MEETING

STATE OF CALIFORNIA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

BOARD OF ADMINISTRATION

PENSION & HEALTH BENEFITS COMMITTEE

ROBERT F. CARLSON AUDITORIUM

LINCOLN PLAZA NORTH

400 P STREET

SACRAMENTO, CALIFORNIA

TUESDAY, SEPTEMBER 20, 2016

8:00 A.M.

JAMES F. PETERS, CSR
CERTIFIED SHORTHAND REPORTER
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A P P E A R A N C E S

COMMITTEE MEMBERS:

Ms. Priya Mathur, Chairperson

Mr. Michael Bilbrey, Vice Chairperson

Mr. John Chiang, represented by Mr. Eric Lawyer

Mr. Rob Feckner

Mr. Richard Gillihan, represented by Ms. Katie Hagen

Ms. Dana Hollinger

Mr. Henry Jones

Ms. Betty Yee, represented by Mr. Alan Lofaso

BOARD MEMBERS:

Mr. Ron Lind

Mr. Bill Slaton

STAFF:

Mr. Doug Hoffner, Interim Chief Executive Officer

Mr. Matt Jacobs, General Counsel

Ms. Donna Lum, Deputy Executive Officer

Mr. Doug McKeever, Deputy Executive Officer

Dr. Kathy Donneson, Chief, Health Plan Administration Division

Mr. Tyrone Espinoza, Assistant Chief, Health Plan Administration Division

Ms. Jennifer Jimenez, Committee Secretary

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

STAFF:

Ms. Shari Little, Chief, Health Policy Research Division

Dr. Melissa Mantong, CalPERS Pharmacist

ALSO PRESENT:

Ms. Yvette Fontenot, Avenue Solutions

Mr. Chris Jennings, Jennings Policy Strategies

Mr. Tom Lussier, The Lussier Group, Inc.

Mr. Tony Roda, Williams & Jensen

Mr. Robert Thacker

I N D E X

P R O C E E D I N G S

CHAIRPERSON MATHUR: Good morning, everyone. We're going to bring the Pension and Health Benefits Committee meeting to order. First order of business is roll call.

COMMITTEE SECRETARY JIMENEZ: Priya Mathur?

CHAIRPERSON MATHUR: Morning.

COMMITTEE SECRETARY JIMENEZ: Michael Bilbrey?

VICE CHAIRPERSON BILBREY: Good morning.

COMMITTEE SECRETARY JIMENEZ: Eric Lawyer for John Chiang?

ACTING COMMITTEE MEMBER LAWYER: Good morning.

COMMITTEE SECRETARY JIMENEZ: Rob Feckner?

COMMITTEE MEMBER FECKNER: Hello.

COMMITTEE SECRETARY JIMENEZ: Katie Hagen for Richard Gillian?

ACTING COMMITTEE MEMBER HAGEN: Hello.

COMMITTEE SECRETARY JIMENEZ: Dana Hollinger?

COMMITTEE MEMBER HOLLINGER: Hello.

COMMITTEE SECRETARY JIMENEZ: Henry Jones?

COMMITTEE MEMBER JONES: Here.

COMMITTEE SECRETARY JIMENEZ: Theresa Taylor?

CHAIRPERSON MATHUR: She's excused.

COMMITTEE SECRETARY JIMENEZ: Alan Lofaso for Betty Yee?

ACTING COMMITTEE MEMBER LOFASO: Here.

CHAIRPERSON MATHUR: Okay. Second order of business is the Executive Report. Ms. Lum.

DEPUTY EXECUTIVE OFFICER LUM: Good morning, Madam Chair, members of the Committee. Donna Lum, CalPERS staff. I have a couple of updates for you on our open enrollment activities, as well as our CalPERS Benefit Education Events.

As we anticipated, during the first week of open enrollment, which was last week, the customer contact center did experience an increase in call volumes. We had over 24,000 calls, which is consistent with what we had last year. But I think the thing that is more important about our performance in the contact center for the first week is unlike last year where we had a average call wait time of about 11 minutes with that large of a call volume, for those members that opted to remain on the line, our call wait time was a little over 3 minutes.

However, we also did achieve answering 60 percent of the calls that came in related to open enrollment in 60 seconds or less. So again, I wanted to share that with you, because it does demonstrate that all of the preparedness that we have, the changes that we've made with our streamlining and our improvements have really paid off during this open enrollment.

We also had several -- or well, we had about 118,000 health subscribers that logged into their my|CalPERS account, the on-line account, of which of that number about 66 percent of them actually went to their health statement, and either made a transaction or spent some time viewing the materials that were on-line.

So that gives us a lot of indication and hope that the on-line statement does have a lot of activity. And I'm certain we'll see more of it as open enrollment continues. And then just to give you an idea of some of the common themes that members are calling about as related to the open enrollment is they're basically seeking confirmation that no action is necessary if they wish not to change their plan.

They're asking questions about where they can find out rates for next year, which are on the website. So we're also pointing them to that. And then some of the members are calling requesting assistance on how to log on to my|CalPERS or how to get -- or how to get an account so that they can view their statements on-line.

So again, we had planned for this type of activity. And I think all is going well and we'll continue to update you as open enrollment continues.

We also recently had our CalPERS Education -- Benefits Education Event that was hosted last weekend

September 16th and 17th at the City of Industry. And again, it was another successful event. It was a 2-day event. We had over 1,400 attendees. And again, we were glad to see Mr. Bilbrey in attendance there, you know, integrating with the members and the attendees.

This event was held right on the heels of the event that we had at Newport Beach, which was on August 26th and 27th. And there again, we had just over 1,200 attendees attend. And so we had quite a bit of activity, and we also again had a couple Board members, Mr. Jelincic, Mr. Bilbrey join the team.

So we are seeing record numbers at nearly every event that we hosted this last year. We have all the planning for the events going forward. The next event that we will have is on January 27th and 28th in Carlsbad. And then we do host the largest of the events here in Sacramento, and that will be in February 3rd and 4th.

So the schedule is available on the CalPERS website. For those that are watching the webcast that are interested in the schedule, you can go to CalPERS on-line to see the schedule. And usually in the -- when we look at the Sacramento event, we have about 4,100 attendees. So there's a lot of planning and activity to ensure that as we anticipate, that will probably be even a larger group to ensure that we have ease of flow and that we can

accommodate for all of the attendees that we plan to see there.

So those are the updates that I wanted to share with you. And I'm available to answer any questions you may have.

CHAIRPERSON MATHUR: Any questions from the Committee?

That's very good news though about the call times. I really think that demonstrates the impact of all of the efforts that you've -- you and your team have undertaken over the last couple of years. So thank you for bringing us to this point where we can actually absorb such a large volume of calls.

It's terrific.

Okay. Mr. McKeever.

DEPUTY EXECUTIVE OFFICER McKEEVER: Thank you, Madam Chair, members of the Committee. Doug McKeever, CalPERS staff.

I've got four updates for you this morning. I'd like to share, and on the heels of Donna's recent update on open enrollment, this one is in relation to that, especially as it relates to the PBM Optum transition that we're going through. So implementation activities have been and are continuing to be well underway. We have collectively, between CalPERS and OptumRx, over 100 staff

who are working diligently to ensure a smooth transition by January 1st, working in group approaches. And a lot of this is based upon lessons learned several years ago when we had the transition of the PBM to CVS.

So based upon the lessons that we learned then, we formulated these teams collaboratively and across the Division and outside stakeholders as well to ensure that all of the areas that we need to account for for a smooth transition come January are accounted for.

I think what's also important is member communications is a large part of that. And that continues to be the case in updating our stakeholders on a regular basis. So each month at the stakeholder meeting, there's an update on how the transition is going with OptumRx.

We continue to work on issues, especially where it comes to escalation procedures, and so that we're on top of those relative to implementation. Once the areas of issue or question come up, the teams are in place to effectively manage those quickly and ensure that the resources are mustered to put on those, and address those, so that as we move into January we're in a good position to launch.

I would also like to note that the request was made by our stakeholders to put the formulary out on our

website for OptumRx. I will tell you that although it is not as comprehensive as some may like, we were able to get that formulary up onto the website at the beginning of open enrollment.

Moving onto the long-term care, I want to just remind the Committee and those watching and in attendance that we're currently in our long-term care solicitation process. Phase 2 of the long-term care third-party administrator solicitation was released on September the 19th to those vendors who passed the first phase.

The solicitation process includes confidential discussions with vendors, evaluation and scoring of vendor proposals, site visits, and a comprehensive negotiation with recommendations presented to this Committee, similar to those that were undertaken during the PBM solicitation.

Confidential discussions are currently scheduled to take place in November, and the evaluation of proposals starting in December. The long-term care contract will be a 5-year agreement starting in January of 2018. And we're going to provide the Committee with a little bit of a larger update, either at its November or December committee meeting.

Several months ago you may recall we provided an update on the Public Employees Pension Reform Act of 2013, better known as PEPRA. As presented, we provided an

update on the data what's been accomplish since that time. And we also identified a few follow-up items that are required, one of which is addressing the issue of pensionable compensation.

At that time, you may recall that we were going to convene a meeting with our stakeholders, and in particular CalHR and the Department of Finance. That meeting did, in fact, take place in which we shared with them data on pensionable compensation, not only our data, but we also provided them with some suggested recommendations that were provided by our stakeholders.

At this point, we are waiting feedback from the Department of Finance on the information that we presented to them with our expectation that we'll have that shortly, which will then help us shape the regulation package that we hope to bring back to this Committee for consideration in December.

And then the last thing on my report this morning, Madam Chair and members, is I just want to let you know that we do not have a Committee meeting in October, so I will not be able to share with you an annual report that will be presented to the legislature on the State of health care for the CalPERS Health Benefits Program. It's a report that is required through statute that was passed last year.

But what I want to make you aware of is that we'll ensure that you all receive a copy of that report, and that that report is posted to the website immediately as it is transmitted to the legislature for their review November the 1st.

And that concludes my comments.

CHAIRPERSON MATHUR: Thank you very much, Mr. McKeever.

Okay. I see no requests to speak on this item, so we'll move on to Agenda Item number 3, the action consent items, approval of the June meeting minutes.

COMMITTEE MEMBER JONES: Move approval.

VICE CHAIRPERSON BILBREY: Second.

CHAIRPERSON MATHUR: Moved by Mr. Jones, seconded by Mr. Bilbrey.

Any discussion on the motion?

Seeing none.

All those in favor say aye?

(Ayes.)

CHAIRPERSON MATHUR: Noes?

Motion passes.

Agenda Item 4, consent items. And I've had no requests to remove anything. So we'll move on to Agenda Item number 5, Proposed Regulations: Clarification of Combination Enrollments.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: Good morning, Madam Chair and members.

CHAIRPERSON MATHUR: Good morning.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: Shari Little, CalPERS staff.

Today, I'd like to briefly discuss Agenda Item 5, in which we seek to clarify through a new proposed regulations package the eligibility rules for combination plan enrollments. As a reminder, combination enrollments refer to a family enrollment type, in which some family members, depending on their age, are only eligible for enrollment in a basic plan, while other family members are only eligible for enrollment in a Medicare plan.

As mentioned in the agenda item, CalPERS has looked at many strategies to control costs, including contracting with a Medicare health plan carrier that did not also offer a basic plan. When we changed the PEMHCA regulations in 2013 to permit this Medicare-only plan option. Our intent was to provide the Board flexibility to pursue this strategy at their discretion.

DEPUTY EXECUTIVE OFFICER McKEEVER: Madam Chair, I'm going to just pause for Shari at this moment and just provide some historical context on this.

One, Shari wasn't here at that time, so it's really incumbent upon me for that reminder. And what I

want to mention to you is when we did the 2012 presentation to you on the 21 initiatives, part of those initiatives were looking at a potential different way in which we would administer Medicare. You may recall that we had presentations provided by certain organizations, one of which looked at offering an option where there would be a third-party Exchange type product that was offered to our retirees.

In order to facilitate that or any other type of activity would have required us to make internal system changes that were required to my|CalPERS, as well as have regulations in place to address this issue of when a member is in a Medicare plan and a combo plan. We did not pursue those strategies. As you may recall, it was something that we felt wasn't prudent at the time, but those regulations were still in place.

And so what Shari is referencing this morning is the fact that there's some ambiguity in those regulations in which some folks may believe that as of today, we could put hem into separate plans. But the changes were never made to the my|CalPERS system, and in addition, this Board and this Committee never directed staff to pursue those options. So hence, the reason for the regulation package before you today.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: So

beginning in 2015 plan year, the Board moved to provide single non-Kaiser Health Maintenance Organization Medicare plan through UnitedHealthcare. Consequently, it's necessary for PERS to clarify our regulations.

Currently, PEMHCA regulations could be interpreted as permitting members with combination enrollments to enroll in health plans provided by different health plan carriers. Staff, therefore, seek, the Board's approval to move forward with proposed clarifying regulations to, first, affirm that members with combination enrollment plans must enroll in one basic plan and one supplemental plan provided by the same carrier when they enroll.

Secondarily, allow members with combination enrollment plans to enroll into one basic plan and one supplemental plan provided by one or more carriers, only contingent upon the Board's future authorization.

In other words, we'd like to preserve the Board's authority and discretion to allow for combination plans into plans offered by different carriers, only if in the future PERS could demonstrate cost savings and improve value to our members.

The proposed change to clarify combination enrollments would be cost neutral to PERS. Any costs associated with implementing the change would be absorbed

through the existing PERS resources. However, without a change, the regulations are subject to interpretation, and staff may increase in time responding to member inquiries and potential appeals related to the combination enrollments.

This is an action item, so we're seeking the Committee's approval to move forward with this change.

CHAIRPERSON MATHUR: Thank you. We do have a few questions from the Committee.

Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you, Madam Chair. Doug, on the my|CalPERS issue that is one of the impediments to -- if the Board were to make a decision, to make the change. Do you have an estimated cost of what would be required if such a change were --

DEPUTY EXECUTIVE OFFICER McKEEVER: If we were to go down that path?

COMMITTEE MEMBER JONES: Yes.

DEPUTY EXECUTIVE OFFICER McKEEVER: Yeah, Mr. Jones -- and I'm going to have to base this off of memory, because at the time in which we brought this to the Committee back in 2012, I know we did an initial analysis looking at what the potential cost would be to change this system.

If I recall at that time, it was very

significant. I think it was in the neighborhood of about a million dollars to make the change to the my|CalPERS system. So fast forward to where we are today, if we were to look at changing to offer this particular advantage, for us, we would have to do another analysis updating that. And my guess would be the price point would be either the same or more, depending upon what the analysis bears out

COMMITTEE MEMBER JONES: Okay. Thank you.

CHAIRPERSON MATHUR: Thank you. This is an action item. What's the pleasure of the Committee?

VICE CHAIRPERSON BILBREY: Move approval.

CHAIRPERSON MATHUR: Moved by Bilbrey.

COMMITTEE MEMBER FECKNER: Second.

CHAIRPERSON MATHUR: Seconded by Feckner.

Any discussion on the motion?

Seeing none.

All those in favor say aye?

(Ayes.)

CHAIRPERSON MATHUR: All opposed. Motion passes.

Move on to Agenda Item number 6, which is the Federal Health Care Policy Representative update. And I believe we have Tom and Tony on the phone.

MR. RODA: Yes, Madam Chair.

CHAIRPERSON MATHUR: Good morning.

MR. RODA: Good morning.

CHAIRPERSON MATHUR: I'll turn it over to you.

MR. RODA: Very good. This is Tony Roda with Williams & Jensen in Washington D.C., and good morning again all the members of the Committee.

I'm going to start and then Tom is going to speak a little, and then I'm going to come back around. We can take questions however you'd like to do it. So feel free to interrupt, if necessary.

I'm going to start off talking about the current legislative environment here in Congress. And talk first about our priority, which has been keeping the federal government out of the affairs of CalPERS and State and local governmental plans. So that goal is achieved through playing defense, and making sure that problematic legislation is not enacted.

If you go back to December of last year, Chairman Hatch of the Senate Finance Committee introduced a Puerto Rico assistance bill that included two problematic provisions for State and local plans. The first I know you're very familiar with, and that's PEPTA, the Public Employee Pension Transparency Act. And that would require State and local plans to recalculate their funded status based on a bond yield curve, which I know you are just not pleased to have to do. That legislation has been around

since 2010.

The other provision in the Puerto Rico bill was the annuity accumulation plan by Senator Hatch, which would be an optional new qualified plan in the federal tax code. And it would -- it's designed essentially, and if you listen to Senator Hatch's rhetoric, to replace DB plans with single, fixed rate annuities for State and local employees. We find both very problematic. We were successful in keeping both provisions out of the law that was enacted on Puerto Rico.

This is a little bit of a moving target. So while there was that victory, tomorrow at the Senate Finance Committee there will be a markup on legislation known as the Coal Miners Protection Act, which would shore up retiree pension and health care benefits for retired coal miners.

We have again worked to keep PEPTA and the annuity accumulation plan off that legislation, and feel good today, the day before the markup, that we will be successful in that effort.

I would like to say that that would be the last such vehicle, but given the climate that we're in, given the investment returns that plans have had, we can't seem to get away from a public discussion about it. In fact, when I turned on Bloomberg this morning, Chris Ailman of

CalSTRS was talking about their returns, and public pensions and funding questions. And it's very much -- it remains in the minds of members of Congress.

So as long as that situation still presents itself, and the returns are what they have been recently, and dragging down the 3, 5 and 10-year numbers, we are in the defensive mode here in Congress.

The other thing I will add before turning it over to Tom is that the Puerto Rico legislation that was enacted, while free of encumbering State and local governmental plans, has four provisions which will affect public pension plans in Puerto Rico. And those provisions again are targeted to Puerto Rico, but they could be used as a roadmap, depending on what is said and what is ultimately done on public pensions in Puerto Rico. It could be used as a roadmap by defined benefit plan opponents in Congress in future years.

So we're going to keep a close eye on PROMESA, which is the Puerto Rico statute that created the oversight board. As it develops, we know there are two strident -- at least one strident enemy of DB plans, Andrew Biggs, who is on the board -- the oversight board, from a think tank AEI. And David Skeel, a law professor at the University of Pennsylvania, is also on the oversight board, and he has talked quite a bit about

allowing states to use Chapter 9, and use the bankruptcy protection to strip themselves of pension obligations. So we'll have our hands full with the Puerto Rico legislation, and watching how that develops.

So I could take any questions on those items, or I could turn it over to Tom now to talk about the Windfall Elimination Provision.

CHAIRPERSON MATHUR: Thank you, Tony. Let's pause here for a moment. I should just note that I actually made a mistake. I skipped over Agenda Item 6, the federal health care policy representatives update. So we'll go back to that one.

Right now, we're on Agenda Item number 7, but let me first call on Dana Hollinger, who has a question.

MR. RODA: Okay.

COMMITTEE MEMBER HOLLINGER: Yeah. My question is this, I appreciate the update. Thank you. I know there's been a move, you know, in the private sector where a lot of major companies are part of de-risking, is they're moving their DB plans over to the insurance carrier. And actually, this is really seen a little bit as a move to de-risk, and also a lot of these major corporations are not in that business.

So on the federal level, what are you doing to -- what's your reasoning or a rationale to combat that about

this, because the reasoning behind that is for de-risking.

MR. RODA: Of course, that's an excellent question. So what I've seen with regards to State and local plans, I've seen a proposal by the City of Philadelphia's Comptroller I believe to head in that type of direction. Senator Hatch's proposal could be looked at as de-risking, because it would replace a DB plan with an annuity accumulation plan.

What we have used to combat Senator Hatch's de-risking plan is to say a couple of things. One is that when you look at the benefit at the end of the day that a participant would receive through that annuity stream that Senator Hatch would set up through his legislation, it would pale in comparison to what you would receive from a well funded DB plan.

And further to that point, we say that the legislation itself would allow a plan sponsor to begin down a road of having -- and that plan only has employer contributions. So if the employer started at 20 percent of payroll, at the very next year that employer could go to 10 under the law. As long as it's done uniformly, they could go to 0 the third year. They could do pretty much what they wanted with regard to funding. And given the political considerations of these city councils and states, it would jump all over the map. So we attack it

first as to kind of replacement income argument.

And second, for public safety, we make the claim that there are no survivor or disability benefits in this annuity program. So that would have to be contracted for separately and would probably be priced prohibitive as a separate insurance product.

And we've made these -- we've said all this to Senator Hatch and his staff. And, you know, they either are unwilling to, you know, modify the legislation or just simply are not impressed that these are real issues. But Dana, that's kind of how we've attacked it.

COMMITTEE MEMBER HOLLINGER: Well, on the first one, I may be inclined to agree, because you're dealing in a situation where they're not well funded and the carriers are offering guarantees. I agree with you on the second. I think that's the stronger argument.

CHAIRPERSON MATHUR: Okay. I see no further questions, so we can move on to Tom.

Good morning, Tom.

Tom, are you still with us?

Well, we might have lost Tom. So at this time, why don't we move on to Agenda Item 6, which is the Health Care Policy Representative Update. Yvonne, are you with us?

Is there a problem on our side?

Sorry folks, bear with us.

DEPUTY EXECUTIVE OFFICER McKEEVER: Madam Chair, may I make a suggestion --

CHAIRPERSON MATHUR: Yeah.

DEPUTY EXECUTIVE OFFICER McKEEVER: -- that while they work on the calling items, that we might move to Agenda Item 8?

CHAIRPERSON MATHUR: Sure.

DEPUTY EXECUTIVE OFFICER McKEEVER: If that's okay with the Committee?

CHAIRPERSON MATHUR: Sure, that sounds fine. Let's do that.

Okay. Agenda Item 8, Risk Profile Review.

DEPUTY EXECUTIVE OFFICER McKEEVER: Madam Chair, members of the Committee, Doug McKeever, CalPERS staff. And Ms. Donna Lum will be presenting this with me.

And this is going to sound extremely similar to those of you who were in the Investment Committee yesterday, because each of the committees is having a report similar to this. This Committee has been delegated the authority to oversee the management of risks related to pension and health administration cost effectiveness, administration of self-funded health plans, approve policies that affect retirement benefit administration, and oversee member and employer service delivery, quality,

and efficiency.

The Committee has direct oversight of two of the 10 enterprise risks that will appear on the new risk dashboard. As mentioned during yesterday's Investment Committee meeting, each risk has an executive owner. And I am the owner of the health care ones, and Donna is the owner of the benefit administration risk items.

The overall format of the risk management framework will be presented to the Risk and Audit Committee later today. But in the event you have any questions related to that, Forrest Grimes, Chief Risk Officer, is here to answer any of those questions.

We're requesting your comments today on the health care administration and benefit administration risk profiles, if you have any, so that we can then incorporate those in the final version that comes back in November to the Risk and Audit Committee for approval.

With that, I will pause and see if you all have any questions on the risk profiles.

CHAIRPERSON MATHUR: Thank you. Any questions from the Committee?

I had a couple actually. So on -- well, I guess the one I wanted to ask about was on agenda item -- sorry attachment 2, page 1 of 4 under risk driver number 3. And I asked this when we talked earlier, Doug, but it's called

lack of participation in the CalPERS health benefit programs. And I think that's really getting at employer enrollment or really -- the risk is really about the pool and the size of the pool, and how important it is that we maintain a large pool in order to continue to have some, you know, strong negotiating power in the marketplace. Is that --

DEPUTY EXECUTIVE OFFICER McKEEVER: That is correct. And so if you think a change to the title would be more representative of that, we're happy to take that away and work on that.

CHAIRPERSON MATHUR: I do think -- I do think it's not quite clear the way it's written right now, and doesn't get at the heart of what the risk is. So maybe a little bit more thinking. I'm not suggesting that my language is all that elegant either, but --

DEPUTY EXECUTIVE OFFICER McKEEVER: That's okay. We -- the intent is known, so we'll take that back and have a change for November.

CHAIRPERSON MATHUR: Thank you.

The other piece that I had raised with you earlier is around the timing of some of these mitigations and controls. And I particularly asked about the DEV, which you explained to me on the phone, but maybe it might be worth mentioning here to that we're going to more

regularly do --

DEPUTY EXECUTIVE OFFICER McKEEVER: Yeah, happy to do so, Madam Chair. So the dependent eligibility verification item is listed, and the question may be why, since we've been through that process, we completed the project.

But as part of the statute, there is an ongoing requirement that CalPERS, every 3 years, validates for the retirees the fact that the dependents that are listed are, in fact, eligible. So for us, it is a continuing mitigation factor for us to pursue, to ensure that the documentation that's required is submitted, and that we review that documentation, so we don't find ourselves in the same position that we did before launching the project.

CHAIRPERSON MATHUR: So I -- I guess I would just suggest with some of these that do have some periodicity to them to include that in the description of the mitigation. And my guess is that there are some other processes around dependent eligibility verification around some of the other groups of our members working with our employers to remind them that they need to, you know, get the proper documentation of dependents, et cetera, that we might want to reference here as well, as part of the mitigation efforts.

DEPUTY EXECUTIVE OFFICER McKEEVER: Sure. We'll be happy to make that change.

CHAIRPERSON MATHUR: Okay. Any other thoughts on the risk profile review?

Seeing none.

Are we back on with -- okay. So let's finish up with 7. Tom, do we have you on the phone?

MR. LUSSIER: Yes, you do.

CHAIRPERSON MATHUR: Great. Well, welcome to the Board room.

MR. LUSSIER: Technology is a wonderful thing.

MR. RODA: Go ahead, Tom. Dana, I'm sorry, your question got cut off. I'm happy to --

CHAIRPERSON MATHUR: I think we'd concluded her questioning.

MR. RODA: Very good.

CHAIRPERSON MATHUR: Thank you, Tony.

MR. LUSSIER: Okay. So I'm going to -- I'm going to move on briefly to the HR 711, which is the Equal Treatment of Public Servants Act, which is unlike all of the issues that Tony discussed where we're playing defense. This is actually a piece of legislation that is the WEP reform legislation that we have been working with a pretty broad-based coalition to try to move.

I want to just give a little history, and then

I'll just give you a sense as to where we are now. We actually were very excited when Chairman Brady decided that it was appropriate to bring the bill to markup in July in the Ways and Means Committee. And as we approach the markup, we were optimistic. Unfortunately, just before the markup, a fair amount of disagreement started to surface amongst the public employee retiree community in general. Some of the large unions started to raise questions, the firefighters raised some questions, and it ultimately got to the point where Chairman Brady was concerned about moving forward and pulled the legislation from the markup.

Since that time, we've been working very closely with him and with his staff and with Congressman Neal, who's the Democratic co-sponsor of the legislation, to try to address the issues that were raised. Some of them were raised in what was part of the original legislation, and some of the issues were raised based on some changes that Chairman Brady was anticipating moving at the last minute.

As recently as last week, I participated in meetings with the International Association of Firefighters, AFSCME, and the AFT with the hope of finding some common ground, so that we might be able to move the legislation at least part way this session.

It's fair to say that we're making progress in

those discussions, in the areas of disagreement, and the needs -- data needs are narrowing, but we're not there yet. And I think at this point to be realistic, our goal, given the fact that Congress will be out for the election season through October, and it's unclear what a lame duck session might look like when they come back, our goal at this point, and I think Chairman Brady is in agreement with this, is that we try to reach consensus, try to move the legislation out of the Ways and Means Committee, possibly even move it through the House to show that this legislation is the right path, and that we're going in the right direction, and then ultimately start over in January with that as a basis.

It's a little unclear at the moment where the Senate is on the legislation. Some of that is policy. Some of it is the politics of the Senate as it relates to the election. So we're trying to be realistic, and I want to be realistic in reporting to you. We think we're making progress towards a WEP reform bill, but we expect that it probably will only make it part of the way this year.

In a related matter, about 10 days ago, Senator Pat Toomey from Pennsylvania introduced legislation that would completely exempt police and firefighters from the GPO and WEP. Many of us -- not to be cynical, but many of

us believe that that probably has more to do with his election than it does any historic involvement in this issue or any serious attempt to address the issue.

And none of us expect that it will be considered in this Congress. But since it relates to one of your priorities, I wanted to share it with you.

On the regulatory front, I also wanted to mention that since we've spoken with you last, the Department of Labor has issued its final rule on the State-run retirement savings program, such as has been adopted in California.

As you know, CalPERS submitted comments in support of that rule. And Tony and I have been monitoring that rule throughout its evolution in the Department of Labor. Everything we're hearing is that folks are pleased with the rule. If anything, the rule offers a bit more flexibility to State and local governments than the original rule. And so I think most folks, and I assume including those in California, are looking forward to moving forward where these plans have been conceived.

What's also interesting in that regard is at the same time that they issued the final rule for State governments, they also issued a proposed rule for State subdivisions, so that perhaps large counties, large cities could go down the same road. There's some discussion in

New York and in Philadelphia already about that. And I think we don't have any reason to believe that DOL wouldn't attempt to complete this rule-making before the end of the year.

Before moving on, are there any questions about either of those issues for from anyone on the Board?

CHAIRPERSON MATHUR: Yes, we do have a couple questions.

Mr. Lawyer.

MR. LUSSIER: Great.

ACTING COMMITTEE MEMBER LAWYER: Hi, Tom. I was wondering about your awareness of any efforts to slow down the effectiveness of the rule or stop it entirely, either through litigation or congressional review, or some other means.

MR. LUSSIER: Well, I think -- I think there's no question that the folks who were opposed to this rule at the beginning are still opposed to it. I think -- I think there will be attempts to litigate. I don't think they'll be -- I don't think at this point, there will be any effort in Congress. We aren't seeing that. No one is talking about that.

My guess is even if they were to try to use the process, which would allow them to override the rule, the President would veto such an action anyway. So I think at

this point, the delays are more likely to come in the judicial environment.

CHAIRPERSON MATHUR: Okay. Thank you.

Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you, Madam Chair. Yeah, Tom, just trying to remember is this the farthest this WEP proposal has gotten in the recent history? I mean, is --

MR. LUSSIER: Yeah, absolutely. In fact -- in fact, I should have said that. As frustrated as some of us are that we're -- that we're, you know, running into road blacks, particularly since many of them are coming from people who are our traditional allies, we are nonetheless, encouraged by the fact that we've never gotten any piece of WEP or GPO reform legislation this far. And we've never had the Chairman of the Committee on Ways and Means and a senior member of the Committee as committed to moving it. So I think that's an important point, that even though we wish we were finishing it in this Congress, I think we're encouraged that we've made more progress than ever.

COMMITTEE MEMBER JONES: Okay. Good.

And then the second question is the Government pension offset, the provision that affects the spouses of widows an widowers, any discussion on that?

MR. LUSSIER: There always is discussion, but I would make the point that Chairman Brady specifically asked all of us -- at the time that he agreed to advance the legislation to do a WEP reform, he specifically asked if we would all agree to address these issues separately. He made the point that they really affect different populations of people. They are -- one is more complex than the other. One is more costly than the other. And that he wanted to move forward and get WEP done, but -- and this is an important point, particularly since he's setting at the head of the Ways and Means table, he has made a commitment to all of us to move on to GPO as soon as we deal with this. So again, frustrating perhaps, but encouraging in the sense that there is at least a makings of a plan forward.

COMMITTEE MEMBER JONES: Okay. Thank you.

CHAIRPERSON MATHUR: Thank you. Anything else, Tom?

MR. LUSSIER: Yeah, I also wanted -- your staff asked us to share some thoughts about the upcoming election and what they -- what it might mean to retirement security. This is obviously a very interesting election, and so there's not a lot to say, but I'm going to make a couple of observations from perhaps the Democratic side and then Tony is going to come back briefly and just make

a couple of comments from the Republican side.

Neither candidate has said much on their websites or in their speeches about retirement security. However, Secretary Clinton's positions, as it relates to retirement security, are helpful to us in this regard. She makes, and has made on a number of occasions, a very clear statement that she is opposed to any effort that would undermine retirement -- existing retirement benefits.

And so we don't see her, and knowing even the people around her, we don't see her, at any point in time, buying into this anti-DB ideology that is out there constantly.

The other issue, and this is incredibly important from the bigger picture point of view, where she is fairly specific is in the realm of expanding not privatizing, and certainly not shrinking Social Security. We've mentioned to you in the past that unfortunately right now that Washington seems to be divided into extremes on Social Security. On one hand, there are folks who believe that it is the root to a greater retirement security and should be expanded. And on the other hand, there are folks who believe that Social Security is an entitlement program that is not sustainable, and therefore should be cut back in some ways.

So she has very clear a policy and very strong

statements as it relates to enhancing Social Security. My guess is that we would see her view that as her avenue for addressing the larger term retirement security benefit discussion.

The other point, and it's a little more subtle, but it's terribly important is from our perspective, when we think about the regulators who would be part of a Clinton administration versus a Trump administration, our instinct is that we would see more along the lines that we've seen over the course of the last 8 years, which means we would see friendly regulators at Treasury, we would see friendly regulators at the Department of Labor, and we would be more likely to continue to advance the kinds of things, like I just talked about earlier, in DOL where we talk about expanding retirement security opportunities.

With regard to the Congress, I think most of us believe that the House will remain in control of the Republican majority. Given our work with Chairman Brady on HR 711, that's a good thing. Where that raises concerns for us goes sort of to the threats that Tony talked about at the beginning. I think we could expect to just hear and see more of the same in terms of hearings and legislative proposals like the PEPTA proposal that will just keep us on our guard.

On the Senate side, I think that who's going to control the Senate right now is pretty much up in the air. What's not up in the air is that no matter who controls the Senate, the majority is likely to be very slim, which means that the only things that will pass the Senate will be those issues that -- on which there is some compromise and which there is some consensus.

Probably from a retirement security point of view, that's a good thing for us, because things that are improvements on retirement security are things that might be able to get that kind of consensus. And those things that would be a tax on our plans, those initiatives to undermine DB plans would probably not get that kind of a consensus agreement.

So it's -- at this point, there are probably more questions there are answers. I think we're all going to be with you in January to speak more specifically about all of this. But from a big picture view, that's where our thinking is right now, and I just turn it back to Tony to share some thoughts from his perspective.

MR. RODA: And Tom, I don't have anything further on the Congress. I think you laid it out pretty well. I'll talk 30 seconds about Donald Trump, Republican candidate. I mean, on Social Security, he has said he doesn't want cuts, but he's a little fuzzier about how

that happens, and his fact that he wants to bolster Social Security. He's said that he wants to grow the economy and increase jobs, and that will bolster Social Security, because more people will be paying the FICA tax.

But he's also drawn a line in the sand on the wage cap of 118,500, that that should not be increased, and that that is -- that would be a new tax in his mind.

I think if we were to see a Trump Administration, we would see officials at Treasury, IRS, and DOL who do not hold State and local plans in high favor, and I think would be a real challenge for us in that environment.

Vice Presidential candidate Mike Pence has toyed with Social Security privatization when he was in the Congress. As Indiana Governor, he had a proposal to steer quite a bit of money, $500 million, to Indiana based start-up companies. And that was a controversial issue.

The only thing positive then that I'm going to say about a potential Trump administration is in the political vein -- and Tom and I talked about this yesterday. He will be sensitive to the needs of public safety. So to the extent we put public safety out in front in Washington, police and fire plans, he will be receptive to that. And an interesting fact is that he is a pensioner from the Screen Actors Guild for all of his work on television. So he knows about pensions. Is he

going to be a friend? I don't think so. Can we mute him a little bit through public safety? I think we can.

But with a lot of things related to Trump, there are a lot of question marks and few answers. So with that, I'll conclude and take any questions that you might have.

CHAIRPERSON MATHUR: Well, thank you, Tony and Tom. I see no questions from the Committee, so I thank you for your time and we'll talk to you -- oh, Henry. Sorry, I spoke too soon.

Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you, Madam Chair. Yeah, I'm looking at your report at this item Public Pension COLA decision the Kentucky case and it indicates that the judge indicated that in very limited circumstances the courts have found the State pensioners had a contractual right to specific COLA levels. Did they identify those types of limited situations?

MR. RODA: You know, I'd have to go back and read the case and get that information for you, but I'm happy to do that.

COMMITTEE MEMBER JONES: Okay.

CHAIRPERSON MATHUR: So next time.

COMMITTEE MEMBER JONES: Yeah. Thank you.

CHAIRPERSON MATHUR: Great. Thank you.

All right. Now, we will move back to Agenda Item 6, and hear from Yvonne[sic] Fontenot. Are you on the line, Yvonne[sic]? Yvette.

MS. FONTENOT: I'm hear. Can you hear me okay?

CHAIRPERSON MATHUR: Sorry. Yeah, sorry, Yvette. Yes, hi.

MS. FONTENOT: No problem. I'm here.

CHAIRPERSON MATHUR: Great. We can't hear you very well, so I don't know if you can get a little closer to your phone or --

MS. FONTENOT: Is that any better?

CHAIRPERSON MATHUR: It's quiet. We're working on our side. Can you try again?

MS. FONTENOT: Okay. How's that?

CHAIRPERSON MATHUR: You might have to speak up a bit, I'm afraid.

MS. FONTENOT: Okay. I will do my best to speak up. Is that a better level?

CHAIRPERSON MATHUR: I'm sorry not much.

Is Chris on the line as well?

MR. JENNINGS: Yes, I am on the line.

CHAIRPERSON MATHUR: We can hear you a lot better, Chris, than we can hear Yvette.

MS. FONTENOT: Chris, why don't you go ahead and start and I'll try and call in from a different phone.

MR. JENNINGS: Okay.

CHAIRPERSON MATHUR: Thank you, Yvette. Thanks.

MS. FONTENOT: Okay.

MR. JENNINGS: Okay. My discussion was going to be focused around one of the hot issue driving purchasers, whether they be consumer, business, private or public plans, like CalPERS or governments, to be extremely frustrated. It also is driving a lot of media interest. And that, of course, is the issue of prescription drug costs and prices.

And this -- this has received much more attention of recent, and I wanted to raise a couple of quick developments and their implications potentially for CalPERS. You also note that in your agenda today, that Doug has laid out for you this is a major issue that you'll be hearing more about later this morning.

Generally, what we're seeing is something that we've always seen, which -- but even more intensively, which is specialty drug prices in the recent years, and now more so, are being priced at extremely high levels, and then subsequently inflating. And we've seen some recent studies exposing these issues. The one by the National Business Group on Health showing that nearly one-third of employers cited specialty pharmaceuticals as the highest driver of costs, and 4 out of 5 said it was

one of their top 3 drivers.

And that -- I want to highlight this one, because it compares with just six percent who cited this as a challenge just a few years ago. And AHIP has raised this issue as it relates to orphan drug costs not just for -- and not related to the treatment of the drugs for which they were approved, but how orphan drugs are now being prescribed for other uses and driving cost.

But what has gotten the most attention recently has been, of course, this development where we're seeing more and more generics with little or no competition increasing prices of bold products sometimes by enormous amounts. The one, of course, that received the most attention was Mylan, and its coverage of -- and it's marketing of EpiPens. That cost of the price increased by over 460 percent, and it raised it continually over the years.

And this has got a lot of attention indeed. The CEO will be testifying tomorrow before the house oversight hearing, and both Republicans and Democrats want to hear from her about this dynamic. And we can talk a little bit about how she's responding and what the reaction has been, if there's interest. But clearly, the Congress and purchaser and public outreach -- outrage has ensued as a result.

Already, in response, we've seen some Presidential candidate highlight this a couple of weeks ago. Hillary Clinton expressed her own outrage and unveiled new transparency and cost review and enforcement policies. And to supplement, you know, a lot of other drug cost containment initiatives she's unveiled. And by the way, parenthetically, Donald Trump has said he supports fairly radical interventions on drug pricing, including reimportation and Medicare direct negotiating.

And just a few days ago, there was bipartisan legislation introduced by Senators McCain and Baldwin called the FAIR Drug Pricing Act, which requires transparency and justification for certain drug products that increase by more than 10 percent. And it requires, if they do and if they're the right drugs that they think are particularly problematic to the Department of Health and Human Services, for the manufacturer to provide an accounting of R&D costs manufacturing costs, and profits.

This is not an explicit price control, but it is a step towards transparency. And this issue will get more and more attention. No one expects, by the way, that Congress will act before the end of this Congress. And I should say, even though this is bipartisan and bicameral, and the Campaign for Sustainable Drug Pricing, which is an offshoot as you know of the National Coalition on Health

Care which is a -- which CalPERS is a leading member of, has endorsed. We don't anticipate immediate activity.

I wanted to also mention though that just recently again the Government Accountability Office released a study on generic drugs showing that 20 percent of generics had at least one price of 100 percent or more.

So what you're going to hear a little bit more is this whole brand, specialty drug price and generic dynamics that tend to be reflecting a bigger trend, that not only reflects pricing problems, but their impact on premiums, and how best to respond to them.

And I -- and clearly, CalPERS has been a leader in highlighting this issue. I would suggest that over time we will -- it will do us well to be able to provide information to Congress about the impact on our overall cost trend, because there will be quite a bit of interested on that.

Lastly, I should just note that this is not just a federal issue, and drug pricing is getting a lot of attention within the State, and as you know, I don't need to tell you, that there is Proposition 61 that has received a good bit of attention requiring that State agencies pay no more than what VA prices are -- VA purchase price is, which is -- may well create -- CalPERS has not taken a position on this, but there are some

legitimate administrative issues on this issue. But I mentioned it because as of this moment, as I present this to you, it looks like notwithstanding an enormous campaign against the Proposition, it is quite popular in California.

I'll stop with the drug dynamics. I think what I might do, Madam Chairwoman, if you don't mind, is I'll turn it back to Yvette, because I think we then want to conclude our conversation with a little bit more about the dynamics going forward as it relates to the potential Trump and/or Clinton administrations, and how they're preparing to govern.

So with that, I'll turn it back over to Yvette.

CHAIRPERSON MATHUR: Sounds good.

Yvette, are you there?

MS. FONTENOT: I am here. Can you hear me?

CHAIRPERSON MATHUR: Much better. Thank you so much.

MS. FONTENOT: Excellent. Okay. Thank you.

CHAIRPERSON MATHUR: Terrific.

MR. FONTENOT: Thanks for filling in, Chris.

So I'm going to talk about the other two key policy areas that we've agreed are sort of critical to ensuring CalPERS receives a high return on their health care investment, and that's delivery system reform, and

the excise tax on high cost plans. And then I want to mention just a couple more issues that have arisen that are of general importance that we just want to make you aware of.

So starting with the delivery system reform effort and our efforts on the regulatory side, obviously, moving the health care delivery system from a value based one -- from a volume based one to a value based one has always been a focus of CalPERS. And as the administration really works to move Medicare and Medicaid in the same direction, we've worked diligently with them to make sure that their efforts are consistent with the steps that CalPERS has already taken, and watch for opportunities to further CalPERS' interests in this area.

Early on, as you probably know, the administration set a goal to have 50 percent of traditional Medicare payments flowing through alternative payment models, which support value based payments by 2018. And a key part of this effort has been their focus on encouraging Accountable Care Organizations, a structure that CalPERS has long been incentivizing within the Medicare program.

So at the end of August, the administration announced the 2015 performance year results that showed that for 2015, the Medicare Accountable Care Organizations

had a combined total program savings of close to 500 million. So not wholly significant in terms of Medicare overall spending, but movement in the right direction.

And they had data supporting the notion that ACOs are improving their performance over time. Another part of the administration's delivery system reform effort is to increase the number of new bundled payment models that really shift Medicare payment from rewarding quantity to rewarding quality by creating strong incentives for the hospitals and clinicians to deliver better care together at a lower cost.

In July of this year, CMS proposed new bundled payment models focused on heart attacks, heart bypass surgery, and hip fracture surgery. And this followed the implementation of the comprehensive care for joint replacement model that began earlier this year, which introduced bundled payments for certain hip and knee replacements, and strongly echoes CalPERS efforts in this area.

So now hospitals and physicians will be responding to similar incentives for Medicare that really reward hospitals that work together to avoid complications, prevent hospital readmissions, and speed recovery. So at this point in Medicare, more than 1,400 providers are currently participating in bundles through

their various bundled payment demos, which is good movement in the right direction.

But while these efforts are an important part of system transformation, they're a work in progress. And by far the largest transformation that will take place will be with the implementation of the Medicare Access and CHIP Reauthorization Act or MACRA, which replaced the sustainable growth rate in the Medicare physician payment formula.

Although, MACRA is separate from the changes that were made in the ACO -- in the ACA and have already been implemented by CMS, the success of much of the delivery and payment reform that have been put in place will really depend on CMS's ability to implement this new physician pay system that gets physicians to be more efficient. And as a result, there's been significant Congressional oversight on a bipartisan basis of the implementation of that Act.

Under the proposed rule that CMS released, physicians would have had to start reporting in January and payment would have been adjusted in later years based on that performance. Last week, the Acting CMS Administrator said that CMS in the final rule will give physicians longer to prepare for the new payment system, meaning that physicians can avoid pay cuts in the first

year just by reporting information in the next year. And they have options for participating in less risky arrangements.

So most of the physician groups, and many in Congress, praised him for this delay, given the ambitious time frame they had put out in the proposed rule. Some physicians who were actually prepared for the new system raised concerns that they'll now get smaller bonuses in the first year. And in addition, payers, including CalPERS through a letter from the National Coalition on Health Care that we helped craft, have expressed an interest in faster movement toward higher risk models that move physicians more quickly towards a value based payment system.

So we'll continue to advocate for this position and make clear with the administration, and the relevant committees, that encouraging physician participation has to be balanced with accelerated movement that will help payers achieve a higher return on their health care investment

In terms of the Cadillac Tax, although the excise tax on expensive plans has been delayed until 2020, a recent survey from the National Business Group on Health found that just 1 in 5 employers are delaying their cost containment initiatives because of this delay in the tax.

The survey also found that 53 percent said at least one plan they offer would hit the threshold, and 35 percent said their plan with the highest enrollment would be subject to the tax.

So despite, I'd say, significant hostility from employer and labor groups with the ERISA Industry Committee to Speaker Ryan's proposed replacement plan, which would cap the tax exclusion of employer health sponsored insurance, the Chairman of the Ways and Means Committee, Representative Brady, has continued to discuss this idea at several hearings about health care tax. And it seems likely that in the context of a larger tax reform debate, this idea of capping the employer sponsored health insurance, the tax exclusion, will likely be explored as a possible replacement for the current excise tax on high cost plans.

In addition, the Brookings Institute continues its work on examining possible reform to the current tax. And we've been in contact with them on that effort. So we'll continue to track and engage in this debate after the election, as we get closer to 2020 regardless of which party wins the Presidency.

With that, I wanted to mention two additional issues before I kick it back to Chris to talk about the election. The first is about the Part B premium. This is

an issue that impacts CalPERS that we're tracking closely. As you may recall, last year we worked to secure a bipartisan cooperation that led Congress to mitigate what would have been an unprecedented Part B premium and deductible increase.

These increases were a result of a hold harmless provision that limits the dollar increase in the Part B premium to the dollar increase in an individual's Social Security benefit. According to the 2016 Medicare Trustees Report, Part B premiums are once again projected to increase significantly for nearly 30 percent of beneficiaries, which will be accompanied by a hike in the Part B deductible as well.

B's increases are once again related to a predicted nominal COLA for Social Security recipients in 2017, perhaps as low as 0.2 percent, which will lead to -- once again, to the application of this hold harmless provision.

So should those Trustees' Assumptions hold, about 70 percent of Medicare beneficiaries will be held harmless, will the remaining 30 percent will shoulder the cost of the expected premium increase. The solution that was advanced last year on a bipartisan basis would allow the Secretary to address these increases, if there is no COLA, so if the COLA comes out at 0 percent. But if the

COLA comes out at 0.2 percent, as the Trustees expect, the Secretary will not have the ability to deal with these Part B premium and deductible increases.

So those affected by the premium increase include new Medicare enrollees, individuals not collecting Social Security benefits, and beneficiaries already paying the income-related premium, as well as dually eligible for whom the State Medicaid program bears those costs.

And unlike the premium projection, the estimated increase in Part B deductible affects all Medicare beneficiaries. So those affected will be those enrolled in traditional Medicare with no supplemental, those who have a supplemental, but don't -- it doesn't cover the deductible, the dually eligible, so State Medicare programs and those who purchase Medigap plans could then bear an expense in the form of a higher premium as many retirees and their employer sponsors. So this is an issue that we will be working with our different coalition partners to urge Congress to advance a solution to address this.

And the last issue that I wanted to mention before handing it back to Chris is something that I'm sure you're reading a lot about and will almost certainly play a role in the upcoming election, and that is the -- really the stability of the exchange marketplaces and the

associated premium increases that have received so much press coverage. It's almost hard to believe that only 6 percent of the population is covered through the exchanges.

So while there's no doubt we've seen some problems with the exchange risk pool, the final contracts between insurers and the government won't be signed until late September. So that means it's still possible that additional insurers will choose to enter new markets between now and then. And the competitive picture could improve.

In addition, there are regional differences in how extensive these problems are, as well as a rural urban distinction. The -- many places in the country have robust choice and competition, including some of the large population centers like Denver, L.A., New York, and Miami. But large areas have limited choice, like the 5 states that now only have one issuer, Alabama, Alaska, Oklahoma, South Carolina, and Wyoming.

The risk pool and the associated premiums are also highly affected by whether the State has expanded Medicaid or not. In fact, according to HHS, premiums for plans sold on the exchanges are 7 percent lower in states with expanded Medicaid programs. And the administration has taken some action to try and stabilize the

marketplaces, including trying to identify and do outreach to those individuals who paid a penalty this fast year for not having coverage.

And at the moment, the administration is also getting ready to review a first-of-its-kind waiver from California to allow undocumented immigrants to buy health insurance on the State's public exchanges. And that waiver will be -- will be controversial and sort of set precedents in a number of ways that we could talk about.

So in Congress, the reaction to this has been that a number of Republican Senators have introduced legislation that would allow consumers to use their tax credits that they got through the Affordable Care Act to purchase plans outside of the Exchange. Simultaneously, a number of Democratic Senators have introduced a nonbinding resolution to ensure that every American has access to a public option, which has obviously been a centerpiece of Senator Clinton's campaign, and we can answer more questions about that.

I think, at this point, I'm going to hand it back to Chris to talk about -- more about the overall transition effort, and what we expect over the next several months, and the election outcomes. And then we can take questions across the Board.

CHAIRPERSON MATHUR: Okay.

MR. JENNINGS: That is if you're still interested in hearing from us, Madam Chairwoman.

CHAIRPERSON MATHUR: Yeah, go ahead. Chris.

MR. JENNINGS: Okay. Well, very, very quickly. It is not at all surprising to conclude that this is largely a policy-free zone campaign. And so it's far more driven by personalities. And as a consequence, sometimes it's hard to kind of get a sense of where all the candidates are substantively.

I'm not going to go provision by provision, but what I will just say is there are some notable differences. Obviously, you have one candidate supporting repeal and replace of the Affordable Care Act and you have another candidate supporting improving the law.

You have one candidate talking about enhancing Medicaid, and another one talking about block granting Medicaid. And, that, of course, was Mr. Trump.

And then on prescription drugs ironically, I think the public hears both of them being outraged by drug pricing, and both of them have both -- you know, have relatively aggressive policies, at least in label, on the importation and direct negotiation.

There's 10 other policies on drug costs that the Clinton Campaign has unveiled that are worth noting at some point, but I promise you it will not be here.

(Laughter.)

MR. JENNINGS: And then lastly, on Cadillac Tax, you have one who clearly is opposing the Cadillac Tax, which is Secretary Clinton. Mr. Trump, as far as I know, has not engaged on this. However, most people who don't know generally what policy direction he may pursue, believe he'll be largely deferential to the Republican leadership, in particular to Speaker Ryan, who has embraced this notion of a cap on the tax deduction.

And so we raise this to you, because it's just worthy of if we move in a different direction, after November, we'll need to be prepared to deal with all these issues. And the last point I wanted to make, and this would be, I think, relevant to all of our reports, is that unlike past Presidencies, except for 2012, and certainly without precedent for both Presidential candidates, they both have formed and been funded to organize their transition offices.

They have staff in place. They're working very quietly behind the scenes. They are not meeting with people -- at least I can tell you about the Clinton folks are not -- until after the election. But they all are working on reviews of both policy, both administrative and legislative they may want to pursue early in their administration, organizational changes, structural changes

of agencies that they may wish to pursue, and lastly personnel. And that's probably cross cutting on both Republican and Democrat.

It's probably worth considering to be preparing how they would likely would like to have this information conveyed, so that we may do some sort of collective contribution of our interest sometime soon after the election, if that's something the Board is interested in pursuing or we can do it one off from various other ways to do this.

But it is -- it is quite clear that we are about to go through a major governmental transition, one less though than the other because if it goes Democrat to Democrat, it will be less so; one very substantial, if he has -- if Mr. Trump comes in.

And I think sometimes it serves you well for us to convey to you that process. And we'll get back to you as we get closer and closer to that moment.

CHAIRPERSON MATHUR: Thank you, Chris. I have a couple of questions. One is I do think that it would be fruitful for us to prepare to communicate with whoever wins the election very quickly following the election, so that we can get our issues in front of them and establish a rapport and open up communication lines as quickly as possible.

I imagine that the rest of the Committee and the Board agrees with that. I see lots of nodding heads. And I'm sure the team is -- you are already talking about that with our staff.

I had a question about the exchange markets. Yvette, you mentioned a few things around sort of some of the market dynamics. I'm wondering in every State are they using risk adjustment the way the California exchange is using it here? And is that playing -- does that have any impact on how sustainable those exchanges are?

MS. FONTENOT: Yeah. It's a great question. The risk adjustment has been pointed to by many of the plans and other stakeholders as kind of being a driving force behind the problems that we're seeing. Each State does their own risk adjustment, meaning within their own marketplace, the money moves from the plans in each State. I'm not -- I think that California's risk adjustment follows the CMS guidelines but is done within the Covered California plan environment.

One of the actions that the administration has taken just recently in their proposed notice that will -- that will detail how the plans have to participate for next year is to make some pretty significant changes to the risk-adjustment model to account for drug spending, to, you know, change the way that the money flows in order

to take account of the higher risk individuals more adeptly.

And I think the sense is that the changes that they've proposed in some ways will help the marketplace, because it will move money to better account for the much higher risk that some of the plans have gotten. The flip side of that and the criticism of what they proposed is that most of those people, the high risk people, are with the big issuers. And so what we're seeing is, and will continue to see under their proposal, is that -- the movement of money from -- really from the smaller plans to the bigger issuers, in this case it's mostly the blue plans.

So I think that CMS is, you know, looking at what they've proposed, and we'll see what they end up doing in the final -- in the final rule. But it will -- it does impact every State's environment sort of independently depending on your plan mix.

CHAIRPERSON MATHUR: And -- thank you. And the other issue that I -- that you hear a lot about is the level of the penalty for not enrolling in health care and the health plan, and that it's too low. Is there any discussion about changing that -- the level of that penalty and what level would actually stimulate higher enrollment?

MS. FONTENOT: Yeah. I mean, it's a good point. The -- you know, this is actually the first year where the penalty for not having coverage is fully implemented. So it's -- you know, so we haven't actually seen the full impact of the penalty level yet. That being said, I remember when we were working on the Affordable Care Act when I was with the Finance Committee, we had a much higher penalty in place in committee, and there was a pretty overwhelming vote to actually lower that amount, because it is -- you know, it is a controversial, you know -- at least politically, it's a controversial proposal to actually have a high amount in that place.

And so the members were really uncomfortable with having a higher amount. And I think, you know, partially maybe because of that, you've seen, as opposed to proposals to increase the amount, the proposals we've actually seen that affect the individual requirement are to get rid of it in places where there isn't enough competition.

And, you know -- or where there isn't a plan or where there's only one plan, it would actually eliminate the individual requirement. So I think you're right that there's -- you know, there's every indication that the penalty should have probably been higher in the first place, but we haven't heard any conversation, at least in

Congress or within the administration, about actually increasing that amount.

And at the same time, I don't think we've seen the full effect of the penalty yet, in terms of people actually paying the full amount, and being made aware that they paid the full amount, and then, you know, having follow-up outreach from the Department and the exchanges and the plans saying are you aware you paid this penalty, and we can make sure that you don't have to pay it in the future?

CHAIRPERSON MATHUR: And the real issue with having too low of a penalty is that lower risk individuals are not signing up to the exchanges, right, so that --

MS. FONTENOT: Exactly, yeah. And that's personally -- I mean, that's personally because the penalty is too low, and frankly, it's -- the other side of that is I think they're looking at the offerings in the exchange and deciding that the greater -- you know, they're not high enough value for them to make that decision yet.

CHAIRPERSON MATHUR: Right.

MS. FONTENOT: So it's -- yeah, it's a bad dynamic the way it's played out.

CHAIRPERSON MATHUR: Okay. Thank you. Any other questions from the Committee?

Seeing none.

Thanks so much for being with us this morning, Chris and Yvette and we'll talk to you soon.

MR. JENNINGS: Our pleasure.

MS. FONTENOT: Thank you.

CHAIRPERSON MATHUR: All right. We will move on then to Agenda Item number 9, value based insurance design.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

Good morning again, Madam Chair and members of the Committee. Shari Littler, CalPERS Staff.

At the July 19th CalPERS Board and Executive off-site, Dr. Fendrick of the University of Michigan Center for Value-Based Insurance Design, or VBID, presented an overview of VBID and discussed how it could fit in to the CalPERS strategies to improve health outcomes and over the long term reduce costs.

Today, we'd like to present staff research and discuss examples of other States' VBID implementations, the importance of communication with stakeholder groups during development, and some of the concepts staff is evaluating.

But before I discuss what other states are doing, I'd like to revisit the concept of VBID, so that we're all on the same page, and briefly talk about CalPERS

implementation of designs that could be considered VBID.

So what is VBID? As you may recall from the presentation, the basic premise of VBID is to encourage health plan members to maintain good health and discourage the utilization of unnecessary health services by aligning out-of-pocket costs with the value of health care services.

For example, just to illustrate the concept, not to imply we're going to -- planning to do this, but a basic VBID strategy might involve reducing copays for certain high value medically-necessary services, like office visits for chronic conditions; increasing copays for low value medically-unnecessary services, like office visits with patient-selected specialists without referral.

But altering co-payments is just one of many possible strategies to affect the out-of-pocket costs. Other strategies could include adjusting deductibles, setting co-insurance rates, implementing reference pricing of services. So what we've done already knowing that health plan premiums are in part driven by member utilization of services, each year we examine health plan benefits utilization data to identify trends, and ways that we might improve the health of our population and mitigate premium increases.

One thing that's been relatively constant in the

CalPERS population is the rate of episode to treat chronic care conditions. The percentage of members with chronic condition has remained static since 2009. Approximately one-fourth of our members have a chronic condition. Treating these conditions account for about 50 percent of the total medical costs.

CalPERS has successfully implemented a variety of benefit design elements that already could be considered VBID, such as lower copays for generic drugs, and reference pricing for hip and knee surgeries. But our hope is that the adoption of additional VBID strategies could provide opportunities to improve the health of our members and bend the cost curve for treating chronic conditions.

Let's take a moment to discuss what some of the other states are doing in this area, and their implementations and outcomes. One of the most studied VBID programs in the public sector was implemented by the State of Connecticut. In 2011, this State implemented a Health Enhancement Program, or HEP, which is a value-based insurance design inspired health plan for State employees.

HEP enrollees pay lower premiums and lower out-of-cost prices at the point of service than beneficiaries who don't elect to participate. The design of HEP plan is fairly comprehensive in scope.

Out-of-pocket costs are adjusted for many benefits, under the stipulation that members commit to certain things such as yearly physicals, age and gender appropriate screenings, and preventative care, free dental cleanings, and participation in disease management programs.

For example, as detailed in the agenda item attachments, the design includes, among other things, elimination of copayments for office visits for chronic conditions, incentive payments of up to $100 annually, if a member with targeted chronic condition, including his or her dependents, complies with all of the HEP requirements in a given year.

In the first year, approximately 98 percent of eligible Connecticut State employees and retirees voluntarily enrolled in HEP. And after 15 months, 99 percent of enrollees had complied with program requirements.

A 2016 study of that implementation found that utilization of preventative services increased substantially in the first two years. And there was also significant decrease in the total number of emergency department visits.

In terms of spend, there was an increase overall, but the authors of the study ultimately concluded that the program's impact on costs may have resulted in other

factors than utilization. Clearly, VBID impacted member behavior, but the jury is still out on the cost impact.

Another State that we reviewed is Oregon. The Oregon Public Employees Benefit Board and Educators Benefit Board provide health benefits to Oregon State employees and collaborated in 2010 to incorporate strategies in their health care program. Their benefit design included no or low copays for preventative surveys -- services, $100 copays for services such as imaging and sleep studies, and $500 copays for member preference and low value services.

Much like Connecticut, members in the Oregon plan must participate in age-appropriate preventative services, and participate in disease management program, if they have a chronic condition. But in Oregon, members don't participate -- who do not participate pay $100 a month premium share.

The cost impact of the Oregon VBID program is still unclear. The member utilization services -- and whether or not it's impacted member utilization services.

Oregon has reported decreases in obesity and tobacco use, improved screening of colorectal cancer, cholesterol, blood pressure and diabetes, and decreases in imaging, sleep studies, and other low-value services. One thing that both states share is the role of stakeholders

in the VBID implementation.

So we understand that stakeholders are the key to our success. And both Connecticut and Oregon employee group support of these programs has been crucial to their success. In Connecticut, as part of the negotiations with State labor groups, proposed VBID as a strategy to improve employee health and address long-term costs. This was seen as a win-win for labor management. Because the design change is mainly focused on reducing barriers, achieving high-value care, acceptance was easier.

Similarly, in Oregon, experiencing large budget deficits, labor groups viewed value-based insurance design strategies as an approach that could address costs while reducing medically unnecessary care.

Going forward, CalPERS staff is continuing to review published literature, interview other health plan administrators who have implemented VBID to identify useful strategies. CalPERS staff will also continue to explore cost savings, long-term implications of various VBID strategies, such as adjusting copays related to chronic conditions, lower value medications, medically unnecessary care, implementing participation, and requirement of members to increase usage of disease management and preventative screening, and consideration of potential pilots to evaluate strategies most effective

That concludes my report. I'm available to answer any questions.

CHAIRPERSON MATHUR: Thank you. We do have some questions.

Mr. Lawyer.

ACTING COMMITTEE MEMBER LAWYER: You mentioned that a overall cost increase in the Connecticut HEP plan, but I was curious about how that compared to other health plans in Connecticut?

DEPUTY EXECUTIVE OFFICER McKEEVER: Mr. Lawyer, that wasn't part of the analysis that we conducted, so we'd have to follow up on that.

ACTING COMMITTEE MEMBER LAWYER: Okay. Thanks.

CHAIRPERSON MATHUR: Okay. Anything else?

Okay. Ms. Hagen.

ACTING COMMITTEE MEMBER HAGEN: Thank you. Good morning.

Reading your item, there's a pretty -- let's see what page it's on, page 3 of 4, it looks like -- a pretty strong statement about high deductible health plans not being a viable option. And I was wondering if you could speak to that? I think in reviewing the item, I think the piece that may be missing from this analysis of high deductible plans is an employer-sponsored HSA, right? So we talk a lot about in here the -- it's not an incentive

for them to pay out of pocket. But if you had an employer-sponsored HSA, that would take that concern away potentially. Can you talk a little bit about that?

DEPUTY EXECUTIVE OFFICER McKEEVER: Yeah. Ms. Hagen, it's -- this has been a -- as you know a subject of quite a conversation with us for some time now relative to addressing a high deductible plan with an HSA and a lot of it's going to be based upon how that's developed.

There are multiple ways in which a health savings account can be established. There's also multiple contribution amounts that the employer puts into that account. So depending upon what those contribution amounts are, probably goes a long way to the effectiveness that that particular plan is going to have.

There was a recent study, and I'm sorry I don't have it with me to cite, but it came out in the last week in which a high deductible -- a high deductible plan tied to a health savings account started to prove to be ineffective for your low wager earners.

In fact, what they found was that those individuals neglected to go in to get care, because they didn't want to use the dollars that were in their health savings account. So it all depends upon how it's designed and developed. And as we move forward, that's something we still need to look at as a potential option, but we

just wanted to make sure that you were aware that there are some issues that have been found with these relative to how they've established them, and what efforts have been done, at least in the states that we cited.

ACTING COMMITTEE MEMBER HAGEN: I'm glad to hear that you're still considering this option. We, in the administration, strongly feel that this is a good option to pursue. And I could probably give you another survey that came out last week that says just the opposite.

DEPUTY EXECUTIVE OFFICER McKEEVER: Right.

ACTING COMMITTEE MEMBER HAGEN: So thank you.

DEPUTY EXECUTIVE OFFICER McKEEVER: I think one comes out about every week.

ACTING COMMITTEE MEMBER HAGEN: Right.

CHAIRPERSON MATHUR: One of the things we had talked about Mr. McKeever is perhaps bringing Connecticut or some other purchaser who has experimented with this particular approach to speak to this Committee and share their learnings or experience. Perhaps, we could answer this question of how does the experience compare with this -- with a VBID compared to other plans at that time? Is that still something that you're working towards?

DEPUTY EXECUTIVE OFFICER McKEEVER: Yes, we are pursuing that. And we're hoping to facilitate that in December --

CHAIRPERSON MATHUR: Terrific.

DEPUTY EXECUTIVE OFFICER McKEEVER: -- so that it would be in advance of any efforts that we then bring forward at the January off-site.

CHAIRPERSON MATHUR: Great. So I think following that just to sort of give the Committee a little bit of a sense, in January, at the off-site, we're planning -- you're planning to bring forward sort of some -- after some further analysis, you're planning to bring forward some potential options for the Board and the Committee to consider and discuss.

DEPUTY EXECUTIVE OFFICER McKEEVER: Yeah. I mean, we think this is an extremely valuable area to look at further and would like your support for us to continue to do that, with the intent that we would come back at the off-site with additional information on VBID, with some suggested approaches for your consideration.

CHAIRPERSON MATHUR: Well, I think there is appetite from the Committee and the Board to further explore this idea, and the value proposition of it for our members. I don't see any -- I don't see any shaking heads, so -- so you have -- you have our agreement that that's how we should proceed.

DEPUTY EXECUTIVE OFFICER McKEEVER: Thank you, Madam Chair.

CHAIRPERSON MATHUR: Any further questions from the committee?

Seeing none.

We'll move on to Agenda Item number 10, Prescription Drugs Utilization and Cost Trend Report.

Mr. McKeever.

(Thereupon an overhead presentation was presented as follows.)

DEPUTY EXECUTIVE OFFICER McKEEVER: Madam Chair, this one will be presented by Ms. Donneson and her team.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Good morning, Madam Chair, members of the Pension and Health Benefits Committee. Kathy Donneson, CalPERS staff presenting Agenda Item number 10.

To my left is Melissa Mantong, our CalPERS Pharmacist, and Dr. Richard Sun, CalPERS Chief Physician.

Agenda Item number 10 provides utilization and cost data for the CalPERS pharmacy program for calendar year 2015. Before I turn this over to Dr. Mantong, I would like to make a few opening remarks about the statistics for specialty pharmacy and to note one correction.

The agenda item and slide deck publicly provided showed CalPERS specialty pharmacy accounting for 37.7 percent of CalPERS total pharmacy costs. That figure

should be corrected and will be corrected in this agenda item to 28.8 percent. So we're quite pleased that it's not 37.

Nationally, Express Scripts reported that specialty drugs accounted for 37.7 percent. So we are well below the national average. You have been provided a revised slide and the agenda item will be corrected and posted.

Secondly, we are still very excited about the new OptumRx contract, which we expect to continue to generate savings in specialty pharmacy as was outlined to the Board when the selection of OptumRx was made.

Third, we've begun analysis of medical pharmacy spending in the CalPERS population. Medical pharmacy drugs are those typically administered in the physician's office, infusion centers, and hospitals without the need for a prescription. They are covered under the medical benefits of our health plans.

In past agenda items, the data has not been made available in order for us to report medical pharmacy trend. But beginning in 2014, we have now the ability to cleanly identify office administered drugs using health care common procedure coding system J codes.

We have provided two years of office administered pharmaceuticals divided into non-chemotherapy and

chemotherapy drugs within attachment 1, which Dr. Mantong will cover when she makes her presentation.

Over the next many months, we will continue to analyze the cost of office-administered drugs, as well as extract outpatient hospital and infusion administered drugs to better understand our medical pharmacy cost, as part of our overall program -- pharmacy program spending and administration.

I will now turn the rest of the presentation over to Dr. Mantong who will walk you through Attachment 1.

Thank you.

DR. MANTONG: Good morning. Melissa Mantong, CalPERS staff.

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DR. MANTONG: Here's an overview of my presentation.

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DR. MANTONG: The data source is the CalPERS Health Care Decision Support System. The data includes all members in all health plans, unless otherwise indicated.

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DR. MANTONG: The total prescription drug cost increased from $1.5 billion in 2010 to $2.1 billion in 2015.

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DR. MANTONG: Here are the annual percentage changes for the total prescription drug costs.

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DR. MANTONG: Next, the average cost per prescription increased from $91.23 in 2010 to $103.10 in 2015.

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DR. MANTONG: Here are the annual percentage changes.

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DR. MANTONG: Next, we will look at the average cost per day supplied, from 2010 to 2015. The average cost per day supplied for most years is around $2 per day.

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DR. MANTONG: Here are the annual changes in costs per day supply from 2011 to 2015.

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DR. MANTONG: Health plans and pharmacy benefit managers may have different generic assignments. For example, a certain brand drug may be assigned as a generic in certain circumstances. To allow comparison, the standard definition of generic by Milliman was used.

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DR. MANTONG: Here is the top 10 non-specialty

drugs.

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DR. MANTONG: Here's a closer look at specialty drugs. There's no standard industry definition for specialty drugs. These are drugs that generally are used to treat complex diseases, high costs, and with serious adverse effects. Therefore, the data shown used CVS Caremark specialty drug list for all plans.

As the table illustrates, specialty drug utilization and costs increased from 2012. Specialty drugs allowed amount nearly doubled from 270 million in 2012 to 587 million in 2015. The only measure that remained unchanged is the specialty member cost share percentage at 1 percent.

For comparison, the 2014 national average member cost share for specialty drugs for large employers was 15.1 percent.

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DR. MANTONG: Here's the top 10 specialty drugs for 2015. The top 10 specialty drugs are primarily used for the treatment of rheumatoid arthritis, hepatitis C, cancer, and multiple sclerosis.

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DR. MANTONG: Medical pharmacy drugs are typically administered in physician offices and infusion

centers and are covered under the medical benefit of the health plans. The medical pharmacy data shown is limited to the health care common procedure coding system, J codes. The total medical pharmacy drug costs increased from 257 million to -- in 2014 to 343 million in 2015. That is an annual increase of 34 percent.

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DR. MANTONG: Here are the top 10 medical pharmacy drugs for 2015.

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DR. MANTONG: And this concludes my presentation. We are available to answer any questions you may have.

CHAIRPERSON MATHUR: Mr. Lofaso.

ACTING COMMITTEE MEMBER LOFASO: Thank you, Madam Chair. Thank you, Ms. Donneson and Dr. Mantong or Ms. Mantong --

DR. MANTONG: Doctor.

ACTING COMMITTEE MEMBER LOFASO: Thank you. Okay.

Two questions. On the medical pharmacy info -- so we talk a lot about ACOs and all of the things we do to try to limit costs at the medical office level. And is there any nexus between all those kind of ACO-type devices and controlling medical pharmacy costs, given that it's administered in that venue, or is that just a mismatch of

a question?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Actually, it gets to the point that we are trying to make about medical pharmacy. There is -- currently, this is the first time. We've actually had the ability to look at medical pharmacy. We're looking at medical pharmacy in the office, primarily now because we can cleanly extract the information on what is happening in the office, as opposed to the hospital administered drugs, where it's very much less clear, not just about the drugs themselves that are being administered, but the mechanism by which they are administered.

However, while for many years we've concentrated on retail, mail, and specialty pharmacy houses, the same drivers that are happening in that space are also impacting the medical side, the health plan side. And so as I said over the next several months, and in working with Optum and our health plans, we expect to really start digging under what drives the cost on the medical pharmacy side. Whether we can manage it through the ACOs or the IHMs is also part of that study and equation.

ACTING COMMITTEE MEMBER LOFASO: Appreciate that very much.

The second question, apropos to Mr. Jennings' comments about orphan drugs and all, and -- can you equate

specialty drugs and orphan drugs, or orphan drugs a lot of the specialty drug population? Is it a small piece? Is it one of those definitional challenges?

DR. MANTONG: Yeah. The challenge with specialty drug is there's no standard industry definition. So each health plan, each pharmacy benefit manager can set its own specialty drugs. So certainly there's -- some of the orphan drugs are high costs, and -- as well as have serious adverse effect, so they could fall under specialty drugs. But there's no clear separation or consistency across plans.

ACTING COMMITTEE MEMBER LOFASO: Appreciate that. Very helpful.

Thank you.

CHAIRPERSON MATHUR: Thank you.

So this medical -- we know, as a general rule, that medical administered drugs are more costly -- it's more costly to admin them in a medical setting than at home -- and infusion at home, for example. So would we potentially consider some kind of copay for medical administered drugs that might be higher? Is there someway to administer that within our current structure or you're still exploring what the options might be, or it's too early to predetermine what they are?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF

DONNESON: Actually, site of care administration is something we've been looking at for at least the last two years. There are infusion drugs -- highly expensive infusion drugs that are adjuncts to chemotherapy drugs that could be safely administered in the home.

There are companies now that offer infusion services in the home under the guidance of a nurse who actually goes to the home and administers those drugs.

Under the PPO plan design, Anthem is -- is working on sites of care for infusion on a voluntary basis, which is how we would also approach it if we were looking at our HMO plans or any plan that administers the infusion site-of-care. We have not looked at any copay differentials yet, because we're still -- I think we're going to come to the point where we'll have a design to bring forward as part of a comprehensive strategy. It's one of many tools that we expect to be able to present to you over the next year, as part of a comprehensive pharmacy strategy.

CHAIRPERSON MATHUR: Okay. Good. Thank you. Are there any further questions from the Committee?

I don't see any, so thank you very much for your report.

We'll move on to Agenda Item number 11, Long-Term Care Program Semi-annual Update.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: We will not be projecting Attachment number 1, which is the attachment to this agenda item. This Agenda Item is number 11, which provides to the Committee the Long-Term Care Program semi-annual update.

I'm Kathy Donneson of CalPERS staff, and to my left is Tyrone Espinoza who's the CalPERS Long-Term Care Manager.

The long-term care semi-annual update provides annual trends for 2013 to 2015 and the first 6 months of 2016. All of the statistics for this agenda item are found in attachment 1. And for this presentation, I'll touch on a few key statistics.

On pages 3 and 4, the population of the Long-Term Care Program continues to decline, primarily due to the death of 2,300 participants who passed away in this time period. The annual premiums paid have declined, but remain above 300 million per year, and the invested asset value of the program has increased to $4.3 billion dollars.

Page 5 provides you the statistics for the 2015-16 rate increases and the count of lifetime and/or inflation policy conversions to 10-, 6-, and 3-year policies. 12.9 percent of the policyholders converted policies in the last year of the rate increase, which was

2016. However, policyholders can still convert to fixed terms should they so desire.

Page 6 provides you an update of the optional daily benefit allowance, or DBA, purchase which is provided to those participants that removed built-in inflation protection or lowered their DBA after the 2010 premium increase. Eligible participants can repurchase up to 100 percent of the DBA in effect at the time those coverages were decreased.

Page 7, 8, 9, and 10 update the Board on participants in active claim status, claims payments, and distribution of claims dollars paid to assisted living, home health, and skilled nursing facilities.

Pages 11, 12, 13, and 14 provides you the open application, website use, and marketing information for LTC4, the current open application. Notable from these slides is the following: On-line application usage is increasing to 62 percent versus 38 percent of paper claim application submissions. The website functionality has been enhanced so that each participate can now obtain their current EOC on-line. And these are the EOCs that are currently attached to their policies.

We have experienced some of the best marketing activities, which have come from our Benefit Education Events, so we thank the CalPERS staff for putting --

holding those and our participation, benefit fairs, and the Education Forum.

And finally, slide 14 provides the timeline for the 2018 long-term care solicitation. And phase 2, as reported by Mr. McKeever, was released on September 19th, 2016.

That concludes my presentation. And Mr. Espinoza and I are available for questions.

CHAIRPERSON MATHUR: Thank you.

Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you, Madam Chair. Thank you, Ms. Donneson for the update.

One of the slides talks to the 90 percent of the initial claims were approved, so that means 10 percent were not. What are some of the reasons why the claims were not approved?

HEALTH PLAN ADMINISTRATION DIVISION ASSISTANT CHIEF ESPINOZA: Tyrone Espinoza, CalPERS staff.

Initially, when an individual files for claim, they have to undergo a benefit assessment. And in that benefit assessment, the nurse or the practitioner that performs that function determines whether or not the participant meets satisfying -- having at least two activities of daily living functions not being able to perform. There's 6 activities of daily living functions.

And so I would speculate the reason for the declination would be attributed to not satisfying at least two of those.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I'd like to add a little more clarification on that. To meet the two or more ADLs, you have to have substantial assistance. And that's measured by a nurse who actually does a physical assessment of the participant. And so if they don't meet with substantial assistance that minimum requirement, then they may be denied.

So having said that, should they believe that they do meet all the requirements to enter their claim status, we do have an appeals and grievance process in which they are allowed to resubmit for reconsideration. And Dr. Sun leads the clinical team and the appeals team that reviews those denials and will either support or overturn them.

COMMITTEE MEMBER JONES: And that information of meeting those requirements is provided in -- before they're requesting to receive the benefits?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yes. The requirements are actually in federal regulation, those requirements, and they're also cited in the explanation of coverage that is appended to each

policy, and for which they can now obtain that -- their own EOC on-line.

COMMITTEE MEMBER JONES: Okay. Thank you.

The next question I have is in terms of the causes of termination, by and large the death is the largest -- one of the largest categories. And do you have the average length of time that -- after someone started receiving the benefit and pass away?

HEALTH PLAN ADMINISTRATION DIVISION ASSISTANT CHIEF ESPINOZA: Mr. Jones, are -- just to -- if you allow me, if you would please just to seek a little bit additional clarification. Are you asking the question the average length of time for claim for a CalPERS member?

COMMITTEE MEMBER JONES: No. Once they start receiving the benefit. And I thought I was interpreting this as then they passed away. And so how long were they receiving the benefit before they passed away is the question?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I believe that's something our actuaries look at. We're not prepared to answer it today. But I believe the actuaries actually do look at that as they prepare the valuation. And the valuation will be presented to the Finance and Administration Committee in November. So perhaps we could look at that specifically in preparation

for that report.

COMMITTEE MEMBER JONES: Yeah, because it's intuitive, because there's another chart in here where when you report out how many of the individuals chose to pay the 85 percent for this -- forever benefit coverage, and then it's intuitive to say, well, why are people paying for this benefit forever when they're only getting the benefit over 2 or 3 years or whatever that number may be? So that's the reason for the question.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Thank you. We have presented in the past that the average length of time in claim is about 3½ years. So we have not really looked at how long in claim to the point of expiration.

COMMITTEE MEMBER JONES: Okay. Thank you.

CHAIRPERSON MATHUR: Okay. I see no further requests to speak on this item, so that brings us to just about the end.

Agenda Item 12, Summary of Committee Direction.

DEPUTY EXECUTIVE OFFICER McKEEVER: Madam Chair, I have 2 items at the direction of the Committee, one is relative to the risk drivers in which we're going to look at the changes that were discussed earlier, the title in one, and then some descriptions in the other.

And then the second is to continue to pursue

looking at an outside employer coming in to talk about VBID. And we're shooting for the December PHBC for that. And then the direction of the Chair was -- and the Committee was to continue to pursue our efforts along VBID and then bring to the January off-site a more robust discussion and potential approaches for your consideration.

CHAIRPERSON MATHUR: Yes. And I had one other thing, and that was to begin communications with the -- whoever wins the election -- whichever administration wins the election following -- pretty early on around our priorities.

DEPUTY EXECUTIVE OFFICER McKEEVER: Thank you, Madam Chair. I did have that one as well. That was the comment Chris had made relative to the transition team.

CHAIRPERSON MATHUR: Correct.

DEPUTY EXECUTIVE OFFICER McKEEVER: Thank you.

CHAIRPERSON MATHUR: All right. That brings us to Agenda Item number 13, which is public comment. And we do have one member of the public who has expressed a wish to speak. Robert Thacker, if you could please come forward. If you could take your seat right here to your very right. The mic is on. If you could introduce yourself and your affiliation for the record, and you'll have 3 minutes in which to speak.

MR. THACKER: Thank you, Madam Chair, members of the Committee. My name is Robert C. Thacker. I am a CalPERS member. I have provided you a written copy of my presentation, but I would like to read it into the record.

This is about health plan enrollment and health plan services. When enrolling in a health plan, CalPERS members must enroll in a plan that is available according to the zip code of their residence or employment. Retired members, of course, are limited to according to their residence.

However, there is no corresponding requirement that health plan services must be provided according to zip code. I understand that this is reasonable for certain specialized medical services. It does not seem reasonable as a policy to treat acute episodes of a chronic condition.

Specifically, number one, in a particular case in which the facts are not in dispute, Kaiser Permanente transferred a Sacramento County member to Solano and Napa counties for treatment of an acute episode of a chronic mood disorder. Kaiser Permanente said that was where the beds were available for the patient during the treatment. And that was very authoritatively stated to us.

This is an enormous burden for family and friends to visit and support a patient, and represents an

undisclosed copay or co-insurance. Additionally, Kaiser Permanente transports the patient away from Sacramento county, but leaves it up to the patient to arrange for return transportation.

The question, of course, is why doesn't Kaiser Permanente provide adequate facilities in Sacramento County? CalPERS health plan administration has said there is nothing specific from the Department of Managed Health Care about providing out-of-area medical services. They are unable or unwilling to direct health plans to provide medical services according to zip code.

I have presented this problem twice at the stakeholder engagement briefing meetings. I suggested that as a minimum, members and enrollees should be advised that they are required to enroll according to their zip code, but health plan services are not so required. I request that you consider this matter and provide appropriate guidance to your members and health plan administration.

We are currently in open enrollment, so a simple clarification or disclaimer on the search for health plan by zip code would be an obvious solution.

Now, by extension, I would assume that since this has been the situation with one of your health plan providers, it would be available to all of your health

plan providers. So I do ask that this be a consideration. It does represent a undisclosed cost, or copay, or co-insurance for the patient or the patient's support and family.

Thank you. I'm pleased -- be pleased to answer any questions.

CHAIRPERSON MATHUR: Thank you for your time, Mr. Thacker.

MR. THACKER: Thank you.

CHAIRPERSON MATHUR: Okay. That brings us to the end of the Pension and Health Benefits Committee meeting. We are adjourned.

(Thereupon the California Public Employees' Retirement System, Board of Administration, Pension & Health Benefits Committee meeting adjourned at 9:57 a.m.)

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

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

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

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

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

IN WITNESS WHEREOF, I have hereunto set my hand this 26th day of September, 2016.

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