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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TUESDAY, JUNE 19, 2018

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A P P E A R A N C E S

COMMITTEE MEMBERS:

Ms. Rob Feckner, Chairperson

Ms. Theresa Taylor, Vice Chairperson

Mr. John Chiang, represented by Mr. Matthew Saha

Mr. Richard Gillihan

Mr. Henry Jones

Ms. Priya Mathur

Mr. David Miller

Mr. Bill Slaton

Ms. Betty Yee, represented by Mr. Alan Lofaso

BOARD MEMBERS:

Ms. Margaret Brown

Ms. Dana Hollinger

Mr. Ramon Rubalcava

STAFF:

Ms. Marcie Frost, Chief Executive Officer

Ms. Liana Bailey-Crimmins, Chief Health Director

Mr. Matt Jacobs, General Counsel

Ms. Donna Lum, Deputy Executive Officer

Dr. Kathy Donneson, 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

Mr. Gary McCollum, Senior Life Actuary

Ms. Renee Ostrander, Chief, Employer Account Management Division

Dr. Richard Sun, Medical Consultant II

ALSO PRESENT:

Mr. Al Darby, Retired Public Employees Association

Ms. Stephanie Hueg, California State Retirees

Mr. Larry Woodson, California State Retirees

I N D E X

P R O C E E D I N G S

CHAIRPERSON FECKNER: Good afternoon. We're going to call the Pension and Health Benefits Committee meeting to order.

The first order of business will be to call the roll, please.

COMMITTEE SECRETARY JIMENEZ: Rob Feckner?

CHAIRPERSON FECKNER: Good afternoon

COMMITTEE SECRETARY JIMENEZ: Theresa Taylor?

VICE CHAIRPERSON TAYLOR: Here.

COMMITTEE SECRETARY JIMENEZ: Matthew Saha for John Chiang?

ACTING COMMITTEE MEMBER SAHA: Here.

COMMITTEE SECRETARY JIMENEZ: Richard Gillihan?

COMMITTEE MEMBER GILLIHAN: Here.

COMMITTEE SECRETARY JIMENEZ: Henry Jones?

COMMITTEE MEMBER JONES: Here.

COMMITTEE SECRETARY JIMENEZ: Priya Mathur?

COMMITTEE MEMBER MATHUR: Here.

COMMITTEE SECRETARY JIMENEZ: David Miller?

COMMITTEE MEMBER MILLER: Here.

COMMITTEE SECRETARY JIMENEZ: Bill Slaton?

COMMITTEE MEMBER SLATON: Here.

COMMITTEE SECRETARY JIMENEZ: Alan Lofaso for Betty Yee?

ACTING COMMITTEE MEMBER LOFASO: Here.

CHAIRPERSON FECKNER: Can you please note for the record that Ms. Hollinger, Mr. Rubalcava, and Ms. Brown have joined the Committee at the dais today.

With that, we move on to the approval of the Pension and Health Committee timed agenda. This is our first attempt at going through this. Just gives us suggested timelines to try and keep us more streamlined and on topic.

Do wave -- what's the pleasure of the Committee?

VICE CHAIRPERSON TAYLOR: Move the agenda.

COMMITTEE MEMBER MATHUR: Second.

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

Any discussion on the motion?

Seeing none. All in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries.

Item 3, Executive Reports.

Ms. Lum.

DEPUTY EXECUTIVE OFFICER LUM: Good afternoon, Mr. Chairman, members of the Committee. Donna Lum, CalPERS staff.

This afternoon, I have two updates for you on

some recent initiatives and activities that have been underway with the customer support teams. First of all, I'd like to give you a brief update on the CalPERS Benefit Education Event that we recently hosted this past weekend in Riverside. I was able to attend the event, along with the CalPERS team members. And once again, it was a very successful event. Our two-day total for attendance was nearly over 1700 attendees, which far surpasses the last time that we were in Riverside, where we had nearly a thousand attendees.

So once again, as I've mentioned month after month; our CBEEs, our CalPERS Benefit Education Events, have been very well attended. It was also very evident and what we're seeing more and more as our members are coming to these events, is that they are planning well ahead in advance.

We notice that they're coming with their itineraries, and I've identified what workshops that they want to attend. And they've been very engaged in the workshops with lots of questions. So we're really fortunate that we have a lot of knowledgeable subject matter experts that are hosting these workshops that are well equipped to answer our member questions.

In addition to that, we were very pleased to have our CEO, Marcie Frost, attend the CBEE in Riverside, where

she was able to give a talk. We called it kind of a customer dialogue at this CBEE with several members, and provided information in what CalPERS is doing to build a strong foundation for our future.

Certainly, Ms. Frost will give you an update in her CEO comments tomorrow. But in addition to that, this was, you know, a great opportunity to be able to provide a lot of real-time information to members during a time when, you know, they're -- they hear a lot of things about what's happening at CalPERS.

In addition, we were very glad to see Board members, both Mr. Feckner -- Mr. Rob Feckner and Ms. Margaret Brown on Friday at the CBEE, as well as Mr. Ramon Rubalcava at the -- on Saturday. This was his first CBEE. And he attended all of the sessions, and was able to give the team a lot of really good feedback.

Our next CBEE is going to be held in Bakersfield on July 13th and 14th. And certainly, you know, Bakersfield in July can be quite hot. So if you're planning to travel to Bakersfield, hopefully you'll be able to be there and be cool.

So that's my update on the Riverside CBEE. And again, I want to thank all the team members that put this on together. It is quite a feat to be able to do it and do it successfully, and they do it month after no.

The next update is centered around activities that we have undertaken related to customer satisfaction, and some opportunities to be able to engage with our members and our employers in different methods than we have in the past. As you know, we currently administer satisfaction surveys to our members and employers, either via member self-service portal on-line, where they can give us feedback after a transaction. We also send out surveys via email, as well as postal mail.

And our systematic approach in gathering information allows us to gain greater understanding about the services that we're providing to our members, as well as information on what we can do to better enhance and provide even a better customer experience.

Acting on the data that we gather, we are able to modify our current business process into alignment with what our customers are expecting of us. And I'm pleased to share with you today that we have three new and exciting ways and methods that we are beginning to solicit additional feedback from both members and employers. They include something that we're calling our customer connections, in-person surveys at our CBEEs, as well as piloting an easy to use survey tool in our regional offices.

So just a little bit about each of those. In

March, we started what we're calling Customer Connections. And this is a program by which myself, and senior leaders in the Customer Support team are making calls directly to members that have interacted with us and have received a service. Members are randomly selected through a sampling that we have. And obviously, we have information from them from their surveys. And we connect with these members by not only asking questions about specifically how responsive were we when you came to us for your service, what was the degree of accuracy in the information that you received, as well as were you treated respectfully, and did you feel like you were a valued member.

And the benefit that we're seeing in these dialogues with our customers is we're getting a lot more feedback than we generally did on a paper survey. In addition to that, not only are they providing us comments on the survey questions that we're asking, but they're also sharing other information about what is concerning them about CalPERS. And this is something that our regional office agents often here.

So it enables us again to take additional information, look at how we can take the feedback that we're receiving, and again further enhance the way that we are providing our services.

Thus far, the overall feedback that we're getting in these calls we're seeing is pretty much aligned with what we've seen in our paper feedback. And that well over 96 percent of all the calls that we're making we're getting positive feedback for the team.

So again, this is something that we are going to continue and -- into the next fiscal year. We're also going to be inviting members of the executive staff to participate in these customer calls. We've chatted a little bit about it. And certainly, it will give them greater insight to the services that we're providing to our members.

The second area that we have initiated additional opportunities to get feedback is at the CBEEs. So at the CalPERS Benefit Education Events this last weekend in Riverside, we had a few team members who had tablets. And we approached members that were either waiting in line or at an exhibit, and again asking them questions very centered around the topics that I mentioned we're asking in our customer connects, and just dialoguing with them and getting additional feedback.

We were able to interview about 50 of the members there were -- that were at the CBEE. And a quick analysis of the results showed that 88 percent of them indicated that they had their issue resolved, while about 12 percent

were still working through the transaction to get the inquiry completed. Eighty-eight percent also felt that their answer or solution was received in a very timely manner. Ninety percent indicated that they were very satisfied with the experience, and 96 percent said, yes, that when asked if they -- if we made them feel like a valued member, we did.

So I think again this is demonstrating the parallels that -- paralleling what we've seen on other surveys. But it is once again another opportunity to dialogue with the members face-to-face and be able to get that feedback directly from them.

And then finally, this is really exciting. This is in our regional offices. This summer we're going to be piloting a point-of-service customer feedback tool. And so currently, we survey about 10 percent of the customers that come through the regional offices, which equates to about 12,000 individuals -- members each year.

About 14 percent of the surveys that we send out are returned and the average level of satisfaction on those surveys is about 91 percent. But we believe that it's necessary to be able to get additional feedback from the members that are being counseled and served at the regional office. And that timely feedback is extremely important to us.

And so as a customer -- as our members complete either their counseling, their paperwork, or the training that they're getting at the regional offices, they'll be provided a hand-held device, which is optional. We won't mandate that every member complete the survey. But the hand-held device is going to have some emojis on them. And I think you're all familiar with emojis. And you've probably seen this feedback technique used before, where you have very unhappy looking emoji to a very wide smiling emoji.

And what we're hoping is that we'll get a wider participation from the members to be able to get that point of feedback immediately, and to be able to gather that. It will also enable us to directly tie -- so what's exciting about it is not only getting the feedback, but this ties into the current technology that we have that's being used in the regional office. So we are able to directly tie the level of satisfaction to the specific service that they received, and by the specific agent that provided the service.

So certainly this is going to give us a lot of information again that will help us to continue to look at how we can leverage the information we have and the resources, and continue to enhance our service.

Mr. Chairman, that completes my report, and I'm

happy to answer any questions you may have.

CHAIRPERSON FECKNER: Thank you. I do want to say that again the CBEE -- that was very successful down in Riverside. It was especially nice to see Ms. Frost there, and see the interaction between her and the people that were attending. A lot of good questions. A lot of good comments when I walked around talking to people afterwards. So it's a great addition. So thank you.

DEPUTY EXECUTIVE OFFICER LUM: You're welcome.

CHAIRPERSON FECKNER: All right. Seeing no other questions.

Ms. Bailey-Crimmins.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Good afternoon, Mr. Chair and members of the Committee. Liana Bailey-Crimmins, CalPERS team member. I am pleased to highlight that the CalPERS Health Program will be sharing the final 2019 rates with you, our members, and employers. Today marks another historical milestone when it comes to delivering the lowest overall aggregate premium increase.

For my opening remarks, I have three items. First, in preparation for open enrollment, I will highlight our upcoming health benefit program workshops, which will be held at the CalPERS regional offices across the State.

Second, I will highlight our desire to partner

with contracting agencies to offer on-site open enrollment fairs, which will assist members and provide them timely information before open enrollment.

And lastly, I'll provide an executive summary on what to expect from today's Pension and Health Benefits Committee meeting.

So the Health Benefit Program workshops, as I said, it will be held at the regional offices. And they are a great opportunity for existing public agencies and school employers to review how their current health resolutions are established and hear about options that are available to them.

For prospective agencies, the workshops share how others have benefited from our health program, and will provide benefit details to determine if we are a good fit for their organization.

As a reminder, public agencies and schools do not need to have a pension contract with CalPERS to participate in our health program. Employers can find the schedule, and register on-line by going to the CalPERS website at www.calpers.ca.gov.

For existing participating agencies, CalPERS is offering again this year an opportunity to schedule open enrollment fairs for their employees. The fairs are a great way to raise awareness on the health -- the CalPERS

Health Program. So then again that they can make informed decisions for themselves and their families.

As in the past, availability for the fairs, as well as the frequency and duration of our health plan partner visits will be limited. But if you are interested, the on-line scheduling tool will be available in early July, so keep an eye out. And also, fairs will be held between August 20th and October 5th.

Today's Pension and Health Benefits Committee looks towards the future. We will be asking the Committee to approve a pilot that evolves our reference pricing model to pharmaceuticals. CalPERS spends approximately $2 billion annually on pharmacy. And our current pharmacy benefit manager contract with OptumRx, there is a contractual requirement for them to implement pharmacy innovations, such as reference pricing.

So therefore today, we will be recommending a 2019 reference pilot for three therapeutic drug classes. If CalPERS experience savings, a hundred percent of those savings will be applied to the 2020 rates.

And now for 2019 rates. Last year, CalPERS' overall aggregate rate increase of 2.33 percent was the lowest in 20 years. For 2019, the team strove for equal or better. And I am proud to report that we have succeeded. The HMO rate we share with you today and

request you approval is 0.37 percent. It represents an aggregate increase across seven HMO carriers, and nine HMO plans, which in itself is amazing.

Healthleadersmedia.com published a recent article that states that the Congressional Budget Office eyes 15 percent as an average premium increase across the nation. Today, CalPERS' overall rate is unprecedented. And the Board and team members worked hard over the last six months, while also negotiating, I have to say, a five -- new five-year contract. And we did all this on behalf of our members and employers.

And now, let's turn the page to the CalPERS self-funded PPO plans. Today, the team will present to this Committee an option to use PPO reserves to smooth the 2019 PERSCare rate. There are two factors we asked for you to consider.

Starting in 2019, we decided to eliminate risk adjustment where members from one plan were offsetting the cost of members for another plan. Also, CalPERS currently has PPO reserves that exceeds our required limit. Today, the team will recommend using some of these reserve funds to smooth the rate increase over two years versus one.

In September 2018, the CalPERS team will recommend a PPO reserve policy for this Board's consideration. The policy will provide guidelines to the

Health Program on reserves and excess monies and how to apply them to premium reductions in the future.

And lastly, Mr. Chair, I'd like to take a moment of privilege and recognize Mr. Gary McCollum our Senior Health Actuary, who has represented CalPERS and been an advisor to this Committee for 12 years. In this year alone we negotiated the new data warehouse contract; we did a new five-year HMO contract; we discussed and eventually eliminated risk adjustment; we eliminated risk corridor, which actually benefits CalPERS because it moves the risk to the plans; we did Health Beliefs. We were all involved in all of it. We launched a regional study. And all of that on -- between the program and Gary.

And so I'd like to again recognize him. His very witty personality, his smile will very be much missed -- be very missed. I will try not to cry. But he has been amazing and I'd like all of us just to recognize him for a moment.

(Applause.)

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: And with that, Mr. Chair, that concludes my opening remarks.

CHAIRPERSON FECKNER: Thank you.

I, too, want to, on behalf of the Committee, thank Mr. McCollum for his continued years of service. These last 12 years, you've given us invaluable advice

over that period of time, and we wish you well on your retirement. Enjoy. You've earned it.

SENIOR LIFE ACTUARY McCOLLUM: Thank you.

CHAIRPERSON FECKNER: Okay. Ms. Mathur.

COMMITTEE MEMBER MATHUR: Thank you.

I also cannot resist and I can't really seek Gary, but -- I cannot resist just taking a moment to say as the former Chair of this Committee for quite a number of years, and having worked so closely with Gary and the rest of the team, just the dedication, skills, talent that Gary brought to his role here at CalPERS. And not only that, always with the members at the forefront of his mind. Truly a mission-driven individual who also brought a sense of humor to the work that he did.

And we're really going to miss you Gary. Thank you for your contributions here to CalPERS.

SENIOR LIFE ACTUARY McCOLLUM: Thank you.

CHAIRPERSON FECKNER: Thank you. All right. That brings us to Agenda Item 4, the action consent calendar. It's the minutes of 2000 -- of May 15th, what's the pleasure of the Committee?

COMMITTEE MEMBER JONES: Move it.

VICE CHAIRPERSON TAYLOR: Second.

CHAIRPERSON FECKNER: Moved by Jones, seconded by Taylor.

Any discussion on the motion?

Seeing none. All in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries.

Item 5 is the information consent item. Having no requests to remove anything, we'll move to Item 6.

The proposed regulation for the definition of full-time employment. Ms. Ostrander.

EMPLOYER ACCOUNT MANAGEMENT DIVISION CHIEF OSTRANDER: Good afternoon. Renee Ostrander, CalPERS team member.

Before you today is Agenda Item 6, the final draft of the proposed regulations, which define full-time employment for purposes of determining CalPERS membership eligibility, reporting over-time positions, and determining compensation earnable and pensionable compensation.

As mentioned in February, this regulation before you provides multiple benefits. It further solidifies the Board's current resolution as a regulation, a step in further strengthening the position already established, continues the practice of the individual employer defining what is full time, and removes the maximum cap to provide flexibility for employers.

The public comment period after the approval by the Board in February commenced on April 13th, and it closed on May 28th. No comments or requests for a hearing were received. So therefore, we're bringing you forward the regulation that was originally presented in February with no changes.

Once approved by this Board, and the final signatures from the Department of Finance are received, this entire package will be sent forward to the Office of Administrative Law for final review and publishing. This completes my presentation, I'd be happy to answer any questions you may have.

CHAIRPERSON FECKNER: Great. Thank you.

Ms. Mathur.

COMMITTEE MEMBER MATHUR: Move approval.

COMMITTEE MEMBER GILLIHAN: Second.

CHAIRPERSON FECKNER: Been moved by Mathur, seconded by Gillihan.

Any discussion on the motion?

Seeing none.

All in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries. Thank you.

Agenda Item 7, Reference Pricing Pharmaceuticals

by Therapeutic Class. Ms. Donneson.

(Thereupon an overhead presentation was presented as follows.).

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Thank you, Mr. Chair. Members of the Committee, this is Agenda Item number 7, Reference Pricing by Therapeutic Class. Kathy Donneson, CalPERS team member.

I will be presenting today with Dr. Richard Sun CalPERS, Medical -- Chief of Medical Office, and he's going to present the bulk of the presentation today. We're down a pharmacist, so the doctor will -- is in.

(Laughter.)

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Thank you.

DR. SUN: Good afternoon. Richard Sun, CalPERS team member.

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DR. SUN: This is an action item for reference pricing pharmaceuticals by therapeutic class for basic health plans serviced by OptumRx, our PBM vendor.

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DR. SUN: If you approve the proposal, it will take effect in 2019.

Next slide.

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DR. SUN: I'll cover the 2019 pricing strategy and our analysis and recommendation for the proposal. We'll also provide an example of how this program works, the choices our members will have, and the next steps.

We'll stay on this slide then

At the april meeting, we presented various strategies for pharmacy, one of which was reference pricing. As we conducted our analysis, we determined that reference pricing by therapeutic class would be the best option. If successful, and if expanded, it would replace the member pays the difference, or MPD design. And this would possibly eliminate most utilization management processes, such as prior authorizations.

The reference pricing strategy improves transparency by providing options for drugs that are a lower cost, but identified as a therapeutic equivalent or alternative. For CalPERS, this strategy should help lower or stabilize prescription drug costs.

We wanted to start with a small number of therapeutic classes. The three classes we recommend are nasal corticosteroid, thyroid medications, and certain estrogens. The reason we selected these three were low generic utilization, formulary compatibility, and low rebate impact.

Next slide.

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DR. SUN: Here's an example of how reference pricing would work using a hypothyroidism drug. The cost for Tirosint, a non-preferred brand medication, is $109 per month. The member pays $50 in copay, and CalPERS would pay $59.

Levoxyl is a generic. This costs $9 per month. Of this, the member would pay $5 in copay and CalPERS would pay $4.

A generic alternative to tirosint is levothyroxine. This cost $5.77 per month. The member would pay the $5 generic copay, and CalPERS would pay $0.77.

If the member would switch the levothyroxine, the plan would save $58, as indicated on page two of the agenda item.

Next slide.

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DR. SUN: Our members would have three options if they are currently using a prescription drug on the reference priced list. Option number one, the member could ask their doctor to switch to a lower cost prescription. Based on one program's experience with reference pricing, approximately 85 percent of members

will choose this option.

Option two, they can ask their doctor to request the medical necessity exception. And if this exception is approved, the member would continue paying their current copay. Something like three percent of members would choose this option.

And option three, they could continue to use the current prescription and pay the difference in cost. Approximately 12 percent of members are expected to choose this option.

Next slide.

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DR. SUN: At the previous presentation, on reference pricing, there is a question about what we would consider criteria for success. Based on previous evaluations of reference pricing, both in the pharmacy and non-pharmacy arenas, the proposal would be considered a success if it reduces costs to members to CalPERS, while keeping member satisfaction, as determined by surveys, and adherence, as determined by claims data, at or above previous levels.

Last slide.

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DR. SUN: For next steps, we are seeking the approval of reference pricing by therapeutic class. We

will provide extensive member pharmacy and provider outreach, as mentioned on page two of the item. The team will monitor the program, and provide periodic updates to you.

In addition, we will continue to research strategies to address the affordability of prescription drugs. That concludes our presentation and Dr. Donneson and I are available to answer questions.

CHAIRPERSON FECKNER: Thank you.

I do want to say that I'm excited about the opportunity to go through this pilot project. I think it's got some great opportunities ahead of it. I do have concerns about just assigning it to our current pharmacy managers, but I do have other Board members who wish to speak.

Ms. Mathur.

COMMITTEE MEMBER MATHUR: Thank you.

Yes, I'm -- I think this is a terrific pilot. I think -- you know, when I -- obviously, we've had a lot of success with reference pricing on the medical side. And when I talk to members they're thrilled with the results that we've achieved through our reference pricing program. And the number one question I get is -- from members on -- with respect to health care is what are you doing about pharmaceutical drug prices? They are too high.

And I absolutely agree with them. I think this is a very sensible step to do this pilot, and then hopefully we'll have -- we'll see the results and we'll be able to expand it to more therapeutic classes.

I also have concerns about simply assigning this work to our PBM. And I would rather see us do a full solicitation. And so I will move that we approve the reference pricing pharmaceutical by therapeutic class program for basic health plans, and that we do a solicitation to identify who would do the work.

VICE CHAIRPERSON TAYLOR: I'll second that motion.

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

Next up is Ms. Taylor.

VICE CHAIRPERSON TAYLOR: Thank you. So I want to thank you for the presentation.

Excuse me.

I had a couple of questions. One was similar to Ms. Mathur. If we came -- I don't know that having it handled under our current PBM would be the greatest idea. I know that we contract out for them to do innovative strategies. I understand that. I also understand this isn't something that -- this is something we asked them to do, so not necess -- they didn't think of it.

So my opinion that we should maybe send this out for, you know -- and I know it's only three medications, but I think my concern here is if we decide to operationalize this, are we -- and include a larger list of medications that could be 20 or more, are they equipped to even think about doing that? So that would be my first question, and then -- go ahead, Ms. Donneson.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: So the reason we went with three therapeutic classes is because we wanted to start simple.

VICE CHAIRPERSON TAYLOR: Right.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Because if we go up to all 87 therapeutic classes, that's where there is the bulk of the opportunity for savings, both for the plan and for the member.

The reference pricing does require that we be able to access the claims -- or the actual Optum databases. And it is an algorithm that runs through that database, based on formulary, you know, Tier 1, Tier 2, Tier 3. We were going to use the three therapeutic classes with Optum alone, because it is small, and there's not -- there's about a three and a half million dollar savings. I have -- of course, I've been contracting for CalPERS -- leading contracting for eight years.

And there are other ways to deal with the

contract issue. It's similar to what we did with Castlight, where one company held a master contract and the others subcontracted. So that's one option. I don't know that we could do this totally independent of OptumRx. However, I think there are ways that we could manage the contract, if we wish to put the subcontract piece out in terms of the algorithms, and -- because it does have to stay integral to the formulary, and all the claims.

So I think we could still do it and get to where you wanted to go without a full procurement, either as a subcontracting procurement, or as we did with Castlight, direct the master contract holder to contract with the subcontractor. We can do that under 22850 of PEMHCA.

So it's -- I understand truly your desire to test -- test it outside of perhaps Optum alone. I think there are ways we could get there, and still have our three classes introduced for 2019, so that -- so that you're not having to wait another year in order to do this.

CHAIRPERSON FECKNER: Thank you.

VICE CHAIRPERSON TAYLOR: Okay. Thank you.

CHAIRPERSON FECKNER: Mr. Lofaso.

ACTING COMMITTEE MEMBER LOFASO: Thank you, Mr. Chair. Thank you for the presentation. Just a couple questions. In April, I asked some questions about

subclasses. I'm curious where we are. And based on the recent comments, I'm wondering if that's something we're putting out to the bidder or to OptumRx. But the general question is what's the thinking where we are now on subclasses?

DR. SUN: Each therapeutic class does have subclasses. The concern I believe was about estrogens. And we decided to limit estrogens to two subclasses, which is limit the number of choices in terms of lowest cost alternatives and therapeutic equivalence.

ACTING COMMITTEE MEMBER LOFASO: But you're still perhaps looking at subclasses for some of the other -- for the other two the corticosteroids and the --

DR. SUN: No, the other two are -- do not have -- the reference pricing program would not assign subclass to those. I'm talking about the other subclasses that have been done in other reference pricing pilots. For example, the one that was reported in the New England journal had 78 therapeutic classes. And for each of those classes, there may have been numerous subclasses.

ACTING COMMITTEE MEMBER LOFASO: Okay. Appreciate that. Dr. Sun, you indicated a reduction -- substantial reduction in prior authorizations. And I kind of thought when you said that you meant when the program goes across the board with lots more therapeutic classes.

But is the belief about reductions in therapeutic classes -- excuse me, prior authorizations not that many patients may find that what the science says is a therapeutic alternative, isn't the right drug for them and their doctor supports them on that, or is it more based on our experience with the non-pharmaceutical reference pricing program?

DR. SUN: It's based on experience with pharmaceutical reference pricing programs. And the fact that only a low percentage of members in the previous program chose to go the medical exception route.

ACTING COMMITTEE MEMBER LOFASO: Okay. One last question. Do you think that physicians will generally be aware of what the lowest cost alternative is, and be inclined to recommend that to your patients, or do you think patients are going to have to do a lot of effort to ask the physician to take a look at the lowest cost alternative for the patient's own fiscal benefit?

DR. SUN: I would say, in general, physicians would not be aware of the lowest cost alternative, based on a particular reference pricing program design.

That's why it's imperative that OptumRx and CalPERS collaborate to get the message out to providers and pharmacies and patients.

ACTING COMMITTEE MEMBER LOFASO: Okay. Thank you

very much.

CHAIRPERSON FECKNER: Thank you. Mr. Miller, did you mean to turn your light off?

COMMITTEE MEMBER MILLER: Yes.

CHAIRPERSON FECKNER: Okay. Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you, Mr. Chair. Yeah, looking at the benefits of this initiative, lower stabilizes CalPERS prescription drug costs, and transform health care purchasing and deliver it to achieve affordability, how can you not support that?

And so, of course, I support that, but I also am concerned about the solicitation process. So I would like to encourage you to find a way to go through some solicitation process.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I would like to add another comment to expanding the therapeutic classes. The three -- we felt that the three would be sort of a test case in terms of how this works, so that we learn how to manage it, similar to hips and knees. You know, we didn't start with everything we could have done with reference pricing.

So this would be our way to learn how it works, how to do it. The savings, while modest now, if you go up to 87 therapeutic classes, at which point -- and this is why I would consider, you know, a subcontract type

relationship with other vendors that know how to actually do this, as redundancy to the program, that potential is in the 20 to 30 million dollar range.

So I don't want to lose site that while it's a small pilot, or practice now, that I believe with some of the complications with other therapeutic classes like diabetes, that really would want a collaboration in terms of outreach to providers, redundancy in how the algorithm works.

Again, it has to be in concert with a formulary, including all the subclass and different ways to administer drugs, oral, you know, injection -- self-injectable, whatever that may be.

So I always expected that as we expanded to more complicated, if it worked here, and we wanted to up -- generalize it, that we would really seriously consider some redundancy with a contractor whose a specialist in this area.

COMMITTEE MEMBER MATHUR: Okay.

CHAIRPERSON FECKNER: Thank you.

Mr. Slaton.

COMMITTEE MEMBER SLATON: Thank you, Mr. Chair.

On the issue of doing a separate procurement or doing some other process to possibly have someone else work with us on this, I'm just concerned about the data,

and, you know, you change too many variables in it, are you going to have -- are you going to able to be satisfied with the results we have or is it due to having a different provider that's helping make that happen?

So I would just be concerned about that issue of changing the underlying provider for this, and then that being part of the reason that you have a different result.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I do want to speak to the provider community particularly. They already struggle with our formulary. They're trying to manage other populations under other formularies. The reference pricing protocols actually started in Germany in 1989. When we had CVS as a contractor, we wanted to do it with CVS.

We spent two years trying to get, you know, CVS to move in this direction. Now, the market has moved in this direction, which is good to know, because we're not first out of the gate. We can actually learn from others.

So in terms of this scale -- in terms of physicians, it may be easier for them to deal with a reference -- with a therapeutic set of data, rather than necessarily one, two, and three tier formularies.

So we have heard a little bit from the provider community that this would be for them an easier program. But as Dr. Sun has stated, we would want to make sure we

had really good outreach to the provides. And, in fact, we are perhaps expanding an academic detailing project would help us do that.

COMMITTEE MEMBER SLATON: Yeah, I was really referring more to the OptumRx part. And if you change that level of communication by having a different -- working with a different body, does that skew the data results that you get as opposed to having it be from the same company? Maybe that's not a -- maybe it makes no difference, but I'd like to know.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Well, actually you can design the evaluation study design I think would take care of that.

COMMITTEE MEMBER SLATON: Okay.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Because it's really about the satisfaction of the member, plus what were some of the other things, Richard on the --

DR. SUN: Adherence.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Adherence, yes. So I don't think it matters which one, or even if you have two, or even three doing it --

COMMITTEE MEMBER SLATON: Okay.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF

DONNESON: -- that adherence is really the goal, and ease of prescribing by evidence-based medicine.

COMMITTEE MEMBER SLATON: All Right. Thank you.

CHAIRPERSON FECKNER: Thank you.

Ms. Mathur

COMMITTEE MEMBER MATHUR: So I've heard your feedback that perhaps a full-scale solicitation would make it difficult for us to actually implement this for 2019, is that -- so -- but I still think it stands that there is a desire, even just -- so that we have comfort in the results, and that our members have comfort in the results to have another vendor participate, or have a role here. So I don't know what the right language is to articulate that, but I'm happy to withdraw the solicitation language, but add something that reflects that, the desire to have another vendor involved in the execution of this pilot and the monitoring and assessment of the pilot.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So just -- so then recommending that there be a subcontract relationship between Optum, because that's where our PBM contract currently is with the data -- the pharmacy data and claims data, but maybe they aren't leading the pilot. Another vendor would be the one kind of leading the information. And then we would continue to bring the results back to determine if we expand. But we'd still

only be talking about three drug classes at this time.

COMMITTEE MEMBER MATHUR: Yeah, still -- still three drug classes. I guess maybe I'll just say as a -- I don't want to be too prescriptive about what device you use to get this -- an additional vendor on board, but that it -- that their -- that -- so I guess the question is do we include -- so if the motion is to approve the reference pricing pharmaceuticals by therapeutic class program for basic health plans to be serviced by a vendor or vendors to be selected by the team, would that accomplish it? And then you know -- you've heard from the -- the feedback from the Committee. You know that that means more than just Optum. Would that -- would that be satisfactory?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Yes, Ms. Mathur.

COMMITTEE MEMBER MATHUR: Okay. So that is the motion, if my seconder is --

CHAIRPERSON FECKNER: Is that acceptable to the second?

VICE CHAIRPERSON TAYLOR: Yeah.

CHAIRPERSON FECKNER: All right. Seeing no other requests to speak. The motion being before you.

All in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries.

Thank you. Great presentation. Item 8, 2019 Health Benefits Rate. 8a is the approval of the HMO plan rates.

Ms. Little.

(Thereupon an overhead presentation was presented as follows.)

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

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

Today, we're seeking approval for the 2019 health plan rates. Joining me today is the famous/infamous Gary McCollum, our Health Actuary. Short timer.

(Laughter.)

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

It's been an exciting year. This time of year is always crazy for the rates team. But this year has been especially exciting I'm going to say with the procurement of a data warehouse vendor. The contract negotiations -- HMO contract negotiations, and of course the elimination of risk adjustment.

So risk adjustment was -- this was the first year since 2013 we haven't included that in our rates. So it was kind of a journey for us.

We had some service area changes in addition to

that. Health Net is going to be removing from Sacramento, Yolo, and Placer counties at the end of the year. Blue Shield Access+ is going to be exiting out of eight counties, San Francisco, Alameda, San Mateo, Contra Costa, Santa Clara, Sonoma, Solona -- excuse me, Sonoma, Solano, and Marin.

And you UnitedHealthcare is going to be -- is not going to be providing coverage in the Bay Area and other northern for public agencies and schools.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

Attachment 1 will show you the 2019 rates for State members. And as Liana mentioned earlier, despite all the changes, we're really pleased with the average weighted -- weighted average of 0.37. This team worked really hard, and we appreciate your patience with us in that process. We know -- we threw a lot of things at you at one time in a six-month span.

But our 2018 final premiums you'll note on these sheets had risk adjustment 2019 do not. 2019 rates for public agency members are also provided in attachment 2.

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HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

Now, I'm going to move to the PPOs, but before I do, I think Ms. Bailey-Crimmins would like to make a

comment.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Mr. Chair and members of the Committee, Liana Bailey-Crimmins. You may have heard earlier, because in many cases reserves and the Health Care Fund and -- is discussed in Finance and Admin Committee. So a lot of times they are discussing the funding, but we are establishing the policy here. So I just wanted to make sure that you're aware we do have $120 million in excess reserves for the CalPERS PPO plans.

But about half of this amount has already been earmarked to buy down the Medicare PPO plan rates and to pay administrative costs that will benefit our members.

Therefore, the PERSCare basic plan we are proposing to use almost all of the remaining -- so when you do the math, that comes down to about 62 million. So we're -- remaining of the 60 million in excess reserves to buy down PERSCare today. So I just wanted to set the record straight.

Thank you.

CHAIRPERSON FECKNER: Great. Thank you.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: So last month, the Committee requested that we bring two options for public comment on the PERS premiums.

I'm going to turn it over to Mr. McCollum to kind of walk through what those options are.

SENIOR LIFE ACTUARY McCOLLUM: Gary McCollum, CalPERS team member. Good afternoon, Mr. Chair and members of the Board.

CHAIRPERSON FECKNER: Good afternoon.

SENIOR LIFE ACTUARY McCOLLUM: I'd like to thank you for the kind words at the beginning of the meeting. I don't -- I'm not sure I deserve them, but they are appreciated. Thank you.

We're going to look real briefly at the PERSCare, PERS Choice rates, and the determination of them. We'll start with just a real quick analysis of the demographics that are in the plans. As you can see from this slide, there's about 35,000 or so PERSCare members. Their average age is 44 and a half.

On the PERS Choice, there's about 160,000, I believe -- 150,000 members. And their average age is about 40. So besides the benefit differential, which, as we know, PERSCare is a 90 percent plan pay, and PERS Choice is an 80 percent plan pay, there's also the demographic differences that play into the rate calculation.

And the removal of risk adjustment has generated rates that are calculated for each plan independently. And the result of the calculation for the PERSCare plan by itself is a fairly significant increase over last year's

risk-adjusted rates.

There is one thing that was brought up in the afternoon meeting with -- was that the stakeholders -- in the stakeholders meeting that we just had. If you look back at 2013, the PERSCare rate that was published for 2013, the year before we started risk adjustment, was $1,029.57. This proposed rate this year, if you choose to buy it down, will be 929.89. That's actually a 10 percent decrease over the last five years. So it's just something to think about.

Now, the -- if we go to the next slide.

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SENIOR LIFE ACTUARY McCOLLUM: Okay. There is the reserve account status. I'm sorry, for the PPO plans. As you can see at the end of the year, it's about 120 million that's excess. And just for information purposes, we're showing the March and the April values of the fund. And you can see that the -- that the excess actually went up for March, and then went down about nine million for April.

One of the characteristics of a PPO plan is that the members have to pay their deductible at the beginning of the year before the plan payments kick in. So it's common for the plan to show good results in the first three or four months. And I think the decrease from March

to April is an indication that the plan is starting to pick up a little more cost.

So we didn't want you to think that the fund is taking off and going to increase at this rate for the rest of the year, because there's no indication that that would happen.

So the 120 million is there, as Liana said. About half of it is still available, about 62 million. And we're proposing -- the buydown is estimated to spend between 35 and 50 million, which if it goes to the high side of 50, that would leave about $12 million left, which sounds like a lot of money. But for a plan that spends $250 million a month, 12 million doesn't go very far.

I believe that's -- that finishes my comments.

Oh, next slide, please.

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SENIOR LIFE ACTUARY McCOLLUM: Oh. Okay. So these are the two options we have for you to approve the rate without the adjusted buydown, or approve it with the adjustment. And the adjustment really smooths the increase. It's not a buydown that will cause a snapback next year. It's essentially a step-up from the current rate to -- to the full unadjusted rate.

And instead of taking the full 38 percent increase this year, the way to look at it is you're taking

20 percent of that increase this year, and you're deferring the other 18 percent until next year.

Next slide.

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SENIOR LIFE ACTUARY McCOLLUM: So there are the rate possibilities. Without the adjustment, it would be $1,071.59, which is a 38 percent increase. With the adjustment it would be 929.89, which is a 19.8 percent increase.

Next slide.

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SENIOR LIFE ACTUARY McCOLLUM: So now we go to the...

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: So we would ask, Mr. Chair, for a decision at this point in time. And then I believe we need to present to the full Board tomorrow. No sorry.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So we'll be asking for a decision on should we buy down or not. I know we wanted to open up for public comment to see if anybody had a comment. And then based on that, we will then publish based on the decision that you guys make what the final PPO rates are today.

CHAIRPERSON FECKNER: Now, we have to take this in two installments, don't we? We have to do the HMOs

first and then the PPOs, correct?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Correct.

CHAIRPERSON FECKNER: Okay. Well, first of all, I just wanted to start off by thanking staff for the deep dive and the hard work that was put into this. You can really see that a lot of work was done. And I also want to reach out and thank the plans that actually listened last month, sharpened their pencils a little bit, and came back to the table.

I just would hope in the future next year that in May we're not having this same discussion and dance, that they come to the table earlier with sharpened pencils, so that we can all really appreciate the fruits of everybody's labor. So I do have another request to speak before I go to the stakeholders.

Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you, Madam Chair. The vote that you're asking for is it just for the buydown that we just discussed or for all of the whole --

CHAIRPERSON FECKNER: Two separate votes.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Two separate votes. First for HMO and then there will be a second decision on the PPO buydown. And then the third decision is for the full PPO selection, so there will be three decisions.

COMMITTEE MEMBER JONES: Okay.

CHAIRPERSON FECKNER: Okay. So the first one is the HMO rates. And I have two requests on 8a to speak, and that's Larry Woodson and Al Darby. Please come forward and introduce yourselves for the record. I see that Mr. Woodson has requested some extra time. Let's start with three minutes, but I'll let you continue speaking if you're running close.

Again, this is on the HMO rates.

MR. WOODSON: Well, thank you, Mr. Chairman. And I realize -- I mean my comments were for both. So I guess I'll come back up for the other.

CHAIRPERSON FECKNER: Well, if you want to do them both now, you're welcome to do so.

MR. WOODSON: Thank you. Appreciate that.

Mrs. Hueg will also be commenting. I did submit written comments to the Board, which I hope you have read and considered. And I'm going to highlight a few of them, and give additional comments based on the final rates, which we just received this morning.

First, I do want to talk about the lack of transparency around the staff proposal to cease risk adjustment, and the Board's approval of that leading up to the December closed session, in which this Committee approved not risk adjusting in 2019. The staff reports

to -- in August and other times prior to that extolled the virtues of risk assessment, pointing out some liabilities as well. But the pros seemed to well outweigh the cons.

So you can understand why we're -- we were shocked to learn that it was abandoned in December in a closed session and approved without discussion at the Board of Administration meeting the following day.

We were informed that risk adjustment was being evaluated, but never that this evaluation was going to result in cancellation. There's a difference between the two.

Also, we were told that by not doing risk adjustment, 70 percent of the members would have lower cost plans, and have their -- in the lower cost plans would have their premiums go down.

And this is true. The implication though is that these members would be saving money. And I looked at the plans. And eight of the 13 plans in 2018 were completely covered by the monthly contribution rate for 10/90 members. So much of the savings -- they didn't have any out-of-pocket savings by this action. And much of the savings will go primarily to CalPERS.

We were just given the final proposed rates in the stakeholder meeting, which we appreciate getting prior to this meeting. Not a lot of time to analyze it. And

stakeholders on Thursday, we were informed by staff that they felt we would be pleased with these final rates. I can assure you we are not pleased with the final rates, and I'll explain why.

First of all, the Anthem traditional HMO plan Anthem apparently did not sharpen their pencils. It is not only higher significantly, they've increased it by $14 more per month since the preliminary rates were released. That represents $193 a month more for the single subscriber or $2,400 a year.

And I'd like to remind the Board that you approved last year Anthem traditional in some counties that never had this plan available as an -- to provide greater choice. And a number of our Butte County people that only had the PPO plans available migrated to this plan and were happy to get an HMO that funded 100 percent of non-preventive care. They're going to be shocked and very unhappy to find they're going to have to pay $2,400 more a year to retain this plan.

And then PERSCare, PERSCare basic we had the asterisk 929 figure in the May. We thought that was going to go down some. It stayed the same, or increased by a penny I think. And that will cost a single plan member $155 more a month, or $1,850 a year. It's a huge hit for the average pensioner. There's corresponding increases

for the combo plan members as well. We have to support using the excess surplus funds, which we had assumed to lower these PERSCare rates.

But we had assumed it was 120 million. We just found out today it's only 58 million. And we made two other recommendations in our written comments. We don't believe that you have the same constraints in setting rates for your self-funded plans, as for the HMO plans with the carriers.

And we encourage you to reinstitute some form of risk adjustment or adjustment among these three plans, which are your plans - you don't have to negotiate that - and make them more affordable for the basic plan member.

Rather than lowering the Select by 164 a month, which forces a much higher rate on Care members, it could decrease -- the decrease could be moderated and moderate the Care increase.

Finally, if the intent is to force members to migrate to Select or Choice, it seems like a cold-hearted tactic, and maybe it's just the result. But for those that need 90 percent coverage due to significant health problems, again they're going to be forced to consider whether they can afford 24 -- 1850 more a year or not.

Again, members in 18 counties can't get the HMO coverage, which would fund 100 percent. We believe

there's time to make additional adjustments given open enrollment does not begin still September. We urge the Board to reject the highest increases and direct staff to find other means to lower them.

Thank you for your time.

CHAIRPERSON FECKNER: Thank you.

Mr. Darby

MR. DARBY: Good afternoon, Mr. Chairman and Committee members. Al Darby, RPEA Vice President.

RPEA appreciates the work of the Committee around the 2019 rates. The overall 0.32 percent for State is very, very attractive. A small increase is -- compared to what is expected in the general market, which is supposed to be closer to double digits. RPEA agrees with all of the observations that Larry Woodson has just made. And we too urge that risk adjustment be restored to the PPO plans.

RPEA appreciates that an effort is in progress by the PHBC Committee eliminate or mitigate PPO regional pricing. The 2019 rates show L.A. basin is 30 percent -- or almost 30 percent lower than SF Bay Area. Contracting agency retirees are faced with serious increases 2019 over 2018 in some areas. Many are not in Medicare and are not Medicare age. Little or no health care allowance from their former employer is something they expect or that

something that they get.

Their pensions average 25K a year, and many don't get Social Security. So you can see that these rates regionally, if they're somehow mitigated or eliminated, regional pricing in those high-cost areas would certainly be much more attractive to these folks, and much more affordable for these facts.

Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you, Mr. Chair. Yeah, I'd just like to have staff clarify one point before we go forward. Mr. Woodson's reference to the 929 for PERSCare. And when we received that number earlier, that was in anticipation of using to drawdown -- using the reserves to reduce that figure. Because without that reduction, I thought it was like over thousand dollars. And so I just want to -- so it changed a penny or so, but it was already reduced from over a thousand dollars to this nine something number.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So in April the preliminary rates -- the true cost of a 90/10 plan is $1,070.

COMMITTEE MEMBER JONES: Right.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: And we

have approximately about 34,000 people in PERSCare. What we were recommending was using excess reserve monies to buy it down. And that buydown takes it to $929.89.

COMMITTEE MEMBER JONES: Right. Yeah. I just wanted to clarify that for Mr. Woodson, because if that anticipation wasn't there, that number would have been over $1,000, and then you would have saw a bigger drop. Okay. All right. Thank you.

CHAIRPERSON FECKNER: Thank you.

Ms. Brown.

BOARD MEMBER BROWN: Thank you, Mr. Chair.

I'd like to urge this Committee and staff to retake a look at risk adjustment among the PPO plans. I know other health plan administrators are successfully using risk adjustment. And so I don't know if we can take another look at a new way of doing risk adjustment among the PPO plans. But, you know, our retirees are really going to suffer under these new rates, especially for people who need a 90/20 plan, who are most at risk.

And so I'm hoping that we will continue to look at how we might reinstitute risk adjustment successfully like other administrators are doing around the state.

Thank you.

CHAIRPERSON FECKNER: Thank you.

So we're on Item 8a. We need to have a motion to

approve the HMO rates. What's the pleasure of the committee?

COMMITTEE MEMBER MATHUR: So moved.

VICE CHAIRPERSON TAYLOR: Second.

CHAIRPERSON FECKNER: It's been moved by Mathur, seconded by Taylor. Again, this is just the HMO portion.

Any more discussion on the motion?

Seeing none.

All in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries.

COMMITTEE MEMBER JONES: Abstain.

CHAIRPERSON FECKNER: Pardon?

COMMITTEE MEMBER JONES: Abstain.

CHAIRPERSON FECKNER: Please not Mr. Jones abstaining.

CHAIRPERSON FECKNER: That brings us to 8b, the PPO organizational rates. I do have three requests from the audience to speak.

Mr. Woodson, are -- you're done with both of those, correct?

MR. WOODSON: Yes.

CHAIRPERSON FECKNER: Thank you.

Mr. Darby?

MR. DARBY: Done.
CHAIRPERSON FECKNER: Done with both of that.
That means Ms. Hueg.
MS. HUEG: Behave boys.
CHAIRPERSON FECKNER: They left you alone, didn't they?
MS. HUEG: They did. Abandoned again.
(Laughter.)
MS. HUEG: I guess I'll use the lit one.
Hi. I'm Stephanie Hueg from California State Retirees, Executive Vice President.
Mr. Woodson has given you some documents. And I'm sure you've all taken a look at them, I hope. And that you will consider them as part of our input.
Today, in the special stakeholder briefing this morning, we were shared with the final proposed rates for the PPOs. And while they are lower, there are still options about which way to go. And we supported the options of utilizing the excess surplus funds of 120 million when it was first brought out.
What we learned today was that -- and I think I heard 62 million, but I could be wrong, instead of the 120 million to help smooth -- I don't know where the other money went, but gone -- to help lower the PERSCare rates.
While we appreciate the work staff has done to

bring down the excess increases to the members more expensive plans, caused primarily by abandonment of risk adjustment -- and I have a comment on that -- we're going to see PERS rates of $929.89 for the basic plans for PERSCare, which represents an increase of $155 a month for member, and annually $1,845 for a retiree. That's not chump change. We also strongly object to the raising of the Anthem -- Anthem's traditional rates to $193 a month more.

Approximately 40,000 members and family members are on CalPERS Care basic, and over 14,000 are retirees and their departments. Regarding the risk adjustment, staff never really publicly informed stakeholders of their recommendation to you, that it should be canceled. It was noticed in the August agenda, as a topic of discussion. It went into the closed sessions at the Committee, and recommendations came in the closed session, and then discussed in the open session during a Committee Chair Report, where it was voted on at that time, and not agendized.

So we really did not have an opportunity to give any input in that. And I don't know if that was on purpose or just a mistake.

Rate changes that affect over 100,000 members should have been openly discussed. And stakeholders input

solicited. In addition, we just learned of the end of -- the exit of Blue Shield Access+ leaving 38 counties in the Bay Area.

CHAIRPERSON FECKNER: Excuse me just eight counties.

MS. HUEG: I'm sorry?

CHAIRPERSON FECKNER: Eight counties. It went from 38 to 30.

MR. HUEG: Oh, I heard -- my problem.

CHAIRPERSON FECKNER: That's all right.

MS. HUEG: Hearing is a problem.

Health Net leaving Sacramento areas. I guess that's Sacramento, Yolo, El Dorado, correct?

CHAIRPERSON FECKNER: Yes.

MS. HUEG: Anthem Select will no longer be including United -- University of California, Davis medical units, and that UnitedHealthcare is leaving northern area. Now that was sort of like a side comment. That's a big deal.

And we'd like to see a map of the zip codes of these affected members to help them to begin the process of searching for new health care plans, and providers, and facilities. And that needs to be done like soon.

And that's my comments. Thank you.

CHAIRPERSON FECKNER: Thank you.

MS. HUEG: Any questions from anybody?

CHAIRPERSON FECKNER: I have a couple of comments, but I don't know if they're for you or not. So we'll see.

MS. HUEG: Okay.

CHAIRPERSON FECKNER: Ms. Taylor.

VICE CHAIRPERSON TAYLOR: Hi. So thank you, Stephanie for your comments. And I appreciate Al and Larry your comments as well. I think -- and I think that with the risk adjustment being done away with, I know that you've talked to the staff about it and the reasoning behind it. I was wondering though if Mr. McCollum, as one of your last acts, if you could -- if you could give us kind of a reasoning why we're looking at what we're looking at now with the -- without the risk adjustment, and how -- honestly what we're looking at is way better than, you know, we would have been looking at it, I think, with the risk adjustment.

I don't know if you can opine on that at all. I know we have some outliers, and sometimes we don't have control over that. But I think that Mr. McCollum can answer to some of that.

SENIOR LIFE ACTUARY McCOLLUM: Okay. What you're looking at is a calculation of each plan's rates based on their population as of 2018 projected into 2019.

One of the problems with risk adjustment is that it created a lot of movement between the plans from year to year. And so the plans were always struggling with their -- with their decisions on what to project. It also had to use a risk factor from 18 months ago as the basis for the risk adjustment. And if their population had changed from that 18-month factor to now, you also had that differential that came into play.

So it created a lot of uncertainty among the plans among us. It created a lot of adjustments on the back end, which nobody sees, except the plans and their subaccount balances, and us, staff members.

But what you are seeing though in these rates is an actual projection by each plan the best they could with oversight by us and opinions by us, you know, and then eventually an agreement by us that that -- that everything is okay for projecting into 2019. And that's the rate that -- that's being proposed.

VICE CHAIRPERSON TAYLOR: Right. And I think one of the things to remember is when we have some of these outlier higher rate increases without the risk adjustment, they're no longer -- they don't have the advantage of having this healthy pool risk adjust their rates down, and then the healthy pool of folks having to pay more.

So you're also stabilize -- I just think it's

important that we understand why. And then that -- you know, there's legal issues that come along with risk adjustment. So I just want to make -- this isn't a decision we made willy-nilly by any means. And no, we're not trying to punish anybody or drive anybody from one plan to the other. It's really just trying to make the plans more fair.

CHAIRPERSON FECKNER: Thank you.

Mr. Jones.

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

I just want to comment on the transparency issue, because I know I've advocated over the last several years that we need to improve transparency. And I know staff has done a good job of moving the agenda, so that transparency -- more transparency could occur. And I just think back to, you know, we started to reach out to the stakeholders to give them early information on our rates. And we even went to a couple years ago giving them a month in advance the rates that we were going to be looking at in June, so that they have an opportunity to comment on it and give input.

So I -- you know, since there's still some concerns on that issue, I would just like to ask that additional efforts be made to improve the transparency,

because I hear about the rate -- the concerns that the members raise about they felt that they weren't aware of certain actions that we had taken.

So I would just want staff to reach out again and see if we could improve that transparency. I know you've done a lot. But I just think that we just need to reach out and see if we could do even more to be sure that our members feel like they're getting the information in a timely manner.

CHAIRPERSON FECKNER: Thank you.

Mr. Lofaso.

ACTING COMMITTEE MEMBER LOFASO: Thank you, Mr. Chair. Following a little bit on Mr. Jones' comments, I think it's fair to say at this juncture that the decision on risk adjustment came as a bit of a surprise to some stakeholders.

But a question for you, Mr. McCollum, because I think you underscored a couple things in your response to Ms. Taylor that, at this juncture in time, we may be, from a rate perspective, experiencing some of the most challenging aspects of canceling risk adjustment. But some of the potential back-end settling out relative to the way plans estimate their rates, the way some member migration has been driven by risk adjustment might point in the future to some backside windfalls that might

ultimately accrue to members.

I'm wondering if you can comment on that, and I'm wondering if staff can think about how as we fully transition out of risk adjustment we might be able to communicate the full story to stakeholders.

SENIOR LIFE ACTUARY McCOLLUM: I can't really agree with the concept of a backside windfall, because I don't anticipate there being any windfall. But you -- unless you want to consider a windfall just to be a settling down of the program. We -- if you look back historically, before risk adjustment was implement, we tended to have approximately three percent or so of the population move from month to month, change plans.

And starting in 2014, and for the last five years, that has jumped up to five to six percent. And so there's been a lot more movement. And I anticipate that that type of plan movement will settle down as the rates settle down, in essence, and the plans propose their rates, their premiums that reflect their population, and there isn't this uncertainty of what risk adjustment will do from year to year.

ACTING COMMITTEE MEMBER LOFASO: Maybe there's still something left in my comment to share information with stakeholders after it settles out, but I'll go to my second issue. And I'll swing it -- swing the bat another

time on this question of migration.

I harken back to Ms. Bailey-Crimmins' opening comments about the aggregate holding down of rates in general. And it looks to me that there are a couple -- a few outlier plans with some pretty stubborn cost drivers in them.

Obviously, an answer -- an example would be Anthem traditional. I'm wondering if staff has a comment on how that these rates reflect actual cost, and there's no risk adjustment offset on the HMO side, what we might think about member migration, given some of the disparities in rates among the plans in the new environment that's going to start in 2019.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: I'll kick it off and then maybe Shari can add to it. So specifically as you're aware, Anthem offers two basic plans with us. So they offer Anthem Select, and Anthem traditional. You will see that Select has gone down. It's gone down because it -- they will no longer offer UC Davis as an offering. But traditional will be offering UC Davis. And they're expecting a migration. As the team dug into any of the outliers, which Anthem traditional was, it seems like, at least on the basic, everything else has gone done, except Blue Shield which is now six percent.

We dug into it, and based on membership, based on claims, and -- they believe it was the accurate cost. And it was not -- in this case, it was not a reflection of risk adjustment. It was just based on where they are in the market at this point.

And maybe, Shari, you can highlight a little bit more on that.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

And I would add to that, Mr. McCollum talked about migration patterns. And with Anthem in particular, they anticipate migration from one plan to the other. And they had more population in other north, as well as in the Bay Area that they didn't necessarily project for.

So the elimination of risk adjustment gives everyone a little bit more opportunity to project in the way that they would traditional, is that accurate? Is that an accurate way of saying it, traditionally versus not knowing the migration patterns from year to year, and trying to speculate on that.

So that's what I think our intent is with that. And I think some of the volatility you see is the product of eliminating that risk adjustment. You'll see every plan but two decrease this year.

ACTING COMMITTEE MEMBER LOFASO: Okay.

Just to close out on my comment, I meant to be

more broad in terms of plan choices. I still think there's another carrier in the Sacramento region that still contracts with UC Davis that someone might still be able to opt for to get to UC Davis as a provider, and get around that Anthem traditional rate increase.

And I, finally, just to load my questions for time. The last speaker made some comment about information and provider choices. I imagine that's something that you'll be focusing on on the open enrollment fairs that you talked about in the introductory comments, Ms. Bailey-Crimmins?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: That is correct. And just for members that are watching, if they are still interested in UC Davis, Blue Shield and UnitedHealthcare both offer, in addition to Anthem traditional, they will be offering UC Davis as an option for 2019.

HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE:

And the other part of your question, we did speak with stakeholders earlier today, and we are going to put together a plan of how we communicate best, so that everyone is very well aware we heard their concerns, and we will certainly work with them on that, as we make changes.

ACTING COMMITTEE MEMBER LOFASO: Thank you.

Thank you, Mr. Chairman.

CHAIRPERSON FECKNER: Thank you.

Mr. Miller.

COMMITTEE MEMBER MILLER: Yeah. Thanks very much, and happy retirement to you.

I'm relatively new. I was not here for the decision on risk adjustment, so I really won't belabor that subject.

The thing that just -- that concerns me going forward, and I think we'll have to really look at, is, you know, the disproportionate impact for the winners here versus the modest improvements on an individual basis for those who benefited from holding down the increases, which is a wonderful thing.

But for folks who are choosing, or feel that they need the higher cost options, whether it be the Anthem HMO, whether it be PERSCare, the hits to them are really big. And especially, you know, stepping in a 40 percent increase over two years, it's better than getting hit with it all at once. And I'm glad that we'll have the opportunity to do that, if we choose to.

But it's still a huge hit for the folks mostly who are going to be having to choose that plan, because they need the features of that plan, and they don't really have too many alternatives to choosing that plan.

And so I don't know if we have a short-term solution to that, but I think it's something we should all pause and think about is how do we address the needs of those folks, and not just in a vacuum, because we've also made plan changes, we've also changed the menu of choices that people may have before them who are in those plans for their needs and their reasons.

So I really think we need to -- you know, as good as we've done in the aggregate overall on these negotiations, and applaud staff for the effort, because I know that was tough, but looking at our members' needs, you know, 35,000 people is not a small number. It may be a small percentage of our members, and we really -- how do we better serve them going forward knowing that we're going to hit them with another probably 20 percent increase or more, as people migrate as they will, if they can, leaving the people who are most in need and most at risk of struggling financially, because of these hits, who are left in those plans.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Mr. Chair, I just want to point out specifically for our PPO PERS Select members the 50,000 individuals were paying more last year to subsidize PERSCare. And so they were paying -- as we look at PERS Select, they were paying last year $661. And they are now no longer doing that. So

it's about fairness. That's one of the reasons we got rid of risk adjustment is really for it to reflect the true cost. So I just wanted to make sure that people were aware that we felt that in order to make the right decision on behalf of everyone, those were types -- some of the conversations we had as a group.

CHAIRPERSON FECKNER: Thank you.

Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you.

This perhaps is my last question. And it was triggered by Mr. Miller's comment about meeting the needs of our members. And several years ago, there were requests or comments regarding the combo plans. And so I understand we made real progress in terms of that. So could you comment on that, because I know I used to get questions, why can't we have combo plans in the various plans. So if you comment on that, I'd appreciate it.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Sure. Just as a reminder to everyone. So a combo family means that someone has -- of age of Medicare, so they are Medicare. But they have potentially a younger family that are dependents. So they're a combination family. And so what we want to make sure -- and those are individuals. Those younger dependents are in basic plans.

And so when we decided to go to UnitedHealthcare

as a Medicare Advantage, it did not cover all the counties last year. We had a conversation about combo families. And as such, people that wanted an HMO offering felt like they had to go to a PPO offering, which was a higher cost to them.

So this Board decided to go ahead and allow us to do Anthem traditional to expand to all counties. Going into 2019 for combo families, the following plans are available to them:

UnitedHealthcare, Blue -- Kaiser, sorry. UnitedHealthcare, Kaiser, Anthem traditional and all three PPOs. So there are six plans options for combo families.

COMMITTEE MEMBER JONES: Okay. Thank you.

CHAIRPERSON FECKNER: Ms. Mathur.

COMMITTEE MEMBER MATHUR: Thank you.

One of the things that I think would be useful looking forward is to now that we've -- we're several years -- I think now five years into this competitive structure, where we have multiple plans -- multiple HMO plans.

I think it would be useful to do an assessment of how that competition has worked and benefited -- whether with it's benefited our members what the results have been.

And also, we could -- as part of that, we could

look at whether -- with the -- how the experience has manifested in terms of sicker populations and healthier population, and how that's sort of spread across the various plans. I think that might a be useful component of the analysis to bring back at a later date.

Thank you.

CHAIRPERSON FECKNER: Great. Thank you.

Seeing no other requests to speak, we do have a couple of motions we have to put forward. The first one I believe is whether or not to use the excess to buy down the rates, correct?

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Yes.

CHAIRPERSON FECKNER: All right. What's the pleasure of the Committee?

VICE CHAIRPERSON TAYLOR: So moved.

COMMITTEE MEMBER MATHUR: Second.

CHAIRPERSON FECKNER: Moved by Taylor, seconded by Mathur.

Any discussion on the motion?

Seeing none. All in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries.

Now, we need a motion to approve the PPO rates for 2019.

VICE CHAIRPERSON TAYLOR: So moved.
CHAIRPERSON FECKNER: Moved by Taylor.
Is there a second?
COMMITTEE MEMBER MATHUR: Second.
CHAIRPERSON FECKNER: Seconded by Mathur.
Any discussion on the motion?
Seeing none.
All in favor say aye?
(Ayes.)
CHAIRPERSON FECKNER: Opposed, no?
Motion carries.
Please show Mr. Jones and Mr. Miller abstaining.
All right. Seeing no other requests to speak on Item 9 -- I mean, Item 8, we move to Item 9, State Annuitant Contribution Formula. Ms. Little.
HEALTH POLICY RESEARCH DIVISION CHIEF LITTLE: Thank you, Mr. Chair.
I think Mr. McCollum is going to finish out his work here by talking about this. We're really putting him to work at the end. Yes.
SENIOR LIFE ACTUARY McCOLLUM: Gary McCollum. I think it's appropriate actually that I finish with an agenda item that talks about retired annuitant contribution rates.
(Laughter.)

SENIOR LIFE ACTUARY McCOLLUM: So this is the retired annuitant contribution rates. Do we have slides for this?

Okay. You will be receiving or the agenda item has the 100/90 formula which is the same as in years past. But this year, there's an additional formula that comes into play. And that is under Government Code section 22871.3, which was added to PEMHCA a few years ago. It creates a new retiree formula that's called an 80/80 formula.

This will be used for all new hires starting in 2016 or 2017, depending on which bargaining unit they belong to. And it will be based -- it will be an 80 percent of the premium covered for the subscriber and 80 percent for the dependents. And it will be based on the four largest Medicare plans. And for this first year, the four largest Medicare plans are Kaiser, United, PERSCare and PERS Choice.

Now, we're bringing this forward this year, even though it's only available to members who are hired in 2016 or '17, because there have been a small number of people who have gone out on a disability retirement hired in 2016 or 2017, and so they fall under this category. So we needed to publish that and have it made available.

This group, since they just started, will grow

very slowly until about 2031 when they will become their normal retirement age. And after that time, the 80/80 formula will grow significantly, and the 100/90 formula will correspondingly decrease, as the members in that formula depart.

So that's my presentation, if there are any questions?

CHAIRPERSON FECKNER: Seeing none. Thank you very much. An easy one for your last one, right?

That brings us to Item 10, Summary of Committee Direction. Ms. Bailey-Crimmins.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: I have two. The first in relation to conversations about risk adjustment. What we will be doing is looking at ways to improve our processes on transparency. So we will be adding that as an item for us to look for. And then the second is an assessment of the effect of competition. Has it given us the outcomes we thought we wanted, and then decide if there needs to be changes moving forward.

CHAIRPERSON FECKNER: All right. Very good.

Seeing nothing else on the agenda, anybody wish to have public comment that has not spoken yet?

Seeing none. Thank you all for your attendance. This meeting is adjourned.

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(Thereupon the California Public Employees' Retirement System, Board of Administration, Pension & Health Benefits Committee closed session meeting adjourned at 2:27 p.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 June, 2018.

JAMES F. PETERS, CSR
Certified Shorthand Reporter
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