MEETING

STATE OF CALIFORNIA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

BOARD OF ADMINISTRATION

PENSION & HEALTH BENEFITS COMMITTEE

OPEN SESSION

ROBERT F. CARLSON AUDITORIUM

LINCOLN PLAZA NORTH

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SACRAMENTO, CALIFORNIA

TUESDAY, SEPTEMBER 19, 2017

8:02 A.M.

JAMES F. PETERS, CSR
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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 Ms. Jeree Glasser-Hedrick

Mr. Rob Feckner

Mr. Richard Gillihan

Ms. Dana Hollinger

Mr. Henry Jones

Ms. Theresa Taylor

Ms. Betty Yee, represented by Mr. Alan Lofaso

BOARD MEMBERS:

Mr. J.J. Jelincic

STAFF:

Ms. Marcie Frost, Chief Executive Officer

Ms. Liana Bailey-Crimmins, Chief Health Director

Mr. Matt Jacobs, General Counsel

Ms. Donna Lum, Deputy Executive Officer

Ms. Kathy Donneson, Chief, Health Plan Administration

Mr. Gary McCollum, Senior Life Actuary

Mr. CJ Nakayama, Manager, Longer-Term Care Program

Ms. Cheree Swedensky, Committee Secretary

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

ALSO PRESENT:

Mr. Tim Behrens, California State Retirees

Ms. Cathy Jeppson, California Teachers Association, California Faculty Association

Ms. Donna Snodgrass, Retired Public Employees Association

Mr. Larry Woodson, California State Retirees

I N D E X

P R O C E E D I N G S

CHAIRPERSON MATHUR: Good morning, everyone. I'm going to call the Pension and Health Benefits Committee meeting to order. The time is 8:02.

The first order of business is to call the roll.

COMMITTEE SECRETARY SWEDENSKY: Priya Mathur?

CHAIRPERSON MATHUR: Good morning.

COMMITTEE SECRETARY SWEDENSKY: Michael Bilbrey?

VICE CHAIRPERSON BILBREY: Good morning.

COMMITTEE SECRETARY SWEDENSKY: Jeree Glasser-Hedrick for John Chiang?

ACTING COMMITTEE MEMBER GLASSIER: Good morning.

COMMITTEE SECRETARY SWEDENSKY: Rob Feckner?

COMMITTEE MEMBER FECKNER: Here.

COMMITTEE SECRETARY SWEDENSKY: Richard Gillihan?

COMMITTEE MEMBER GILLIHAN: Here.

COMMITTEE SECRETARY SWEDENSKY: Dana Hollinger?

COMMITTEE MEMBER HOLLINGER: Here.

COMMITTEE SECRETARY SWEDENSKY: Henry Jones?

COMMITTEE MEMBER JONES: Here.

COMMITTEE SECRETARY SWEDENSKY: Theresa Taylor?

Alan Lofaso for Betty Yee?

ACTING COMMITTEE MEMBER LOFASO: Here.

CHAIRPERSON MATHUR: Well, it looks like we have a quorum, so we'll get right into the meat of the agenda.

First order of business is Executive Report.

DEPUTY EXECUTIVE OFFICER LUM: Good morning, Madam Chair, members of the Committee. Donna Lum, CalPERS team member. This morning I have a couple of updates that I'd like to share with you.

And first off, I'd like to give you an update on some recent activities that our team members across the organization have had related to the recent hurricanes. As you know, over the last couple of weeks, Florida, Texas, and surrounding states have been recovering from the devastation of the hurricanes. And following Hurricane Irma and Harvey, our teams contact -- did some outreach and to about 170 retirees that were impacted in the zip codes by those -- by the two hurricanes.

We reached out to find out whether or not they had received their August warrant. And then we also wanted to find out if they anticipated that they would be impacted in receiving their September warrant.

And luckily, we were able to reach more than 50 percent of the members by using the contact information that we had on file. We left messages for about 25 percent of the members -- the additional members. And unfortunately, we weren't able to reach the other 25 percent. However, we are still conducting outreach to try to reach them with the contact information that we have.

I am pleased to share with you that approximately 90 percent of our retirees currently have direct deposit. And as we were doing our outreach to the impacted members, we were able to move several of them from their paper warrant to direct deposit. And just emphasizing the 170 retirees that we reached out to are members or retirees that were currently receiving paper warrants and not on direct deposit.

In our efforts, we were able to do a couple of things. We were able to wire transfer dollars for those that were able to confirm hadn't received money. We were able to change banking accounts and route money to existing banks that they had access to. And more importantly, we were able to get information in a variety of ways to ensure that they would not be impacted by not having the funds.

We are continuing to do more aggressive communication and outreach to our retiree membership. Being able to use these hurricane disasters as an example of hopefully being able to transition the other 10 percent of the retirees that are continuing to receive paper warrants. So I think that this was, you know, an excellent effort among a number of our team members in the outreach. And I can speak for the team members that made calls that were able to actually reach the individuals

that our members really did express a great deal of gratitude an appreciation.

It's a difficult time that they were experiencing, and to know that CalPERS had their best interests in hand in wanting to make sure that they received their retirement warrant.

So that's the first update.

Next -- yes, I'm sorry.

CHAIRPERSON MATHUR: No, I just wanted to say thank you -- I just wanted to express my thanks to you and the whole team for really going above and beyond to try to reach all of these members, because in such a precarious situation, the last thing you need is for the funds to run dry, and particularly when you're trying to get out of town or find a place to live temporary. And so it really means a lot, I think, to our members.

DEPUTY EXECUTIVE OFFICER LUM: Thank you.

And then secondly, we are in full swing with open enrollment. And we've completed the first week, which ran from September 11th through September 15th. And I'm happy to share with you that we've experienced a number of improvements in the customer contact center, when we compare our performance of the first week this year versus last year.

And just to give you a couple of examples.

Although we did experience a one percent increase in the number of calls -- we had about 200 additional calls over last year. Despite the increase in volume, our average wait time improved by 70 percent. Last year, during the same time, the average wait time was about three minutes and 22 seconds. And we are averaging less than a minute in the first week of open enrollment.

Secondly, our service level -- our established service level is to answer 80 percent of the incoming calls in 60 seconds or less. In this area, we improved by 59 percent over last year, from 59 percent to 74 percent. And again, this was a -- nearly a 26 percent improvement. So our members are waiting less time on the call.

And then lastly, we do track the number of, what we call abandoned calls. These are a percentage of calls in which the member calls into the contact center, but either, you know, decides on their own to hang up the call or feels that the wait time might be too long. Last year, we had a four percent abandonment rate call during the first week of open enrollment, and this year we're down to one percent.

So we believe that a lot of the proactive planning that we did in anticipation of open enrollment, our enhanced training to our contact center agents, the work that we've done with our employers to help their

members -- their employees use the my|CalPERS on-line access to be able to access their open enrollment materials, as well as the partnership that we've had with a number of our retiree associations who have also been assisting the retirees and -- with information for open enrollment, I think all of those things have aided in a successful week. And we're certain that we will finish the entire open enrollment with a number of positive impacts.

And then lastly, I wanted to wrap-up this year and give you a final update on our CalPERS Benefit Education Events. We concluded the calendar year with our last event last week, September 15th and 16th in Garden Grove. The last time we were in Orange County, it was in 2015. And again, it was another successful event. We had a 37 percent increase in the attendance.

As we've seen with all of the CBEEs this past year, we've had a great number of success in terms of the number of attendees. And when we look back at the nine events that we conducted this year, we were able to educate and provide assistance to more than 12,500 attendees. These events are very important. They enable our members to come and interact face-to-face with our team members. And we also did a lot of education and a lot of demonstration on my|CalPERS, really promoting the

on-line accessibility for our members.

One of the things that we experienced in Garden Grove again, and I think we did in one of our other CBEEs, is we were able to assist a member right there on the exhibition floor with doing a end-to-end retirement application from establishing the account, to assisting with the actual application, and processing it through.

So we will continue with our CBEE schedule. We have our events kicking off in January. The first CBEE that we have scheduled will be in San Luis Obispo on June 26th and 27th. The remainder of the CBEE schedule is on the CalPERS on-line website.

And, Madam Chair, that completes my report.

CHAIRPERSON MATHUR: January 26th and 27th?

DEPUTY EXECUTIVE OFFICER LUM: Yes. I'm sorry, what did I say?

CHAIRPERSON MATHUR: You said June.

(Laughter.)

DEPUTY EXECUTIVE OFFICER LUM: Oh. January.

CHAIRPERSON MATHUR: Terrific.

DEPUTY EXECUTIVE OFFICER LUM: Thank you.

CHAIRPERSON MATHUR: Thank you very much, Ms. Lum.

Ms. Bailey-Crimmins.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Good

morning, Madam Chair and members of the Committee. Liana Bailey-Crimmins, CalPERS team member. For my opening remarks, I have four items that I'd like to provide you and update. Many of them actually complement what Ms. Lum just provided you.

CalPERS and OptumRx have partnered to increase the support for our health care members affected by the Hurricane Harvey and by IRMA. Also, I would like to provide you an update on the 2018 open enrollment, and then the new health contract solicitations that are currently under way, and then lastly the employer outreach efforts that are scheduled for September.

So the first one is CalPERS' members are our number one priority. So over the past month, the country has come together in light of devastation that has hit many families. And CalPERS specifically has approximately 2,000 PPO basic members in Texas and in Florida. To ensure that CalPERS members living in those impacted areas have a piece of mind that their medication needs are being met, OptumRx has taken the following proactive steps:

First, they have lifted the refill too soon and the drug utilization review edit requirements for 60 days. Also, CalPERS has agreed to allow OptumRx to override medications on a case-by-case basis, and at the discretion of a pharmacist, and when it's clinically necessary.

For BriovaRx and BriovaRx Infusion Services, Briova actually has been very proactive. They've called members residing within those impacted areas, specifically related to their specialty medication refills coming due within the next 14 days. The goal is to determine how and where the members want to receive their medications.

In addition to calling the members, Briova has also faxed all of the retail pharmacies in the Florida and Texas member networks, and made sure that they are aware of this need to refill too son, and also emailed members where we had email addresses on file informing them of what to do and how to contact them.

And then for 2018, the open enrollment obviously is underway, and we have expanded our communication. So in addition to written, we have now -- we are now using email. And so we have sent three emails -- or we plan to send three emails to all the CalPERS members regarding open enrollment. In August, we sent an email to subscribing members on releasing the on-line health plan statements in my|CalPERS.

A second email was actually just sent last week informing members that open enrollment is underway. And then the last one will come next week to remind everyone that open enrollment will close October 6th.

And then for August 28th through the first week,

we just completed as Ms. Lum mentioned, we've had over 57,000 members access health information via their my|CalPERS account. This is a 17 percent increase over 2016. And as in previous years, open enrollment and eligibility teams receive about 5,000 to 70 inquiries during this period. And with just wrapping up the first week, there have been nearly 2,200 transactions. And those transactions, 83 percent of them were to make plan changes.

For contract updates, CalPERS utilizes a third-party administrator to collect health information for our 1.4 million total covered lives. We use this data specifically related to making sure for health care trends and premiums and looking at data over a 10-year period. Our current agreement expires November of 2018. And we want to make sure we have enough time to Transition and implement the new system.

So we have released the data warehouse solicitation on August 18th. We are looking for technical data warehouse administration services, and actuarial analytical services. We anticipate an award date of April of 2018.

And then for 2019 through 2023, HMO procurements. Yesterday, we released our HMO solicitations to current health plans doing business with CalPERS, and also others

that have shown interest. A friendly reminder, CalPERS will be soliciting the HMO and PPO contracts on separate cycles. And the current timeline has us bringing the contracts for Board approval in February of 2018, which will be the catalyst for the plans to enter into the 2019 premium negotiations.

And for employer outreach, the CalPERS Health Program holds quarterly health policy discussions with our employers. Upcoming health policy initiatives are things that we talk about open enrollment, summary of benefit changes. And our next policy discussion is scheduled for September 29th at the Walnut Creek Regional Office. And currently, the employer response is very positive, and we have over 41 participants currently registered. And the number continues to go up every single day.

And in closing, I want to personally thank the Board members, the employers, retirees, the CalPERS team members that joined us on September 12th at the CalPERS Health Care Summit. CalPERS partnered with the National Coalition on Health Care to bring the who's who of health policy and innovators to discuss how health care affordability and coverage means something to all of us.

And it was a great day filled with shared perspectives from economists, providers, purchasers, health plans, and others just to name a few. Again, thank

you for everyone that participated.

And, Madam Chair, that concludes my opening remarks.

CHAIRPERSON MATHUR: Thank you very much.

Any questions from the Committee?

Seeing none. We'll move on to Agenda Item number 3, Approval of the Minutes

COMMITTEE MEMBER JONES: Move it.

VICE CHAIRPERSON BILBREY: Second.

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

Any discussion on the minutes?

Seeing none.

All those in favor say aye?

(Ayes.)

CHAIRPERSON MATHUR: All those opposed?

Motion passes.

I've had not requests to pull anything off of Agenda Item 4.

So we'll move right into Agenda Time 5, long-Term Care Program Semiannual Report.

Ms. Donneson.

(Thereupon an overhead presentation was presented as follows.)

HEALTH PLAN ADMINISTRATION DIVISION CHIEF

DONNESON: Good morning, Madam Chair, members of the Committee, Kathy Donneson, CalPERS team. We're here to present the semiannual report for the Long-Term Care Program. This reporting period looks at 2014, 2015, and 2016 calendar years, and then compares those years to the first six months of 2017.

Joining me at the table today is CJ Nakayama. He is the Long-Term Care Program manager, and he will be making this presentation. CJ.

LONG-TERM CARE PROGRAM MANAGER NAKAYAMA: Thank you. Madam Chair, members of the Committee --

CHAIRPERSON MATHUR: Can you just move your microphone up just a tiny bit. Thank you.

LONG-TERM CARE PROGRAM MANAGER NAKAYAMA: There you go.

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LONG-TERM CARE PROGRAM MANAGER NAKAYAMA: Madam Chair and members of the Committee, CJ Nakayama, CalPERS team member with the Health Plan Administration Division. I'll be presenting Agenda Item 5, the CalPERS Long-Term Care Semiannual Report.

Throughout this report, I'll be referring to attachment 2, which contains the details which I will highlight today.

Today, I will be covering the program updates,

current program offering, customer service, and then I'll be available for questions. Moving on to the program updates.

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LONG-TERM CARE PROGRAM MANAGER NAKAYAMA: I'd first like to say that over the last few years we have greatly stabilized the program. And I'd like to thank the Committee, as well as the stakeholders, for their continued support. From June 2013 through June 30th of 2016, we had a funded status of over 100 percent, and a positive margin. This has been since the implementation of the stabilization plan.

The current funded status and margin as of June 30th, of 2017 will be presented in the 2017 annual valuation, which will be presented later this year.

I'd like to draw your attention to attachment 2, slide 3, key statistics. Since our last report, we have had a decrease of approximately 2,000 participants to just over 128,000 The primary reasons for this decrease were due to death, but they were also due to voluntary disenrollment, nonpayment, and benefit exhaustion.

Additionally, our current funded status has gone from -- has grown from 4.2 billion to 4.4 billion since the last report.

Moving on to claims that are in attachment 2,

slide 5, our claims analysis indicated the average length of claim was 3.4 years, and that the majority of our claims came from our original product series that was offered from 1995 to 2002. This is to be expected based on the population of that original product series.

Then we move on, and we looked at who we are providing benefits to and how much we were providing. This is where we can really tell that we have a meaningful coverage that provides meaningful benefits to our participants. As of June 30th, 2017, we had over 7,200 people in claim, and paid, in the first six months of 2017, approximately $149 million. Since the program's inception, we have paid over $2.2 billion in benefits.

Then we looked at the claims to see if anybody received any discounts from our preferred provider network. Our preferred provider network is something that's contractually required of our TPA. It currently has 1,975 contracted providers that provide anywhere from a 5 to 20 percent discount.

When we looked at the people in claim, and analyzed who was utilizing these contracted providers, we found approximately two percent of the participants in claim utilized these providers for an approximate annual savings of $1.2 million.

Moving on to the daily benefit amount purchase

option, on attachment 2, slide 10.

CHAIRPERSON MATHUR: Can I ask you to just forward the slides, so that the audience can see also?

LONG-TERM CARE PROGRAM MANAGER NAKAYAMA: Oh, this in reference to the attachment 2, the presentation is just -- it has the highlights that we're covering.

CHAIRPERSON MATHUR: Oh, I see. It's not in -- okay. Thank you.

LONG-TERM CARE PROGRAM MANAGER NAKAYAMA: Not a problem.

CHAIRPERSON MATHUR: Okay.

Sorry to interrupt you flow there.

LONG-TERM CARE PROGRAM MANAGER NAKAYAMA: Oh, no. No worries. No worries.

Moving on to the daily benefit purchase option that's on attachment 2 of -- or slide 10 of attachment 2. We were tasked with that initiative by the Board in October of 2012, and it provided eligible participants the ability to purchase the daily benefit that they lost due to mitigating a rate increase without being subject to underwriting. We mailed this offer in April of 2017, and we mailed approximately 1,400 offers, 473, or approximately one-third, accepted this.

Now to talk about our long-term care solicitation. We recently presented this to the Board in

June, so I'll be brief. The solicitation tack over a year with the contract award, as I said, in June of 2017. We feel that the overall solicitation was a success, and that we obtained a more favorable contract. And we also decreased the complexity of the contract by obtain -- by negotiating a single per member per month price for all the services within. The contract will become effective January 1st of 2018.

Now, we will move on to our current program offering --

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LONG-TERM CARE PROGRAM MANAGER NAKAYAMA:

-- which is LTC4. This offering was opened for enrollment as of December of 2013. And over the last year, we have expanded eligibility to align with Internal Revenue Code 26 USC 7702B. This allows us to outreach to all prospective participants allowed under the Internal Revenue Code for a State run long-term care plan.

Since opening the program, we've received almost 3,500 applications. And our current enrollment is over 2,000 in our current LTC4 plan. We continue to try to increase enrollment through various marketing efforts. We are primarily focused on employer benefit health fairs, CalPERS Benefit Education Events, and the CalPERS Educational Forum for Employers.

As we close-out this year, part of the negotiations during the solicitation, the third-party administrator will now have marketing supports in place to assist us in our outreach efforts.

At this time, I will move on to customer service. This begins on attachment 2, slide 15.

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LONG-TERM CARE PROGRAM MANAGER NAKAYAMA: Our third-party administrator receives approximately 10,000 calls per month. These are split between three categories, customer service, claims, and rate increase. The rate increase call volume is negligible as we have not had a rate increase since 2016. And the remainder of the calls were split fairly evenly between customer service and claims.

One thing that's very important when we look at customer service is customer satisfaction. Following someone's phone call to our third-party administrator, they are asked to take an optional survey. This optional survey is rated on a scale from 1 to 5, with 5 being the best.

We looked at three different areas: The overall rating, the ability of the representative to understand and resolve the issue, and the overall courtesy and professionalism of the representative. When we analyzed

and tabulated the scores of a 4 or greater, across all three of these categories, there was one to two percent increase.

This concludes my presentation on the customer service section. We've also covered program updates and the current program offering. I'd like to thank the Committee for their time today. This completes my presentation, and I'm available for questions.

CHAIRPERSON MATHUR: Thank you very much, Mr. Nakayama. We do have a question. Mr. Jones.

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

My question relates to the causes for termination in terms of the exhausted benefits. And I was just wondering are the members included in this category because their value of their plan was exhausted or is it because they selected a shorter term coverage period, or what are some of the disaggregated information in there?

LONG-TERM CARE PROGRAM MANAGER NAKAYAMA: When a -- when a participant elects their plans, after there -- there's lifetime plans, and there's no defined benefit there, but the remainder of the plans have a defined term three, six, or ten years, and that equate -- that adds up to a total coverage amount.

Once that total coverage amount has been

exhausted, they no longer have any coverage. In essence, they've used up their plan.

COMMITTEE MEMBER JONES: And so are the majority of the members there the three-year category or the six-year category.

LONG-TERM CARE PROGRAM MANAGER NAKAYAMA: I do not have that information at this time.

COMMITTEE MEMBER JONES: Okay.

LONG-TERM CARE PROGRAM MANAGER NAKAYAMA: We could get it, if you'd like.

COMMITTEE MEMBER JONES: Okay, please.

CHAIRPERSON MATHUR: I think that would be -- that would be interesting to the Committee to have a sense of sort of how it breaks down a little bit more.

Thank you.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Madam Chair, I would like to also speak the partnership policies that are one to two years that are offered between CalPERS and Department of Public Health. So we do have shorter term policies than three years, and we'll look at that as well.

CHAIRPERSON MATHUR: Thank you.

That sparked a couple other questions. Mr. Lofaso.

ACTING COMMITTEE MEMBER LOFASO: Thank you, Madam

Chair.

Just one questions. Thank you very much for your presentation. So if I look at slide 6 and slides 3, I see decreasing enrollment and increased claims. Should I be concerned about that or are there other variables that I should think about?

LONG-TERM CARE PROGRAM MANAGER NAKAYAMA: These have been -- it's been presented in the past. There's a chart that has how claims would be rising and how enrollment would be decreasing based on when participants came in.

When we look at the overall health of our fund, we really do look to the funded status, as well as the margin. And those have been over a hundred percent and the margin positive for -- since 2013 after the stabilization.

ACTING COMMITTEE MEMBER LOFASO: So perhaps other variables are the length of the claim, the savings from the preferred providers, those kinds of things?

LONG-TERM CARE PROGRAM MANAGER NAKAYAMA: Correct.

ACTING COMMITTEE MEMBER LOFASO: Thank you.

CHAIRPERSON MATHUR: Thank you.

Mr. Jelincic.

BOARD MEMBER JELINCIC: You mentioned that only

two percent of our people are using the preferred provider. Have we done any work to find out why so few are using it? Are people aware of it? Do we know anything about that?

LONG-TERM CARE PROGRAM MANAGER NAKAYAMA: We have -- we haven't dug into those analytics. We have done articles in our long-term care newsletter that goes out to all the people letting them know of our preferred provider network. Within the long-term care scene, many people like specifically choosing who's going to serve them. And unless those people are on the contracted network, then the people won't be using them.

BOARD MEMBER JELINCIC: And when you do that outreach, do you point out that the member can save money? It's not just the system that saves money, it's their pocket book that is being impacted?

LONG-TERM CARE PROGRAM MANAGER NAKAYAMA: We point out that there's discounts on the services that they receive and the prices that they pay.

BOARD MEMBER JELINCIC: And do we point out that the discount goes to them?

LONG-TERM CARE PROGRAM MANAGER NAKAYAMA: Yes, it's a reimbursement program.

BOARD MEMBER JELINCIC: Okay. Thank you.

CHAIRPERSON MATHUR: Okay. Thank you very much.

LONG-TERM CARE PROGRAM MANAGER NAKAYAMA: Thank you.

CHAIRPERSON MATHUR: So that's going to bring us to Agenda Item number 6, CalPERS PPO plans.

(Thereupon an overhead presentation was presented as follows.)

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Madam Chair, members of the Pension and Health Benefits Committee, Kathy Donneson, CalPERS team.

We have, in the past, been talking about looking at our plan designs to incorporate a value-based insurance design into one of our PPO plans, and we will continue that dialogue today.

But in looking at our PPO plan for PERS Select as a potential VBID design, we have also looked at our PERSCare and PERS Choice plans as well to see how they align in position.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: As a background for our agenda today, we will be discussing the background. And I want to spend a little bit of time talking about the historical development of our PPO plans. We will also talk about the effect of the -- how we look at the three plans together rather than just a VBID plan as a separate in isolation.

And finally, we're going to look at just a little tiny bit at how risk adjustment affects the Select plan in terms of the premium and where we may want to position the VBID plan in terms of risk adjusting or not risk adjusting.

And I have Mr. Gary McCollum with me today to talk about any actuarial information you'd like to have.

So I want to move on to the history of our PPO plans. In 1989, we stood up the PERSCare plan as a self-funded PPO plan with a 90/10 benefit, that is 90 percent of the cost share -- after cost share was borne by the employer and 10 percent by the member.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: In 1993, we added the PERS Choice plan. Again, the share of cost was, after -- the employer contributions after-share of cost was 80 percent for the employer and 20 percent for the employee. In 2008, we stood up the PERS Select plan as a self-funded plan. And we did that as we looked at a narrower network for hospitals. And it still had that 80 percent, 20 percent contribution level between employees and employers.

But if they used -- if they went and used a tier 2 hospital instead of a tier 1 hospital, which was the lower cost hospital in the network, that then became a cost share of 70 percent and 30 percent.

As our plans have developed over time, and as we have looked at continuing to add value to the PPO plans, between 2007 and 2010, we really started to focus on the population health of the plan, not just the disease management within the plan. We looked at those services that might better serve the healthier population to keep them healthy, preventive services. We looked at generic versus brand -- preferred brand and non-preferred brand. We looked at the integration and consolidation of providers into integrated health models.

So there is a foundation in terms of population health, integrated health models, redesign of our pharmacy programs, and a value-based purchasing design approach. And we want to continue that, and we are continuing that.

In terms of our value-based purchasing design at the time we looked at the health of the population, we also looked at the cost and where services were being delivered. And we did that because we wanted patient safety and quality to be remain -- to be constant or improve, and that the only thing we would vary as we moved our members -- guided our members to different locations for services would be the cost component.

In 2011, we implemented the value-based purchasing design for hip and knee replacement surgeries. And that has proven to be a good -- a success, in that we

are paying the actual price for those services at a fixed price.

In 2012, we expanded our value-based purchasing design, again holding cost and quality constant to seek better services in ambulatory surgery care centers and outside of the more expensive outpatient hospital services. And in 2018, you gave us permission to go ahead and continue to expand that component of value-based purchasing.

We are also now, in 2018, looking at medical pharmacy. And again, you allowed us to improve our plan design such that we would be guiding our members to lower cost providers in terms of provider administered pharmaceuticals, out of the more expensive outpatient hospital and into the less expensive physician's office infusion center and home.

We now come to continuing to look at value-based insurance design. And that is looking at our benefits as an insurance product, and how to align those benefits to guide our members to higher value care away from lower value care.

And in looking at where we are going to -- in -- through this presentation, we're going to be looking at the value-based insurance design. But again, I'd like you to bear in mind that value is not just about insurance,

cost quality, but it's also about whether a procedure or not is necessary.

We are not here today to talk about the overuse or underuse of misuse of services. But as we look at our benefit design, I would like us all to bear in mind that that is one of our strategic planning initiatives that we will continue to review going forward.

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HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: As we looked at a possible VBID design, we looked to Connecticut and Minnesota in terms of how they were using a value-based insurance design. And we looked at it in the context of how we were doing value-based purchasing. And we -- in comparing those three approaches, which you'll find in attachment 1, we felt that some of the constraints for the Connecticut and the Minnesota approaches might be difficult to implement. Whereas, we have experience with implementing purchasing designs and insurance designs.

And so we believe that the approach we're putting forward is a CalPERS-unique approach, incorporates the ideas from those other two states, but it becomes a unique approach through CalPERS.

In looking at redesigning the PERS Select VBID, in January, when we had the CalPERS off-site, we looked at

the idea that we could do insurance design that would give the PPO Select, if it became a VBID, the attributes of an HMO without being an HMO, therefore available to 58 counties within California.

And we continue to look at that design in terms of what do we -- how would we guide our members to value care. And we talked about the -- our current TPA is Anthem and the enhanced personal care program, which has an attribution model. That is, our members voluntarily attribute to a primary care physician. But as you know, they can go outside of primary care. They can go direct to specialists. They actually could go direct to an orthopedist that may direct them to surgeries within a hospital.

So as we looked at a value-based approach for Select, we would include such things as mandatory attribution to a primary care. That would be a VBID provider who would direct the care up to other VBID services.

We also looked at the idea of providing deductible credits if they chose to do healthy approaches to their own care, which would include a health risk assessment, smoking cessation program, if they had a chronic condition, that they would participate in chronic condition programs on a more mandatory versus voluntary

basis.

We also talked about the idea that we could direct them to laboratories for chronic conditions, such as regular six-month checks on hemoglobin A1Cs. And if they went to those laboratories, they would get a reduced cost share.

So we discussed many of those ideas in January, and we put out just a sample matrix on how to look at insurance design as the Select product, and then as the VBID product. But as we looked at those -- that specific design, we also thought how do we compare our PERS Choice plan and our PERSCare plan to a VBID design?

And that -- you will see that we have arrayed the three PPO plans in attachment 2. Again, we -- this is part of conceptualizing a VBID plan, but aligning it to our Choice plan and our Care plan.

And as we move forward, we would be bringing back a more solidified approach in terms of using not just our internal actuary, but our external actuaries, and the Anthem actuaries to not only just look at the three plans in alignment for insurance design, but how did they benchmark against what other employers are doing.

I would also like to turn to Mr. McCollum to just briefly, very briefly, touch upon the effect of risk adjustment on the three plans though Choice tends to

remain fairly stable in terms of being risk adjusted, whereas Select and Care tend to interact in terms of member migration.

And so I'll turn to Mr. McCollum.

SENIOR LIFE ACTUARY McCOLLUM: Thank you, Kathy. Good morning, Madam Chair, members of the Committee. Gary McCollum, CalPERS -- excuse me, CalPERS team member.

As she mentioned, risk adjustment is currently one of our choices that we have chosen to do. And we've made no decision yet on whether we would risk adjust the VBID product. It's too early in the creation process.

As we go along and get more involved in the creation of it and look at the impact of what risk adjustment would do, we will come to a decision as to whether it would be in the best interests of CalPERS and of the members to risk adjust it, along with the other PPOs, or not risk adjust it.

But just briefly, to illustrate the effect of risk adjustment.

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SENIOR LIFE ACTUARY McCOLLUM: If you look at attachment 3, page 5, there's an illustration of what risk adjustment currently is doing. And if -- on that, there's a chart there. The PERS Select plan before risk adjustment you'll see is $474. That's the cost of the

plan with its current members. After we risk adjust it, that premium goes up to 661. That's an indication that the PERS Select plan currently has younger and healthier lives in it, and it gets risk adjusted up.

Now, the PERSCare plan is the exact opposite. The PERSCare plan has older less healthy lives in it, and it's premium by itself is over $1,000 there. And after risk adjustment, it goes down to 776.

Now, those two risk-adjusted premiums, 661 and 776, align with the value of the plans compared to each other. The Select plan has a different network. It's a narrow network that's more efficient, and a slight benefit difference in the tiered hospitals.

The PERSCare plan has a richer benefit, so it should cost more, and it does. And that difference there is about 18 percent. And that reflects the difference between the plans in their benefit designs and their network differentials.

So that's my brief discussion on risk adjustment. I'll pass it back to Kathy.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Moving on to what will be our next steps.

--o0o--

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: We will continue to engage the actuarial teams

within CalPERS, the external actuary consulting firm and the Anthem actuaries. And that will take us about a month or so to do the real analytics, and to flesh this out a little more in terms of the three plans and how they relate to each other, and then how it -- how those two plans, Care and Choice, would relate to Select as a VBID plan.

So we will take some time during the next few months to flesh that out fully and come back in December with an update to the Board.

I believe that since we are looking at insurance design and benefit design, it is possible to develop some of the -- to develop a VBID insurance design for 2019, and we would continue to explore that with you into February, and then also continue to look at premiums associated with not just a VBID, but the other PPO plans as well.

That concludes my report, and we're happy to answer questions.

CHAIRPERSON MATHUR: Thank you.

Before I turn to questions, I just do want to say that I think, you know, this VBID option is really -- I think the Board has expressed -- the Committee and the Board has expressed great interest in this, particularly as you noted, I just want to highlight, this -- you know, in the rural -- in a lot of the rural counties where we've

been unable to offer a true HMO. We've tried different things, and EPO in some counties. But it's been very hard to get a true HMO structure.

And so this could provide an alternative that is very HMO like, and so would help sort of solve -- bridge that gap in those counties which currently don't have access to each HMOs. So I think it's very attractive and depend -- obviously, the devil is in the details, and we'll continue working on that.

But to the extent that we can offer something meaningful to our members, I think -- I think there will be some appetite for that.

I do have a couple questions from the Committee. So, Mr. Jones.

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

Yes, Ms. Donneson, I'm looking at the -- what you provided to us on the value-based insurance design. From a historical point of view, you talked about Connecticut, PERS Select and then the Minnesota design. And I was looking at the CalPERS pros and cons, and it's kind of striking that -- I guess my question is what do you plan to do to deal -- going forward to deal with the cons? You've got -- it may lower prem -- may not lower premiums enough to satisfy employees -- employers; higher employee

cost burden for use of hospital facilities for Care; members avoid Care because of higher cost share; member confusion and dissatisfaction.

So those are some serious cons in terms of going forward. So I just would like to get a sense of how you plan to deal with those going forward.

CHAIRPERSON MATHUR: Mr. Jones, I'm sorry, were you referring to attachment 2 or to the agenda item itself?

COMMITTEE MEMBER JONES: Oh, attachment 1.

CHAIRPERSON MATHUR: Attachment 1.

COMMITTEE MEMBER JONES: Attachment 1, page 2 --

CHAIRPERSON MATHUR: Thank you. Just to get everyone in the same place.

COMMITTEE MEMBER JONES: -- 51 of the iPad.

CHAIRPERSON MATHUR: Thank you.

COMMITTEE MEMBER JONES: Thank you.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: These cons, of course, we wanted to lay them out, because they do represent the things we have to think about, not only in the design, but also in how we communicate to our members, but also our providers, because it's going to be really important, as we've learned in hip and knee replacement surgeries, ASCs, all of integrated health models, population health, all of

those items have required a lot of thought in terms of cons associated with moving forward with different innovative ideas.

We do have risk mitigation in place in terms of -- in terms of these cons. And I think that the best risk mitigation is going to be looking at the PPOs together. If you take the choice, which has the most population, and get -- and has a relatively stable and -- plan, then our members do have choice.

So to -- they do not have to go to a VBID, but I think it's going to be attractive to members who do care about their health, even chronic condition members. I think you will see -- even though there may be some higher cost shares, I think you're going to see movement to a VBID, not just because of a lower premium, but because the focus is on health.

The other part of that spectrum is the Care, the care product. There are those that are in Care that are going to stay in Care. And by looking at our three together, we can design product delivery in terms of our providers and our population health that may better serve that population. So we've tried to identify these cons, and they do look -- they do look like they would be difficult to surmount.

But we've been doing an awful lot of this work

for over 15 years, and I believe that we, together with my team and our external stakeholders, would have the ability to develop three products that would meet the needs of CalPERS as modern products moving forward.

CHAIRPERSON MATHUR: Well, maybe they're better not called cons, as much as challenges, that we need to figure out how to mitigate --

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yes.

CHAIRPERSON MATHUR: -- because obviously we're not going to -- we're going to do all we can to avoid having these problems crop up.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yes. This was an attachment that we put out --

CHAIRPERSON MATHUR: Yeah.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: -- in the July off-site, when we discussed this with the Minnesota team.

COMMITTEE MEMBER JONES: Okay. And I think your response about the members will have a choice is ultimately the right decision, so we're not forcing this on our members. Okay.

CHAIRPERSON MATHUR: Thank you.

Mr. Lofaso.

ACTING COMMITTEE MEMBER LOFASO: Thank you, Madam

Chair. Thank you all for your presentation.

A good example of the leadership CalPERS got to show off at the summit last week, and what we're doing going forward.

As we've been talking about VBID, it seems like the $64,000 question is are the deductibles about cost shifting or are they about behavior change?

And certainly, the HMO observation the Chair made, you know, relates to that. But just from a -- and I know there's a lot of details you have, but just in terms of your thinking, I wonder if you could just sort of walk me through and give me a flavor. The $5,000 family deductible obviously gets one attention.

But just sort of walk me through in a practical since as to how a member avoids that deductible by -- through behavior change.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Thank you. One of the reasons we arrayed the three plans is that they all currently share the same cost share. In looking at the three plans and in forming our thinking coming forward today, while we gave the example of the high deductible, we would probably moderate that high deductible. We'd look at the level of incentives. If you look at the chart, the chart identifies incentives if you do certain things, if you attribute -- if you

follow certain behavioral -- behavioral efforts administered by the physician.

We'd probably look at moderating that a bit, in terms of where the cost share would be. I think if you think about -- after the member share of cost, I think we would look at maybe 70/20 aligned to 80 -- or 70/30, aligned to 80/20, aligned to 90/10. We would look at the three in concert, not one independent of the other. And we would probably look at some additional design on the Care product as well, so that as we come forward thinking about this, savings that accrue to the employer would be collectively accruing across the three plans, rather than a single plan.

So we went back actually and we've looked at this, the original design, and we're continuing to think about how we deal with a VBID cost share in concert with the Choice cost share and the Care cost share.

ACTING COMMITTEE MEMBER LOFASO: Thank you. Waiting for details, but that's -- appreciate that. Thank you.

CHAIRPERSON MATHUR: Thank you.

Mr. Gillihan.

COMMITTEE MEMBER GILLIHAN: Thank you Madam Chair. Thank you for the presentation and your continued work on this front. I have a couple thoughts and these

probably won't be a surprise to my colleagues on the dais.

We continue to be concerned about the rate of increase in the health care costs and spending, and what it means on the employer side in particular, as well as to our members. But the question I have is this enough to move the needle? Is this -- if we were to go down this path, is there enough benefit both to the participants and the employers to make it worth our efforts? And I know that's a question that we'll answer over time. I'm not expecting an answer today.

But my sense is this may not be enough to make a meaningful change in the overall strategy. And secondarily, I just want to make sure that we don't put so much focus on this that we lose sight of other things we need to be doing with our other providers to held them accountable for the rate increases they pass on to us every year. And that includes on the prescription drug side as well. And I see it looks like we're going to have some public comment on that. So I'll reserve comment on that until that time.

Thank you, Madam Chair.

CHAIRPERSON MATHUR: Thank you.

Ms. Hollinger.

COMMITTEE MEMBER HOLLINGER: Yeah. Thank you. And thank for your work on this. I know in other areas of

insurance industry, when we're looking for cost savings, it ends up being an out-of-pocket. And one of the things that they've done to incentivize behavior and lower premiums is getting members like Fitbit that automatically gets monitored if you do certain levels of activity, keeping your premium lower, et cetera, checking in in certain times with a health care coach and diet.

So I see trends that we're able to monitor that. And obviously we don't know yet the long-term impact, but at least it's incentivizing behavior.

CHAIRPERSON MATHUR: Thank you.

Mr. Jelincic.

BOARD MEMBER JELINCIC: I've been in Kaiser since the 5th grade, so I clearly am not afraid of narrow networks, nor gatekeepers. But as I listened to the presentation, there were a few things that struck me.

One was the comment, well, we're looking for cost savings that accrue to the employer. And, you know, our real obligation is to our beneficiaries. The goal has got to be better health outcomes. And incentivizing people to do the right thing is probably a good thing. Well, it is a good thing.

But I will point out that, you know, lower benefits lead to lower costs. And insurance just seems to work out that way. So I think we need to make sure that

we're really focusing on the positive health outcomes not necessarily the costs. And I will give a heads up to the employers, and quite frankly the unions, they need to start thinking about this.

If we go down this road, it may very well have an impact on the 100/90 formulas, the 80/80s, the 85/80s. And so both sides need to think seriously about how that may impact them and their future negotiations. And so I just toss that out as a heads up. That's not PERS' problem. Although obviously, it impacts our members, and so we ought to be at least mindful of it.

Thank you.

CHAIRPERSON MATHUR: Thank you.

Excuse me. Well, I think this is the beginning of a conversation that we will continue to have over the next several months in advance of rate negotiations next year and benefit decisions next year.

So I see no further requests on this item, so that brings us now to Agenda Item 7, which is summary of Committee Direction.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Madam Chair, I have one item. It's to provide an enhanced long-term analysis, specifically referring to the three-, six-, and ten-year enrollment data. And we'll be bringing that back to you.

CHAIRPERSON MATHUR: And to break out the exhausted benefits by type, I think, by sort of what caused the exhaustion of benefits.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Thank you, ma'am.

CHAIRPERSON MATHUR: Okay. Thank you.

All right. That brings us now to Agenda Item 8, which is Public Comment. We do have several members of the public who wish to comment. And I have received a request to allot each speaker five minutes, and so I will do so.

I will read your names, and if you could please come up to these two seats to my left. The mix is already on. You'll have five minutes in which to speak. And please identify yourself and your affiliation for the record.

So Tim Behrens and Larry Woodson are up first, and then Kathy Jeppson and Donna Snodgrass following them.

MR. BEHRENS: Good morning, Madam Chair and members of the Committee.

CHAIRPERSON MATHUR: Good morning.

MR. BEHRENS: Tim Behrens, the President of the California State Retirees. I'd like to thank you for the opportunity to comment today.

My remarks this morning regard CalPERS PBM

contract with OptumRx, which took effect in January replacing the CVS Caremark PBM contract. As you know, and you've heard before from me and others, there have been numerous implementation problems which CalPERS and Optum have been addressing. CSR believes progress has occurred, but unfortunately we continue to receive numerous complaints from our retiree membership.

These complaints fall into several categories: Increased and excessive costs for the same drugs under Caremark; prescription denials; repeated denial of appeals; long hold times and multiple transfers with OptumRx customer service; and the inability to speak with the same representative familiar with the issue on follow-up calls.

These situations have caused financial hardship, extreme stress, and, in some cases, potential negative health consequences especially for our older retirees.

And I would refer -- as an older retiree myself, that I'm talking about even older than me, 80-year olds, we're getting a lot of calls from our 77 to 85 year old retirees regarding these issues.

CalPERS announced when entering into this contract that approximately 10,000 members would be negatively impacted with regard to cost and prescription of availability. We have been hearing from those 10,000.

Their stories are compelling and in some cases shocking to hear.

We have concluded that the vast majority of the complaints stem from the OptumRx formulary, which is significantly more restrictive than the prior CVS formulary. Some commonly used drugs have been changed from tier 1, under CVS, to a higher tier, or removed entirely from the formulary now being used.

Pre-authorization restrictions have been imposed on some drugs, which were not required under the old CVS. We believe the only solution at this time is for CalPERS to amend the current contract and changed the formulary to be consistent with the former CVS formulary.

This Board approved a five year 4.9 billion dollars contract with Optum. This is an average increase for drugs of 8.4 percent per year, over five years from the CVS contract. You are paying for more. It's costing us more, and I think we both are receiving less.

We request immediate review of the Optum and CVS formularies in order to correct the hardships created for those 10,000, if not, many more members.

Larry Woodson, CSR's chair of Health Benefits Committee has been the primary recipient of our member complaints. He will be sharing a few of those member stories at this time with you. If you have any questions

for, me I'd be happy to answer them.

CHAIRPERSON MATHUR: Thank you, Mr. Behrens.

MR. BEHRENS: Thank you.

CHAIRPERSON MATHUR: Mr. Woodson, I think your mic has been turned off -- oh, now it's on.

MR. WOODSON: Hello.

CHAIRPERSON MATHUR: There you go.

MR. WOODSON: Okay.

Good morning. Larry Woodson, California State Retirees. Thank you for the opportunity to comment.

As Mr. Behrens stated, I've been the primary recipient of member complaints regarding OptumRx. I think the website and some customer service issues have improved, but we continue to have a steady stream, and actually increasing stream of complaints regarding excessive cost, prescription denials, denials of appeals, and confusing information.

I've spoken with many members and want to share just a handful of their stories with you, so that you understand the nature of the negative impacts that this contract is having on what CalPERS staff projected to be about 10,000 members. I'm providing no names or locations, but all were willing for me to share their experiences.

First, I received an email and had a phone call

with an 86-year old lady who'd been receiving Nexium due to side effects from a generic. And unde CVS, she paid $40 for a 90-day supply. Her prescriptions were rolled over January 1 from Optum -- or to Optum, and she received a new 90-day supply from their mail order service. Two weeks later she received a bill for $543. She had no prior notice of this outrageous price. She tried to resolve this with Optum and CalPERS to no avail.

She was hospitalized for 10 days in an unrelated matter, returned home, and returned to a second notice saying she was delinquent in her payment.

This is one of many complaints I referred on to Optum's account executive. And Mr. Ring to his credit, has been very responsive, able to help some -- resolve some of these issues. He was able to get this bill reduced to $100 and the retiree was very relieved, but it should not require elevation to a vice president to get resolution, and $100 is still excessive.

Other members have notified me more recently of excessive costs for Nexium as well. One was quoted a price of $240, another $600, last week I had a quote of that. And then a 93-year old lady said she was given a quote of $793. The same 93-year old lady was also denied two other prescriptions she had been getting with CVS unless here doctors filed for exception and

pre-authorization. She receives part-time in-home support, does not drive, and told me this has caused her great stress.

The worst case I think is from an elderly lady who has Barrett's esophagus, which can lead to esophageal cancer, if untreated. Dr. Mark Hynum, a physician on our CSR Health Benefits Committee, informed me that prescription strength Nexium is indicated for patients with Barrett's esophagus who continue to have symptoms on generics, which was this woman's case. And yet, she was denied on appeal until the third level when she finally was allowed. And she's been without that critical drug for eight months.

Another example, an 86-year old lady also had her blood pressure medication jump from $40 under CVS to $92.50 under Optum. Another elderly retiree had been receiving lidocaine patches for chronic neck and back pain, avoiding opioids, and CVS had provided the patches at a tier 1 reasonable cost. Optum required pre-approval request for this same thing, and she was -- it was denied.

A number of members have complained that pre-authorizations or appeals submitted by their doctors have been lost or delayed by Optum. There are many more stories in which drugs were available at a reasonable cost under CVS and are now bumped up to higher tiers or not on

the formulary. They include Atacand, Levothyroxine, Zolpidem, VESIcare and many more.

Members are frustrated, angry, don't understand how CalPERS could have agreed to a contract that hurts them like this. It's hurting members, especially on lower fixed incomes in their pocket books, and in some cases could potentially affect health.

There are too many examples of the Optum formulary obstructing the patient-doctor relationship, and imposing impediments to establish reasonably priced drug treatment.

In conclusion, Medicare Part D changes may affect some of this, but it cannot account for the breadth of problems members are having, nor the extreme cost increases for the same drugs. It's clear that members will continue to face these problems unless the formulary is changed to mirror the former CVS formulary. Please direct staff to explore this alternative. I've submitted written comments with additional complaints.

Thank you for your time.

CHAIRPERSON MATHUR: Thank you very much for your comments. We have two other speakers who want to speak on OptumRx and then I'll ask Liana Bailey-Crimmins to come up and address some of the concerns you've raised.

Okay. So we have Kathy Jeppson and Donna

Snodgrass.

MS. JEPPSON: Good morning. Thank you for the opportunity to speak before the Board. My name is Kathy Jeppson, and I am a retired - she said with a smile - Emeritus professor from the Cal State University system.

I'm a current CPA licensed in California and active, and I have attended all of the last 10 years CalPERS Board meetings for California Teachers Association.

The reason I'm here today is to comment on the continuing problems with the changeover of OptumRx, and like CSR to request that you amend the current Optum formulary to mirror the former CVS Caremark formulary with the same tiers.

I don't think that the Board is aware of all of the continuing problems with OptumRx, but I want to make sure that you understand that I do not think that is the fault of anyone, particularly the fault of the staff at CalPERS.

The reason for that is that originally most people were told to contact Optum directly. Word gets around fast, and many complaints then went directly to Optum bypassing CalPERS. As a consequence, CalPERS I don't think has been totally aware of all of the continuing ongoing problems.

There's always going to be problems with the changeover, and this is no exception. One example that I worked on was for another faculty member at a different campus. With the prior pharmacy manager, he received Lotemax for his deteriorating eye condition. His co-pay was $50, which was for a one week supply.

When he went to refill the prescription after the changeover, he was told that his co-pay had jumped to $182 per week, which is almost a 400 percent increase over the prior co-pay. This would result in an annual co-pay for one prescription of almost $10,000, of course subject to the maximum out-of-pocket amount that a member has to pay.

Lotemax is still in the Optum formulary, but was moved up to a tier 3. And with a tier 3, the pharmacy manager can increase the co-pay, which you can see that they did. He appealed twice and was denied. And he was going to go to the next level of appeal, but his two physicians felt that they had already spent enough time on the appeal and did not want to continue, because it's lengthy and time-consuming. And as the member, he didn't feel that he could continue on his own.

Now, this is just one example of a problem that I have looked at. And I think something needs to be done with -- and I've heard that CalPERS, the staff, is working with Optum, but I don't think that they realize how many

people this is -- members it is affecting.

So thank you for your time.

CHAIRPERSON MATHUR: Thank you very much, Ms. Jeppson.

Ms. Snodgrass.

MS. SNODGRASS: Hi. Good morning. This is Donna Snodgrass, Director of Health Benefits, Retired Public Employees Association.

And I just mirror everything that my colleagues have said before and I have -- I'm going to add to that. Since January this year, RPEA has been receiving requests for help dealing with OptumRx. Some of them were normal transition issues.

They began with the co-payment increases, as much as from $40 for a 90-day supply of a medication to $900 co-pay, and no Walgreens in the vicinity near them. You've heard some of those before.

And I'll give credit to the CalPERS staff that every issue that I've escalated to staff management has been dealt with, but it shouldn't have escalated to that point to begin with. Optum has been unresponsive at times at the lowest level, when we make the phone calls to the numbers that have been given to us.

And the contacts we receive now have gone from simple phone calls and emails from our members to

multi-page letters having to line-out the difficulties that -- that they've been having over and over and having to re-contact.

The member, in this case -- and these have been forwarded again to the staff. I just want to make it known that this shouldn't be happening. One gentleman in Gustine, California put the prescription in, didn't get it, sent it in for the 90-day supply, got close to the end of his -- what he had at home, made a phone call, and they had lost the request to refill.

So he resubmitted all the paperwork to Optum as requested, still didn't receive the medication, made another phone call to Optum and was told that the medication had shipped, give it three days. He waited the three days, nothing. Called back to Optum, a different operator, the medication has been shipped. He says, well, it's not here. I don't understand.

So she put him on hold and went and checked some things and said it hasn't even been filled. We don't know why the notation says that it has been shipped to you. So it's a run-around situation and now the member is out of his medication at home, so he's got a gap.

We have another member in Pie Town New Mexico with a simple request that other pharmacy providers have given her a simple receipt because she has a third

insurance to reimburse her co-pays for expensive medication for her husband. OptumRx has refused to give what she needs -- the receipt she needs for this other insurance that she's historically received. They told her it's not our job. You need to call CalPERS to get this documentation.

To make it a little more disturbing, the phone call to CalPERS staff, at the lowest level, said that she had to call OptumRx, and that was the end of that phone call. This, I believe, is being handled by management staff now, but I just wanted to call to your attention that there's -- appears, at times, maybe not always, that the attitude in customer service is not there that we need.

And, yeah, we're old people, but we shouldn't be ignored. This is -- we're looking at overall health.

So I just think that that needs -- the attention needs to be called to that. We need better customer service along with the other issues that are going on.

Thank you.

CHAIRPERSON MATHUR: Thank you. Well, I want to thank all four of you for raising these really important issues that obviously are impacting our members. I think our team is aware of a lot of the issues that have -- that you've articulated, and has been working very hard with

OptumRx to rectify them, but I'll let Ms. Bailey-Crimmins respond.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Madam Chair, members of the Committee, our members are our priority. And immediately following this meeting, we will be meeting with the retirees and Optum and we will bring back a report to you on what we've done to rectify the situation.

I do want to let you know the numbers are stating that prior auths have gone down, even though statistically things are moving in somewhat of the right direction. There was an alarming statistic that the overturn rate is still on the increase, which is not acceptable to us and not acceptable to our members.

So with that, we take this seriously, and I hope our members know that they remain our priority and we will get this resolved.

CHAIRPERSON MATHUR: Thank you very much.

We have several members of the Committee who have questions or comments.

Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you, Madam Chair. Yeah. This information and reports it's compelling. And so I'm glad to hear you say that right after this meeting you will be meeting with our retirees

and Optum. And I just would like to make sure we exhaust a review of our contract with Optum, and see what options we have to deal with some of these issues, and report back to us to let us know what steps we can take, because this can't continue to go on this way.

CHAIRPERSON MATHUR: Mr. Gillihan.

COMMITTEE MEMBER GILLIHAN: Thank you, Madam Chair. So this is enraging. We pay a ton of money for this benefit, and to hear that our retirees, who are some of our most vulnerable population we serve, are being treated as a number on a file rather than human beings with compassion is unacceptable. And I -- Madam Chair, I would ask that we bring Optum's CEO in front of this Committee to explain their perspectives on customer service and servicing our clients, because this is outrageous.

CHAIRPERSON MATHUR: Thank you for that suggestion. I think I will work with our team to invite Optum to come up and speak with us. I think that is a good suggestion.

Mr. Bilbrey.

VICE CHAIRPERSON BILBREY: I want to echo the comments of my fellow colleagues on this Committee about the issues. I mean, this is impacting people's lives and their health, and could have very serious impacts on their

health. And I want to see us do -- make some actions sooner than later. I don't -- you know, we've talked now a little bit how far do we go when we keep talking about it's getting better, but not yet. We're not good enough.

I hope that by the end of the year we make a determination either to stay with Optum, move from Optum. We definitely need to look at the formulary situation. That's been going on now for months and months. And if we need to, at the next meeting, make some changes in the formulary, then I think we need to do it. So it's a very big concern.

CHAIRPERSON MATHUR: Thank you, Mr. Bilbrey. Mr. Lofaso.

ACTING COMMITTEE MEMBER LOFASO: Thank you, Madam Chair. Definitely echo Mr. Gillihan's suggestion about the CEO. I've got to say the data is challenging to understand. Prior authorizations are up, they're down. As I was listening to the comments, and I've been trying to recall all of the transition discussions we had last year. And I remember we seem to have a decent sense of isolating the impacted population. I do remember a significant figure out there that was bandied about, about prescriptions under CVS that previously required various steps to get them, that would not have those steps at Optum. There was sort of a suggestion that it might be

easy over here and more difficult over there.

And my recollection is our focus was how will the pop -- subpopulation for which it's difficult, have their time to settle it all out, you know, get through the pre-authorization process again and again.

I'm wondering if Optum could put this in a better context for us. If we had enough of this data last year to get a sense of what that population was, it would be really great if Optum would tell us what happened in a digestible format. What are the population who had the overlap from the less advantageous position? How many were initially denied? How many were ultimately approved and any other variables?

And they can throw in the ones who got the windfall from the better -- if they want, but -- I'm not trying to make a PR point for them. So if that would be possible, I think that would be good.

I have a customer service question. I don't know if it's fair to direct it to Ms. Lum. But I have heard this issue about constantly going back to the call and a different rep. And clearly, this is a system where the same case requires lots of follow up. And I, myself, have heard anecdotes of individuals who've had to walk through that thing. Is that a standard in call centers? I know this is not necessarily kind of quite the situation in the

ones that you directly administer, Ms. Lum. But is this a standard that you understand that we require of the outsourced call service, if you could elaborate?

DEPUTY EXECUTIVE OFFICER LUM: Thank you. Again, Donna Lum, CalPERS team member.

So just to clarify, the members that are using OptumRx are contacting the OptumRx contact center, not the CalPERS contact center. I do believe that there are provisions within the contract that we have with OptumRx that do address performance and wrap-up.

I don't know what those are in the contract. I'm sure that Liana has a team member that is here that can address that. But it isn't unusual that there are some -- there are those types of performance measures, and it just depends on how they're being managed, and how much emphasis is being put on them.

And in these cases, certainly our members are feeling very distressed with the service that they're getting. And I would hope that we are looking at how that performance measure is being addressed and whether it is really wrap it up and move on, or if they are attempting to really service the member as we would hope that they would.

CHAIRPERSON MATHUR: I think the specific question, if I can restate it from you, is that this

question of whether you can go back -- when you call back, if you can get the same representative to help you again? I think it's pretty typical that you don't get the same representative. You get whoever is next in the queue, is that right? And are there systems --

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: That is correct, Madam Chair. In addition to Mr. Lofaso's comment regarding customer service, we have the ability, which we've -- I talked to the team before I came up here. We will be doing -- listening to all of our calls, specifically to hear what type of customer service they received, if they received conflicting or wrong information, and we'll be addressing those service levels within Optum within their contract terms.

So we will be doing that. We do it periodically. But because of this situation, to the upping that we are, we will be upping those listening statistics to bring that back to you.

ACTING COMMITTEE MEMBER LOFASO: Appreciate that. And I -- I mean, I'm not an expert on call centers, and I appreciate it's difficult to get a system to get back to Joe after you spoke to Joe. But I think I've also heard suggestions that the files were such that individuals felt they had to almost start from scratch. And I'm gathering that's a performance metric.

And I really appreciate you coming up to speak, Ms. Lum. I don't know who's entirely responsible for the outsourced contracts. I didn't mean to put you on the spot, but anyway, thank you.

CHAIRPERSON MATHUR: Well, yeah the quality of the notes from call to call is really a significant component of good customer service, I think.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS:

Absolutely. And we've actually, as we reported prior, Donna's team is actually trained. We went -- actually gone down to their contact center to let Optum know what quality of customer service we expect to deliver to our members. And so they've had one-on-one training, both from her team, our team specifically on how to deal with our retiree population, because, you know, there's a lot of complexities, where we wanted to make sure that things were streamlined, that it's efficient, and they get the right information, because we want to make sure that they receive the same quality of service from Optum as they would if they had called Ms. Lum's contact center.

CHAIRPERSON MATHUR: Yeah. And have they fully staffed up now? I know they had to hire --

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: They have.

CHAIRPERSON MATHUR: -- a hundred or so?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Yeah. So they are staffed up. The big thing for us obviously is return -- you know, when they have retention issues. So they've been able to keep their numbers, but they're fairly new contact agents.

CHAIRPERSON MATHUR: Okay. We have a few other questions or comments.

Ms. Glasser-Hedrick, please.

ACTING COMMITTEE MEMBER GLASSER-HEDRICK: Thank you. Yeah, I support all the comments that have been made by the Committee. But I did want to ask, we've heard a lot today from the retirees. Is this an issue that's more widespread among active members as well, or are the drugs in question drugs that are more consistent with ailments that elderly people tend to have or retired people have?

GENERAL COUNSEL JACOBS: I'm sorry to interrupt, if I may, Madam Chair. This is public comment, and it's fine to ask staff a question or two about what we've heard, but I would suggest that the better way to proceed, at this point, would be to agendize it for a future meeting, so we could have a more -- a fulsome discussion of these issues.

CHAIRPERSON MATHUR: Thank you for the recommendation.

Let's talk about agendizing it for November then.

I know we have a very crowded agenda in November, but still I think the urgency of this merits it.

Are there -- so if that's okay, Ms. -- if there are any -- if members of the Committee have specific questions they want addressed in November, please make sure to let me and Ms. Bailey-Crimmins know, and we'll make sure to have those answers in November.

I think there are still a few who wish to speak, so I'll turn to the other Committee members.

Mr. Feckner.

COMMITTEE MEMBER FECKNER: Thank you, Madam Chair. I want to thank the retirees for speaking today. I spoke to a group of retired PECG members a couple of weeks ago. They had similar comments and complaints about Optum. I appreciate the fact that you're willing to meet with the retirees after this meeting.

However, that's not meeting in my opinion that needs to take place. It's the meeting Mr. Gillihan brought forward that the CEO of Optum needs to come here. This is a very large and lucrative contract for them, and they can either handle it or they can't. And it's time to fish or cut bait.

CHAIRPERSON MATHUR: Thank you.

(Applause.)

CHAIRPERSON MATHUR: Ms. Hollinger.

COMMITTEE MEMBER HOLLINGER: Yeah, I agree with Mr. Feckner. And the only thing I would add that I'd like to see agendized, are there any sanctions in the contract that you could address in November for their failure to service our retirees and live up to the terms of the contract?

Thank you.

CHAIRPERSON MATHUR: Okay. Thank you.

Mr. Jelincic.

BOARD MEMBER JELINCIC: Yeah, I hope the invite to the CEO is sort of like an invite to come to the principal's office and talk to me.

I'm -- you know, this is not a new complaint. I'm glad that it's finally gotten the kind of attention it has. But my question is how much control do we have over the formulary?

CHAIRPERSON MATHUR: I think maybe questions like that we'll make -- we'll just bring back in November the answers to those questions. It will be part of the November item. We're not -- so that we don't expand this public comment into an agenda item that's not noticed.

BOARD MEMBER JELINCIC: Can I at least get, we have a lot of control, little control, just a general answer?

CHAIRPERSON MATHUR: Do we have an answer?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: A formulary is very fluid. And so even if we had stayed on the formulary of CVS Caremark, based on patient safety and medication changes, they change. So we do have -- in fact, we've -- the launch of our OptumRx contract, their formulary was every restrictive. They've pretty much followed what was off the CMS website, and we had had a customized formulary with CVS Caremark. And we have worked really hard over the last, you know, six to ten months to align it more to what our members need, but it sounds like there's a lot more work to be done.

BOARD MEMBER JELINCIC: So we have some, but not a great deal.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: That is correct.

BOARD MEMBER JELINCIC: Okay. Thank you.

CHAIRPERSON MATHUR: Okay. Thank you.

That concludes public comment. Is there any -- is there any other member of the public who wishes to speak at this time?

Seeing none. That brings us to the end of our agenda. We are adjourned.

Thanks, everyone.

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(Thereupon the California Public Employees' Retirement System, Board of Administration, Pension & Health Benefits Committee open session meeting adjourned at 9:23 a.m.)

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

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

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

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

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

IN WITNESS WHEREOF, I have hereunto set my hand this 25th day of September, 2017.

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