

CHIEF HEALTH DIRECTOR MOULDS: Great. Apologies. Good morning. Don Moulds, CalPERS team. I'm here this morning with the task of leading you through a discussion about raising rates in the CalPERS Long-Term Care Program. We're in an unfortunate situation, where any resolution is going to add to the financial burden facing our policyholders. Over the next few minutes, I'm going to discuss options our team has developed in an effort to lessen those hardships while also protecting future benefits for policyholders.

I think it's helpful to begin with a review of where things stand with respect to the Long-Term Care Program. Back in the spring, the team alerted the Board and the public that CalPERS was facing the potential need to reduce the discount rate for the Long-Term Care Fund in light of recent returns of fixed income investments, investment which are the Long-Term Care Fund's primary holdings, and to adjust actuarial assumptions in the model it uses to project future costs.

In September, our Chief Actuary, Scott Terando, shared in the Finance and Administration Committee that based on the work conducted by his team and validated by outside actuaries, the Long-Term Care Program is about 69 percent funded and faces a shortfall of about $2.1 billion. He also shared that absent intervention, we would need to adjust the discount rate for the long-term care investment fund from its current five and a quarter percent down to about four percent.

Given the challenging situation and the resulting potential for extraordinarily high rate increases, we committed to engaging in a thorough process to consider every possible option to minimize the rate increase, maintain the sustainability of the program, and protect the coverage our policyholders are relying on.

Specifically, we've been exploring two ways to lessen the needed rate increase. The first is by taking action to improve our investment returns. The second is through changes to the benefit design, which policyholders could take up on a voluntary basis to provide rate relief.

Yesterday, in the Investment Committee, you heard there is room to improve our projected returns. Doing so reduces the total premium increase needed by about 40 percent. But as you also heard, even with the improved discount rate, stabilizing the Long-Term Care Fund will

still require significant premium increases.

Today, in PHBC, we are seeking your approval on two items. The first is a premium increase that will apply to all long-term care policies. This will be divided unevenly over two years. The second is approval of components of an optional benefit package that policyholders may take up in lieu of that premium increase. I'm going to start off with the premium increase.

As you heard Scott and Christine articulate Monday, base on the revised discount rate that was adopted yesterday by the Investment Committee, we are proposing for your consideration to reach the amount of the needed premium increase by raising rates over two years. The first increase would be 52 percent. And it would be implemented starting in July of 2021. A second smaller rate increase of 25 percent would go into effect one year later in July of 2022.

There are a couple of reasons why we're proposing a two-year rate increase that is split in this way. The first is that it distributes the increase over more than one year, but avoids the need for the cumulatively higher rate increase required, if we were to spread it over multiple years.

And second, we are currently developing a novel

benefit package that I am hopeful we -- will be both attractive to policyholders and cost savings. I will talk about that more in a minute.

The high-end value of that benefit package could be commensurate with the cost of the second year rate increase of 25 percent. So if successful, the novel benefit package may be able to be offered in lieu of the second benefit increase or at least offset it considerably.

So those are the proposed rate increases, 52 percent starting next July and 25 percent starting in July of 2022. If approved, policyholders will be made aware of the need for these increases through multiple communication channels and at least 60 days before they receive the first one by way of a formal letter.

The second request is for authority to offer the additional benefit designs that are laid out in the agenda item. These are designs not currently available to policyholders that we have identified as options that, together with other benefit designs authorized by the Board in the past, could be used to create benefit package -- packages that policyholders may take up in lieu of the premium increase, which would be implemented in July 2021.

Today, we are asking for your authority to offer

benefit designs that include, one, a copay option of 10 to 20 percent that would create cost sharing based on which benefits are being paid. Two, an extension of the elimination period for both non-partnership and partnership policies. Three, reduced benefit period by varied amount -- varying amounts for facility, comprehensive, and partnership policies, and a three percent compound inflation protection option for partnership policies.

In addition, we are asking for the authority to develop and potentially adopt an enhanced partial benefit upon lapse provision that would be available to all policies that don't already contain the non-forfeiture optional benefit. As its name suggests, the partial benefit option would pay for limited long-term care services, based largely on a policyholder's premium contributions over time, should they stop paying their premiums as a result of the rate increase.

It is not a cash buyout. The policyholder would only be eligible to receive benefits if they otherwise qualified to go on claim. We have not decided whether to implement this, but are seeking approval, if we determine it is prudent.

These new benefit design options, if authorized, and if then implemented, would be used in conjunction with

benefit designs currently available to create modified benefit packages for individual policyholders, so they could ultimately realize a zero percent rate increase for 2021. The new benefit designs would also be available to policyholders for partial mitigation of their rate increases, once implemented.

This means that the policyholder could choose a subset of these benefits that make the best sense for her or him. We do not anticipate using all the benefit design modifications for each of our policyholders. Your authorization of these options gives us additional tools to address the needs of policyholders on a customized basis.

I want to turn next to 2022. A few times I've discussed the challenges facing our Long-Term Care Program, but also mentioned the emergency of novel long-term care insurance models that invest heavily in home retrofits, falls prevention, early and targeted in-home assistance, and other in-home supports with the goal of enabling policyholders to stay in their homes much longer and to delay costly institutional care for longer as well.

As I've noted, this is what survey after survey tells us people want and there is emerging evidence that these kinds of investments can significantly reduce costs.

COVID has also brought to light the need for better ways of enabling seniors to age-in-place for longer. As the COVID death toll approaches a quarter million Americans, it's important to remember that about 25 percent of those individuals were infects in nursing homes. A year from now at the November 2021 Board meeting, our goal is to bring an optional plan design that incorporates state-of-the-art strategies for aging in place. If approved, we are confident that such an option can offer meaningful improvements in the lives of our policyholders, and can more effectively manage costs over the long term.

Care models designed to able aging in place have typically received high consumer satisfaction scores -- higher consumer satisfaction scores than conventional long-term care. But unfortunately, they are not widely available as offerings from commercial long-term care insurers. They exist, but they aren't yet to scale.

Related models have been more widely employed in some of the State Medicaid-Medicare dual eligible demonstration project, that project authorized by Obamacare, and in Medicaid managed care.

So in the coming weeks, we will be releasing a request for information about moving forward with a model that would be tailored specifically to CalPERS Long-Term Care Program beneficiaries. And after reviewing that

information, we intend to move forward with a request for proposal. We will also continue with our ongoing consultation with national experts to help shape our new options. As I stated earlier, our goal to have such a model full developed prior to the second premium increase that would be due July 2022, and that policyholders would choose -- who choose it, could be able to offset most or all of the second rate increase.

Before I conclude, I want to make a few additional comments. This first is that the volatility facing the long-term care market right now is very high. You are well aware of the challenges it has faced since its inception in the 1990s, but COVID adds an additional layer of unpredictability. Tragically, we know that COVID will change the mortality projections actuaries use to model future costs, but there is not a lot known about the long-term disabling effects on those who survive the disease.

The institutions that house individuals who can no longer live in their own homes are also facing intense financial pressures and many in the industry expect the type of consolidation that can decrease supply and increase cost.

The regulatory environment surrounding nursing homes and assisting living -- assisted living is also

likely to change, as we learn more about what types of settings are safe in a pandemic and which ones are not.

I raise these challenges, because the premium increases we are proposing are our best estimates as to what is needed to stabilize the Long-Term Care Fund, but we cannot guarantee that premiums won't need to be raised again in the future.

Similarly, we are hopeful that the proposed new benefit design that we will be pursuing in 2021 will give our policyholders a high quality option that, over the long term, is better situated to stabilize their future cost exposure, but we cannot guarantee that such an option will eliminate the need for future rate increases entirely.

Second, I want to again remind you and the public that the CalPERS Long-Term Care Fund is entirely distinct from its other fund. None of the actions you are considering today affect either the CalPERS pension fund or its health fund.

The final thing, I want to do is acknowledge again the difficult situation we now find ourselves in and the obvious hardship it creates for our policyholders. I can't -- I can say with full confidence in our team and the exhaustive process we've undertaken over the last few months that if there were any other way of addressing the

current shortfalls in the Long-Term Care Program, we would be pursuing them.

Many of the challenges facing the CalPERS Long-Term Care Program are not unique to us. They are industry-wide. In fact, the majority of other long-term care programs are facing similar pressure to raise rates.

The acute difficulty facing CalPERS's program is that it is a closed book of policies. By design and by statute, any shortfalls must be met either through improved investment returns, through modifications of the benefit, or through premiums. The asset allocation options the Investment staff will be bringing to the Board in February should significantly improve returns. And I'm hopeful that the benefit design changes I outlined above, as well as the one we will be developing in the coming year, represent meaningful alternatives for our policyholders.

Of course, none of this means that the premium increases policyholders will be facing starting in July aren't a terrible burden. That concludes my remarks and I'm happy to answer any questions.

CHAIRPERSON FECKNER: Thank you, Mr. Moulds.

I have Ms. Ortega.

COMMITTEE MEMBER ORTEGA: Thank you. Thank you, Don. Mr. Moulds, I have had a question just to help me

understand a little bit about the benefit design changes and how they relate to offsetting a premium increase. So I wasn't sure if I fully understood how you described -- each of the items would have sort of their own value towards how much it might buy down a potential member's increases, is that right?

CHIEF HEALTH DIRECTOR MOULDS: Yeah. Let me -- let me try to add a little bit of detail and it's perfectly reasonable for you to find them somewhat confusing. They are complicated.

But essentially, the way it works is this, there are many, many different benefit designs within the CalPERS Long-Term Care Program, so over time, people have customized their benefits and the benefits have evolved over the history of the program, which dates back to the 1990s.

So the benefit design proposals that we're looking for for approval for today essentially are added tools that will allow Long Term Care Group, which is our third-party administrator, work with us to put together a customized policy for each individual member of the Long-Term Care Program that would bring their -- their total cost down to zero. That's going to differ for different policyholders, because the costs in their benefits design -- in their benefit -- in their policies

is going to differ from one to the other.

So when they receive their letter 60 days in advance of the rate increase, they will have an option that is sort of tailored to them, if they want to choose that option.

They will also be told that they have the option of working with Long Term Care Group to choose from the various options that we would be making available to buy down in a more customized way. So, if, for example, they decided that they didn't want copays, but wanted a shorter duration, or -- or didn't want to give up their inflation protection, they would have the ability to do that.

They would also have the ability to buy down their premium increase partially. So if they wanted to see a 25 percent rate increase, the folks at Long Term Care Group could work with them to design a benefit option that would do essentially that.

COMMITTEE MEMBER ORTEGA: So just one quick follow-up, if I may, Mr. Chair. Is just -- am I understanding correctly that an individual could potentially offset their increase for 2021 entirely by opting in to some of these changes, because I heard you say to zero and that's what I want to understand.

CHIEF HEALTH DIRECTOR MOULDS: That's correct. Yeah, by contract, we're required to provide -- to provide

a reduced value benefit design to every policyholder that would allow them to buy them down to zero. Those typically would result in other costs to members in the form of copays or extended elimination periods, et cetera. But they -- we are required to provide them with that option.

COMMITTEE MEMBER ORTEGA: So let me ask this question, and not understanding what -- fully what your -- what the requirements are under a program like this. What concerns me is the notion that an individual may opt into these benefit changes now in order to avoid cost increases in the short term. But when we think about the volatility issue and what the long-term risk is in the program, they may still be facing long-term premium increase. And what I'm wondering is if it wouldn't be better, although maybe allowed, so you can tell me if I -- f that's the case, to have everybody facing some sort of increase in 2021, even if they opt in to some of these changes that keep it from going as high as 50 percent?

So I'm thinking shouldn't we take action now to try to shore up the longer term risk. And if we instead give options to buy you down to zero, we're not -- are we really doing enough to improve the plan long term?

CHIEF HEALTH DIRECTOR MOULDS: So that's -- that's a great question. The challenge is that the

contract binds us in two ways. The first is to provide if the member -- if the policyholder so chooses, the full benefits that they contracted with us to provide when they signed up for the plan. And the second is the option to take up these benefit increases -- or to buy down the policy to a zero percent premium increase.

So we -- we cannot tell them that they should take a particular benefit reduction or similarly that they -- that they shouldn't. Does that make sense?

COMMITTEE MEMBER ORTEGA: Yeah. So let me just confirm my -- I'm understanding your response. There is no ability under the current contract to both pass on a premium increase based on the long-term cost of the program and offer the design changes. So again, what I'm getting at is a -- like a floor of an increase that we know is going to be necessary over the long term and not letting them just sort of avoid any impact in 2021.

CHIEF HEALTH DIRECTOR MOULDS: That's correct. They would -- they need to be provided the option of fully buy -- of fully buying down or buying down partial.

COMMITTEE MEMBER ORTEGA: Okay. Thank you.

CHAIRPERSON FECKNER: Thank you.

I have Mr. Jones.

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

Yeah, on Mrs. Ortega's question, I think -- I thought I was following, but I'm reminded that when we raises the rates to 85 percent, that was an overall increase for everybody. And after that rate increase, then the member had an option to select various copay options to bring down that 85 percent rate increase. So what I heard you respond to Ms. Ortega it seemed like it's different. Clarify that for me.

CHIEF HEALTH DIRECTOR MOULDS: Sure. I can -- I can try the -- the rate increase -- so the member will get a letter, as I understand it, and I was not there for the last rate increase. But the member would get a letter indicating the rate increases that they would be facing and also informing them of their ability to buy them down. That -- that -- they receive that letter at least 60 days ahead of the rate increase. And at that time, they would either -- they could either choose to -- to buy it down entirely or salary, or to pay the rate increase.

What I don't know for sure and I can certainly get back to you on this is the specific timing about when that buydown happens, whether it happens sometime between the letter and the rate increase or after the person would be -- would be theoretically on the hook to pay the rate increase. I can answer that question for you off line. But in either event, the choices are essentially the same

choices.

COMMITTEE MEMBER JONES: Okay. Thank you. And so as kind of a follow-up to that, such this is a two-step phased process where we would be adopting the rate increases at the November meeting. What if those are not approved, then would it change all these options that are -- we are approving today?

CHIEF HEALTH DIRECTOR MOULDS: So -- so this is the -- this is the aging-in-place option that we'll be developing the -- over the course of the next year, is that the one you're referring to Mr. Jones?

COMMITTEE MEMBER JONES: Yeah, I'm looking at all of these options under the recommendation for today that we'll be voting on --

CHIEF HEALTH DIRECTOR MOULDS: Yes.

COMMITTEE MEMBER JONES: -- but we're not voting today on the actual rate increase of 52 percent and 25 percent for year one and year two, is that correct?

CHIEF HEALTH DIRECTOR MOULDS: No, you will be voting on those today.

COMMITTEE MEMBER JONES: Okay. But it's not included in this item.

CHIEF HEALTH DIRECTOR MOULDS: I believe --

COMMITTEE MEMBER JONES: I don't see it rather. Maybe it's there. I just heard you comment -- I just

heard you make reference to it, but --

CHIEF HEALTH DIRECTOR MOULDS: We -- I'm sorry. So we did not include the specific numbers in -- in the -- in the agenda item, because we were still working -- as you heard in the Investment Committee yesterday, we have been working to try to finalize the recommended discount rate. And the specific premium increases are tied to the discount rate. So Scott Terando yesterday translated the discount rate to the premiums and those are the ones that we're bringing forward today seeking approval for.

COMMITTEE MEMBER JONES: Okay. Yeah, because I think it's a little confusing to me then, because I was looking at the executive summary and it said that at the November 20th meeting, we will be adopting the rate increases. So whoever moved this need to include in their motion those rate increases that you referred to earlier, is that correct?

CHIEF HEALTH DIRECTOR MOULDS: That sounds like a good idea. Thank you.

COMMITTEE MEMBER JONES: Okay. Thank you. And then the second part of my question is the method -- at least a different part of the question is that does this -- do these proposed program changes reflect any input from the policyholders?

CHIEF HEALTH DIRECTOR MOULDS: We have been -- we

have had some of these discussions at stakeholder meetings. We have not gone into a lot of detail about these options in particular. They are -- they are standard in the industry and they're the ones that our actuaries have identified as being meaningfully valuable, meaning that they are the tools that they know they -- that would -- they would be able to use to reduce premiums.

The -- you know, the one thing that I want to reemphasize here is that we are asking for approval to include these potentially in the options that we use to buy down, so we do not anticipate using all of them for every policyholder. They are what I just described them as options and policyholders would be able to choose among them.

COMMITTEE MEMBER JONES: Okay. Okay. Well, thank you, Mr. Moulds.

CHAIRPERSON FECKNER: Thank you.

Ms. Greene-Ross.

ACTING COMMITTEE MEMBER GREENE-ROSS: Thank you very much. So I understand this is a necessary mitigation strategy that's very complicated. And I think the main concern the Controller would have is we have 117,000 participants in this plan. I don't know what percentage would be right at the brink of needing long-term care or

already in the middle of using long-term care. And so the concern, because this is a lot of moving pieces and very complicated, is the Long Term Care Company contracted and doing the communications or is our staff working with them, because it seems to me like the communication is going to be so one-on-one with each individual, unless you can write a letter and explain when we get down to choices for each of the participants on you can keep this benefit or you can keep that benefit and it's going to cost this much or that much.

It seems like it's going to be very custom, you know, designed. I don't know if all 117,000 are going to want an individual consult. But how will we be communicating this, part one. And part two is as part of that communication, how do we communicate with family members who, if the member is already getting long-term care, and they need to apply, and they're in the middle of using the Long-Term Care Program and this transition is going on when you're using the care, how do you communicate to family members who may be caring for a parent and want to use the insurance to pay for that?

CHIEF HEALTH DIRECTOR MOULDS: So a couple of things. First, in answer to your question about -- about when our policyholders will be using long-term care, the height of the -- of the claims -- of the -- which means

the -- you know, the payout will be in about 20 years. There are a lot of -- of the policyholders obviously that will be going into claim sooner than that.

On the question about communication, we would be using all of the avenues that you just described. So the PERS -- the PERS internal communication team, the website, our own staff, but also Long Term Care Group, our third-party administrator communicates as well, both through their call line and proactively.

We have done this unfortunately before, raised rates significantly. And so we will be relying in part on past communication strategies, but we've started to look at them and improving them. And we're going to marshal all of those resources to overcommunicate this to policyholders

Your point about caregivers is a very good one. I will talk with Long Term Care Group and others that -- you know, that are in this space about how we might effectively engage caregivers. My guess is that that can be challenging in some instances, but I know in other instances, some policyholders have designated caregivers, whose information Long Term Care Group has. And, you know, I would need to walk through all of the HIPAA implications of those kinds of communication. But Long Term Care Group is -- is a third-party admini -- is the

largest third-party administrator in the country. They have lots of clients who have been going through Similar challenges. They are versed in doing these rate increases and I feel good about them as a partner in this.

ACTING COMMITTEE MEMBER GREENE-ROSS: I appreciate that. I know this is not going to be -- none of this is easy. So thank you -- thank you for that information.

CHAIRPERSON FECKNER: I have Mr. Rubalcava.

VICE CHAIRPERSON RUBALCAVA: Thank you, Mr. Chair. Don, I have a couple -- I have a questions on the customized plan and then a question on the process.

It is a difficult situation you stated yourself. But I still want some clarity on the -- on how the -- the benefit options -- benefit changes options are going to work. So you mentioned that people get individual -- will get individual letter. They can pick their customized -- off a menu for example. So is the intent to give them like, for example, say they pick a coop -- a copayment option of 20 percent, but you also give them the option of what 10 percent would look like. Will there be like a percentage increment in dollar amounts or also like -- for example, is there like a price list assessed a copay option will mean plus -- will be on net -- a decrement of certain percent or would -- or does it matter based on

their demographic, and age, and -- I mean, is it individual on that level or is it like a price list, like 180-day elimination period means so much.

CHIEF HEALTH DIRECTOR MOULDS: Yeah. It would not be a price list. That amount of information can be difficult. What it would be is a -- is a customized -- and when I say customized I mean, you know, they will typically take a group of like policies and say, okay, for these policies with this type of benefit design, these are the places where you can realize the most significant savings. And they would -- they would be offering two things to the policyholder. The first is just a pre-designed package to bring those -- their -- their premium increase down to zero. And the second is the option to contact Long Term Care Group to work with them to design something that is more customized. And that's where the discussion would take place.

VICE CHAIRPERSON RUBALCAVA: Thank you.

And then the other question is more on the process. Once they make a selection modifying their plan design, do they have the opportunity later on -- I know we don't have open enrollment periods, but do they have an opportunity later on to revert or make some other changes, either for more benefit flexibility in the premium or perhaps, because -- I hate to use the word adverse

selection, they realize that maybe 180 day elimination is not for them and they need -- they can't wait that long. I mean, is there a -- what's the long term -- I mean, I know it's kind of difficult just to figure out how to explain this now and decision, but what happens --

CHIEF HEALTH DIRECTOR MOULDS: Yeah. Sure.

VICE CHAIRPERSON RUBALCAVA: Can we even think that far ahead?

CHIEF HEALTH DIRECTOR MOULDS: Typically, there are some -- there's some flexibilities, but they are limited. So as you -- if you were to do a future buydown for example, you could opt to go with different options, but you cannot necessarily repurchase insurance that -- that you have given up, in most cases.

VICE CHAIRPERSON RUBALCAVA: Thank you for your explanation.

CHAIRPERSON FECKNER: All right. Thank you. Seeing no other requests to speak, this is an action item. What's the pleasure of the Committee.

VICE CHAIRPERSON RUBALCAVA: Mr. Feckner.

CHAIRPERSON FECKNER: Yes, sir.

VICE CHAIRPERSON RUBALCAVA: I think Mr. Moulds' presentation said it at the beginning. It's a difficult situation. Nobody wants to impose premium changes, but the situation is there's not enough investment coming in

and the mortal -- I'll move the -- I'll move the motion. I'll move the staff recommendation, Mr. Feckner.

CHAIRPERSON FECKNER: Thank you, Mr. Rubalcava. Is there a second?

COMMITTEE MEMBER MILLER: I'll second.

CHAIRPERSON FECKNER: Mr. Miller.

Mr. Miller will second it.

And I agree with you, Mr. Rubalcava, there is no -- no easy answer for this one. This is making the best of a bad situation, I think.

I do have a couple of requests to speak from the public. Mr. Fox.

GENERAL COUNSEL JACOBS: Can I interject at this point just to clarify that the motion is what Mr. Jones said should also be included, which is the specific recommended premium increases of 52 percent and 25 percent in the next to years.

VICE CHAIRPERSON RUBALCAVA: That's correct, the two-year phase-in of the premium, given the new discount and also the menu of benefit changes -- potential benefit changes options -- or option of changes, yes. I'll leave it as yes.

(Laughter.)

VICE CHAIRPERSON RUBALCAVA: Thank you.

CHIEF HEALTH DIRECTOR MOULDS: Thank you, Mr.

Jacobs.

CHAIRPERSON FECKNER: Thank you.

Mr. Fox.

STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair. The first speaker from CSR Tim Behrens.

MR. BEHRENS: Thanks, Kelly. Rob and Committee, it's been a fascinating conversation. There are -- there don't seem to be any solutions. I understand why the rates have to go up. I just wonder whether or not there's something that we haven't thought of yet. I know other states provide in-home treatment to reduce the number of days people spend in nursing homes, which would be what long-term care provides. Maybe we should look down the road somehow of working together to produce some kind of legislation that would reduce and enhance the quality of life for our senior citizens in California and keep them in their home, and pay their family to give them those services, and reduce the use of long-term care benefits.

And that's all I have to say. It's very discouraging.

Thank you.

CHAIRPERSON FECKNER: Thank you very much.

Mr. Fox.

STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair. From CSR, Larry Woodson.

MR. WOODSON: Good afternoon. Larry Woodson, CSR. Thanks for the opportunity to comment. So I guess starting off that one -- I guess it goes without saying, because it has gone without saying, if CalPERS happens to lose the current class action lawsuit, you know, it's back to the drawing board, because it would face additional probably significant increases. But I know you've got to deal with the matter at hand, pending that.

So it doesn't look like there's really any good option. I guess my only comment really is to kind of mirror Karen Greene-Ross's comments about the communication strategy. After the stakeholders' meeting, I -- or at the stakeholders' meetings, when this was covered, I expressed confusion about the rather bureaucratic, jargon-ish language and the options one through six, and actually was provided a more layperson definition of some of these. And I think that needs to be part of the communication strategy, if this is adopted, and when it goes out to members, because the current language in this is -- I mean, it was confusing to me and probably some of the Board members. The average subscriber is not going to get it.

That's it. Thank you.

CHAIRPERSON FECKNER: Thank you. Anyone else, Mr. Fox?

STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair. One last caller on 6d. J.J. Jelincic.

MR. JELINCIC: Hi. J.J. Jelincic, RPEA, Director of Health Benefits.

RPEA is not taking a position on this agenda item. We did not have enough information to take a informed position. It's only today that we are getting the most basic information, such as the proposed rate increase. Even today, we lack details of the proposal and the financial implications of each. That is not enough time for a reasonable analysis. We do not know what information the Board has had and chose to keep secret. It is -- if like us, you are getting this information for the first time today, it is unlikely that it would be prudent to make a decision today.

If you've been withholding information for constituents, that says something about your commitment to transparency. Many of these proposed changes make sense or at least seem to, but maybe not. The only thing that is situation is that this situation is a mess. I wish you good luck and thank you.

CHAIRPERSON FECKNER: Thank you. And Mr. Jelincic, your continued negative comments about what the Board is hiding from this -- from the constituents is just getting old and tiring. We're not withholding information

from constituents and we just want to leave it at that.

So moving forward, I have Mr. Miller.

COMMITTEE MEMBER MILLER: Yeah. Thank you. I just had a -- I had a couple quick comments. One, just again thanks Dr. Moulds and the entire CalPERS team. This is -- this is another one of those, you know, painful roads that we have to walk down. And there -- you know, unfortunately, we don't have a bunch of good options to choose from. They're all difficult and painful, but I think we -- we do need to move forward with this. And this does at least provide some choices for our impacted policyholders. And it just -- there are really avoiding the decision, not going forward really just doesn't seem to be a good option for us.

And I appreciate the hard work that went into all this. I also appreciated some of the comments about some of the lessons and some of the issues for the future being forward-thinking about the needs of -- for long-term care, assisted living. The challenges that institutions are finding in this, especially in this pandemic environment, and the real opportunities to kind of learn and partner with the industry, with the caregivers and the organizations that represent them throughout the country, and even the -- the industries that are providing technological solutions and tools that may make helping to

say in the home or even institutional care easier, whether that be telemedicine, whether that be biometrics and telemetry, and those type of things. So I think it gives us a lot more to think about and potentially opportunities to, you know, continue to cultivate those partnerships to make things better for our members and everyone in the future.

Thanks.

CHAIRPERSON FECKNER: Thank you.

Ms. Brown.

COMMITTEE MEMBER BROWN: Thank you, Mr. Chair.

I just want to state that I'll be abstaining on this motion. I know too many people directly impacted by the last -- buy the last increase, and I don't know that they'll be able to stay in the program with this new increase.

I'd just like to state that I hope that CalPERS has learned this very hard lesson and that we don't jump into other product offerings or even investments we truly don't understand.

Thank you.

CHAIRPERSON FECKNER: Thank you. Seeing no other requests. Motion is before you.

Ms. Hopper, please call the roll.

COMMITTEE SECRETARY HOPPER: Margaret Brown?

COMMITTEE MEMBER BROWN: Abstain.
COMMITTEE SECRETARY HOPPER: Henry Jones?
COMMITTEE MEMBER JONES: Aye.
COMMITTEE SECRETARY HOPPER: David Miller?
COMMITTEE MEMBER MILLER: Aye.
COMMITTEE SECRETARY HOPPER: Eraina Ortega?
COMMITTEE MEMBER ORTEGA: Aye.
COMMITTEE SECRETARY HOPPER: Ramon Rubalcava?
VICE CHAIRPERSON RUBALCAVA: Aye.
COMMITTEE SECRETARY HOPPER: Theresa Taylor?
CHAIRPERSON FECKNER: Excused.
COMMITTEE SECRETARY HOPPER: Shawnda Westly?
COMMITTEE MEMBER WESTLY: Aye.
COMMITTEE SECRETARY HOPPER: Karen Greene-Ross for Betty Yee?
ACTING COMMITTEE MEMBER GREENE-ROSS: Aye.
COMMITTEE SECRETARY HOPPER: Mr. Chair, I have six ayes, one abstention from Margaret Brown with a motion being made by Ramon Rubalcava and David Miller seconding it for agenda Item 6d.
CHAIRPERSON FECKNER: Thank you very much. Takes us to Agenda Item 7, information agenda items. 7a is summary of committee direction.
Mr. Moulds
CHIEF HEALTH DIRECTOR MOULDS: Great. Thank you

Mr. Chair. I have two. The first came from Ms. Brown asking for specific numbers in each of the PPO plans, which we will make available to the Board in very short order.

And the second was a -- was a request for an answer to the question about the exact timeline of the -- of the benefit -- the benefit -- I'm sorry, the rate increase benefit -- mitigation options, and specifically whether they happen in advance of the proposed rate increase applying to particular members or at the same time, and we will make that information available as well.

CHAIRPERSON FECKNER: Very good. Thank you. Seeing nothing else on that item.

Item 7b is public comment. Mr. Fox, anybody from the public that wishes to make comment?

STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair. I believe we have Tim Behrens from California State Retirees.

MR. BEHRENS: Thanks, Kelly. I don't have any more comments today. Thank you.

CHAIRPERSON FECKNER: Very good. Thank you.

Anything else, Mr. Fox.

STAKEHOLDER RELATIONS CHIEF FOX: No, Mr. Chair. That concludes all public comment for this Committee meeting.

CHAIRPERSON FECKNER: Very good. So that brings us to the end of our agenda. I'm going to call to adjourn the meeting.

Mr. Miller, do you think 1:30 for Finance?

COMMITTEE MEMBER MILLER: Yes, sir, Mr. Feckner. That will be perfect.

CHAIRPERSON FECKNER: Okay. Okay. Well, thank you all for being here today. This meeting is adjourned. This is the last meeting of the PHBC for 2020.

Hopefully 2021 will be better for all of us.

So with that, on behalf of the Committee, we wish you all a safe and sane holiday season. And we will be back with Finance at 1:30. Thank you all for being here.

This meeting is adjourned.

(Thereupon California Public Employees' Retirement System, Pension and Health Benefits Committee open session meeting adjourned at 12:34 p.m.)

CERTIFICATE OF REPORTER

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 24th day of November, 2020.

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