MEETING

STATE OF CALIFORNIA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

BOARD OF ADMINISTRATION

PENSION & HEALTH BENEFITS COMMITTEE

OPEN SESSION

CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM

FECKNER AUDITORIUM

LINCOLN PLAZA NORTH

400 P STREET

SACRAMENTO, CALIFORNIA

TUESDAY, JUNE 17, 2025

8:30 A.M.

JAMES F. PETERS, CSR
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APPEARANCES

COMMITTEE MEMBERS:

Ramón Rubalcava, Chair

Kevin Palkki, Vice Chair

Malia Cohen, also represented by Deborah Gallegos

David Miller

Eraina Ortega, also represented by Nicole Griffith

Jose Luis Pacheco

Theresa Taylor

Yvonne Walker

Mullissa Willette

BOARD MEMBERS:

Michael Detoy

Fiona Ma, represented by Frank Ruffino

Dr. Gail Willis(Remote)

STAFF:

Marcie Frost, Chief Executive Officer

Matthew Jacobs, General Counsel

Kim Malm, Deputy Executive Officer

Donald Moulds, PhD, Chief Health Director

Rob Jarzombek, Chief, Health Plan Research & Administration

Julia Logan, MD, Chief Clinical Director

APPEARANCES CONTINUED

STAFF:

Jared Shinabery, Chief Health Data Strategy Officer

ALSO PRESENT:

Terry Battenburg

Margarita Brown

Catherine DeLou, Tahoe City Public Utilities District

Michael Friedman

J.J. Jelincic, Retired Public Employees Association

Brynnen Lopez, Truckee Sanitary District

Dolores Ridgeway

C.T. Weber

Larry Woodson, California State Retirees

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PROCEEDINGS

CHAIR RUBALCAVA: Good morning, everybody. We're going to begin the Pension and Health Benefits Committee. And the first order of business is roll call, please.

BOARD CLERK ANDERSON: Ramón Rubalcava.

CHAIR RUBALCAVA: Present.

BOARD CLERK ANDERSON: Kevin Palkki

VICE CHAIR PALKKI: Good morning.

BOARD CLERK ANDERSON: Malia Cohen.

David Miller.

COMMITTEE MEMBER MILLER: Here.

BOARD CLERK ANDERSON: Eraina Ortega.

COMMITTEE MEMBER ORTEGA: Here.

BOARD CLERK ANDERSON: Jose Luis Pacheco.

COMMITTEE MEMBER PACHECO: Present.

BOARD CLERK ANDERSON: Theresa Taylor.

COMMITTEE MEMBER TAYLOR: Here.

BOARD CLERK ANDERSON: Yvonne Walker.

COMMITTEE MEMBER WALKER: Here.

BOARD CLERK ANDERSON: Mullissa Willette.

COMMITTEE MEMBER WILLETTE: Here.

CHAIR RUBALCAVA: Thank you. And before we go into closed session, I believe Don Moulds has an announcement.

CHIEF HEALTH DIRECTOR MOULDS: Thank you, Mr.

Chair. I just wanted to remind stakeholders in the room that immediately upon adjournment of closed session, we will be convening in Room 1140 to provide the stakeholder update that we do annually. So we're slated to run about an hour and half here. I think hour an half to two hours is probably more realistic, so we will be convening there sometime between 10 and 10:30, but upon adjournment.

CHAIR RUBALCAVA: Thank you, Mr. Moulds.

After that announcement, we will now recess into closed session for items 1 through 4 from the closed session agenda. We will reconvene in open session after the Risk and Audit Committee.

Thank you, everybody.

(Off record: 8:32 a.m.)

(Thereupon the meeting recessed into closed session.)

(Thereupon the meeting reconvened open session.)

(On record: 11:34 a.m.)

CHAIR RUBALCAVA: Good morning, everybody. We're back in open session of the Pension and Health Benefits Committee. And we'll continue with the remainder of the open session agenda.

Please call the roll.

BOARD CLERK ANDERSON: Ramón Rubalcava

CHAIR RUBALCAVA: Present.
BOARD CLERK ANDERSON: Kevin Palkki.
VICE CHAIR PALKKI: Good morning.
BOARD CLERK ANDERSON: Malia Cohen
COMMITTEE MEMBER COHEN: Present.
BOARD CLERK ANDERSON: David Miller.
COMMITTEE MEMBER MILLER: Here.
BOARD CLERK ANDERSON: Nicole Griffith for Eraina Ortega.
ACTING COMMITTEE MEMBER GRIFFITH: Here.
BOARD CLERK ANDERSON: Jose Luis Pacheco.
COMMITTEE MEMBER PACHECO: Present.
BOARD CLERK ANDERSON: Theresa Taylor.
COMMITTEE MEMBER TAYLOR: Here.
BOARD CLERK ANDERSON: Yvonne Walker.
COMMITTEE MEMBER WALKER: Here.
BOARD CLERK ANDERSON: Mullissa Willette.
COMMITTEE MEMBER WILLETTE: Here.
CHAIR RUBALCAVA: Thank you. We're also going to have to do the attestation for people who are -- or Board members who are work -- are remotely -- attending remotely.
So let me read the statement. Good morning, Board members. We've just transitioned into open session. Since we are not all present in the same room like we

usually are, I will -- I must remind you that this is a -- oh, this is the wrong one. Sorry. My mistake.

Thank you. We'll start again. Sorry about that, folks. Good morning, Board members, because we are not all present in the same room and Board members are participating from Remote locations that not access -- that are not accessible to the public, Bagley-Keene requires that remote Board members to make certain disclosures about any other persons present with them during open session. Accordingly, the Board members participating remotely must each attest whether, one, they are alone, or two, if there are one or more persons present with them who are at least 18 years old and the nature of the Board's relationship to each other. At this time, I will ask Dr. Willis to verbally attest accordingly. Please --

BOARD MEMBER WILLIS: Yes.

CHAIR RUBALCAVA: Yes. Thank you, Dr. Willis. And for the record, we also have Frank Ruffino here, Michael Detoy. And who's not a member. I think that's it, right? Yvonne is a member. That's it. Thank you very much.

So now, we'll proceed and we'll start -- I want to correct something I said earlier. We're not -- we are going to proceed with the agenda, but we're just going to

take the infor -- consent items and then go into one action item, which is the long-term care third-party administrator award of contract, and then we'll break for lunch.

And the information items, which is the PBM contract recommendation, and the preliminary 2026 premiums for the HMOs and the PPO will be after lunch.

Okay. Let's start with executive report, Mr. Moulds and Kim Malm, please.

DEPUTY EXECUTIVE OFFICER MALM: Good morning. Kim Malm, CalPERS team. Today, I wanted to give you a few updates that impact our members that are going on right now in the Customer Services Support Branch.

First, I want to provide you an update to our benefit verification process. As you may recall, I mentioned from my March update that we kicked off the 2025 benefits verification cycle. The process is now conducted annually to prevent overpayments due to unreported member deaths. In March, we sent over 10,000 letters to retirees that met certain risk thresholds, which includes age, benefit amount, the last time they made contact with CalPERS, and the last time they saw their health care providers.

In April, we sent a second reminder, if we had not heard back from those members from the first letter.

At the end of May, we sent a third reminder letting members know that we'll be holding their August 1st warrant, if we have not received their verification before roll closes in July.

From this effort, over 270 deaths were reported across California and 32 other states. Those unreported deaths resulted in over $2.3 million of overpayments and we have collected over 1.3, or 57 percent, so far. The benefit verification project continues to be a very important tool, as we continue to try and reduce overpayments.

Also, another tool that we continue to find significant value in is the utilization of Socure as our death verification vendor. To date, they have reported over 500 deaths and resulting in over $5.2 million of overpayments. We've collected over $4 million of those overpayments in the last two years, or 80 percent.

As I mentioned in March, we also sent a file to Cedar Financial, the collections firm we contracted with to assist in recovering large debt. They have begun their preliminary work of $2.3 million of collections that we've sent them.

I'm happy to see that these efforts are continuing to reduce death overpayments and improve our collections process.

Now, I'd like to move to cover a new Spanish class offering. In 2024, we implemented a class on planning your retirement basics in Spanish. The feedback was positive. The video is now available on our CalPERS YouTube channel. In addition, a week from today, on June 24th, we'll be presenting a new Spanish class offering, *Basics of Your Retirement Application and Beyond*. Currently, there are 75 attendees registered so far.

I'll close with an update on our CalPERS Benefit Education Events. Since our last meeting in March, we concluded our second in-person CBEE of 2025 in Burbank on April 11th and 12th with 913 attendees. We just concluded our latest virtual CBEE last week on June 11th and 12th with over 2,000 attendees.

Our next CBEE is virtual. It's scheduled for August 13th and 14th and registration will open in mid-July. And then the planned CBEEs for next year in 2026 are: Monterey, January 9th and 10th; Anaheim, April 10th and 11th; and, Redding June 5th and 6th of 2026.

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

CHAIR RUBALCAVA: Thank you, Ms. Malm. Any questions or comments from the trustees?

Okay. We'll start with Trustee Pacheco.

COMMITTEE MEMBER PACHECO: Yes. Thank you, Ms.

Malm for you question. I just want to ask a question about the video on the Spanish video.

DEPUTY EXECUTIVE OFFICER MALM: Um-hmm.

COMMITTEE MEMBER PACHECO: How many -- how -- when did they -- when did they come out and how many views has it had on the unique views, do you know?

DEPUTY EXECUTIVE OFFICER MALM: That's an amazing question. I probably have the answer to every other question about that that you have, like where to find it.

(Laughter).

DEPUTY EXECUTIVE OFFICER MALM: And how many people took the class. I do not know how many views, but I will find out that formation.

COMMITTEE MEMBER PACHECO: Oh, that will be perfect. No. I just -- I just think it's a great idea about the number of persons that are watching it and how it's -- how it's being perceived. Thank you so much.

DEPUTY EXECUTIVE OFFICER MALM: You got it. Thank you so much.

CHAIR RUBALCAVA: Thank you.

Trustee Palkki, Vice Chair -- Committee Vice Chair.

Whoops. Hold on.

VICE CHAIR PALKKI: Thank you, Mr. Chair. Thank you so much. I've received numerous phone calls and

emails through the school employees and really just how much they truly appreciate the bilingual capabilities that have been pushed through. They're really excited about the website, so thank you for all that work that you and your team have really put to in -- put the work into to make sure that our members have the access that make them feel comfortable in receiving the information.

So thank you for that.

DEPUTY EXECUTIVE OFFICER MALM: Thank you. I can't take credit for the website. That would be IT and Public Affairs, but I will for the classes that David's team has developed. So thank you so much.

CHAIR RUBALCAVA: Well, thank you.

Mr. Don Moulds.

CHIEF HEALTH DIRECTOR MOULDS: Great. Thank you, Mr. Chair. We have three very meaty items today, so I'm going to keep my remarks short. Primarily, I want to update you and those listening of two provider terminations we've been following, both of which have had the potential to cause disruption for our members.

The first was a dispute over terms between Hoag Health Systems in Orange County and Blue Shield of California. Hoag had issued a termination notice to Blue Shield, which would have gone into effect on June 30th, but which was extended out two weeks to mid-July. Over

the weekend, we learned that Hoag and Blue Shield have come to terms, and Hoag has subsequently repealed its termination. This is very good news for the 1,200 or so CalPERS members who would have been affected.

CHAIR RUBALCAVA: Very good news. Thank you.

CHIEF HEALTH DIRECTOR MOULDS: Yeah. The other update is on the potential contract termination between Blue Shield of California and the University of California Health System. The current contract between Blue Shield and UC health expires on June 30th. And earlier in the spring, UC Health noticed Blue Shield of their intent to terminate the contract unless there were significant changes to its terms.

Roughly, 10 days ago, UC Health reached out to Blue Shield to extend the termination date to July 9th. The good news is that leadership between the two organizations is meeting regularly to try to negotiate a deal. The bad news is that they are still very far apart. I'll remind the Board and those listening that the vast majority of these disputes reach resolution. And when parties do get to termination, it is typically short lived. I don't want to sugarcoat this one though. The impasse between the two parties is significant. And even with the short extension of the termination date, they are -- they are running out of time. At this point, I

have to say that it is -- that the possibility of a lapse in the contract is very real.

If there is a lapse, it would affect all of the University of California health systems, which includes UC Davis, UC San Francisco, UCLA, UC Riverside, UC Irvine, and UC San Diego. It would also affect roughly 20,000 Blue Shield Access+ CalPERS HMO members and 15,000 CalPERS PPO members.

Letters informing HMO members of the potential contract termination were sent out in early May, in accordance with the Department of Managed Health Care regulations. Letters to PPO members who accessed UC Health hospitals in the last year would go out closer to the termination date.

I'll remind you and our members that the termination would only impact CalPERS Basic members. Medicare members will still have access to all UC doctors and facilities.

We're in regular communication with both UC Health and Blue Shield leadership on this one, and we'll report back with any updates. We're also using multiple communication channels to keep all of our members informed. In addition, we're meeting regularly with Blue Shield and Included Health to ensure that they, along with the CalPERS team, are well prepared to assist impacted

members. This includes counseling members on their continuity of care protections, which are significant under California law, or assisting them to find alternatives in-network provides during a lapse.

That concludes my remarks. Happy to answer questions.

CHAIR RUBALCAVA: Thank you, Mr. Moulds. Any questions, trustees?

I do not see any questions, so let's -- thank you for your comments, and now --

DEPUTY EXECUTIVE OFFICER MALM: Can I follow up with one --

CHAIR RUBALCAVA: Yes, please.

DEPUTY EXECUTIVE OFFICER MALM: -- answer. So thank you to Brad Pacheco for this answer, but the video was posted about year ago, and there's been 2,800 views, Director Pacheco. So I just wanted to make sure I answered that question. Thank you.

CHAIR RUBALCAVA: Thank you for that information.

Now, we have the action consent items.

COMMITTEE MEMBER MILLER: Move approval.

VICE CHAIR PALKKI: Second.

CHAIR RUBALCAVA: Move approval, second by -- moved approval by Mr. David Miller and seconded by Trustee Kevin Palkki.

And do we have a consensus?

Do we need to call the roll?

Consensus.

(Ayes.)

CHAIR RUBALCAVA: We have -- the ayes have it.

Okay. Thank you, everybody. Thank you, David.

And now, we go to the information consent items.

Oh, any -- okay. We asked for the ayes.

Any nays?

Yes. We already did the attestation.

BOARD CLERK ANDERSON: She's not on the Committee.

COMMITTEE MEMBER TAYLOR: She's not on the Committee. Okay.

CHAIR RUBALCAVA: Any abstentions?

Okay. The ayes have it. So the action consent items, 3a and 3b, are approved.

Now go -- we'll -- next item is 4a and b the information consent items. Do we have consensus there.

Yes.

The Controller speaks for all, so we have con -- oh, nobody was pulled -- nothing was pulled, so now we move to Item 5a, which is the action agenda item that a lot of us are looking forward to, so which is the request for proposal on the long-term care third-party

administrator, TPA. And I believe we're -- yes, Don Moulds and Jared Shinabery.

CHIEF HEALTH DIRECTOR MOULDS: Yeah, and I'll just turn it over directly to the Jared.

CHAIR RUBALCAVA: Jared, please proceed.

(Slide presentation).

CHIEF HEALTH DATA STRATEGY OFFICER SHINABERY:

Good morning, Mr. Chair and members of the Committee. Jared Shinabery, CalPERS team member. Today, I'll be presenting on Item 5a seeking your approval on the intent to award a five-year contractor for the long-term care third-party administrator, for TPA.

[SLIDE CHANGE]

CHIEF HEALTH DATA STRATEGY OFFICER SHINABERY: In August 2024, we issued a request for proposal, or RFP, for the next five-year TPA contract. This process allowed us had to explore new opportunities in the industry that could provide greater benefits to CalPERS and our policyholders.

And we approached the RFP with four primary objectives: Lowering the overall cost of the program to ensure long-term financial sustainability, enhancing customer service and technological innovation, including advancements in data and analytics, fraud detection, and electronic visit verification; securing more favorable

contractual terms, including modifying how administrative services fees are collected -- or calculated; and ensuring that CalPERS partners with a TPA that has proven that they can administer a long-term care program the size of CalPERS with our roughly 77,000 policyholders.

[SLIDE CHANGE]

CHIEF HEALTH DATA STRATEGY OFFICER SHINABERY: We received proposals from three prospective TPAs, illumifin, our incumbent administrator since the program's inception in 1995, CHCS Services, better known as Wellcove, and Davies Life and Health.

[SLIDE CHANGE]

CHIEF HEALTH DATA STRATEGY OFFICER SHINABERY:

All three met the minimum qualifications and moved to -- onto phase two of the RFP late last year, which involved the submission of technical and fee proposals. And all three also moved to the finalist interview phase in February.

TPAs are scored on the -- on the strength of their technical proposals, their fee proposals, and their interview. After a thorough evaluation, illumifin emerged as the bidder with the highest total points and advanced to contract negotiations. I'd like to walk you through the key factors that led to illumifin advancing to that final stage.

[SLIDE CHANGE]

CHIEF HEALTH DATA STRATEGY OFFICER SHINABERY: When considering the experience of the three TPAs, there are some clear differences with illumifin standing out as the largest long-term care TPA in the nation with over 1.9 million long-term care policies and over 50 insurers, including the top 10 carries in the U.S.

While Wellcove and Davies also demonstrated respectable experience in client bases, illumifin's size and track record provided added confidence in their ability to manage CalPERS book of business.

In terms of their technological and claims oversight capabilities, all three present -- all three presented platforms with the technological advancements that we were speaking. For example, all three supported electronic visit verification, which is a mobile app that ensures at-home care visits by independent providers occur as scheduled while recording the exact time, location, and duration of the services provided. This technology reduces the risk of billing errors and fraud.

Similarly, all three use advanced tools for detecting fraud, waste, and abuse leveraging AI to enhance oversight. However, illumifin was the only bidder with in-house software for both electronic visit verification and fraud detection, eliminating reliance on

subcontractors for these critical services.

In terms of the data and analytics platforms, illumifin proposed upgrading CalPERS to their Snowflake platform, which represents a significant enhancement over our current system. That said, Wellcove and Davies also offered strong data platforms.

Overall, we were impressed by the technical proposals from all three TPAs and we felt confident that any of them could be a capable partner for CalPERS with illumifin having an edge.

[SLIDE CHANGE]

CHIEF HEALTH DATA STRATEGY OFFICER SHINABERY: We did see substantial differences in the fee proposals. Administrative service fees are calculated on a per member per month basis with different rates for members who are on claim that is actively receiving long-term care services versus those who are not on claim.

To evaluate the proposals, we projected costs over the life of the five-year contract, including any transition costs. Illumifin submitted a fee proposal with the lowest overall costs, Wellcove was a close second, and Davies was not competitive on fees.

[SLIDE CHANGE]

CHIEF HEALTH DATA STRATEGY OFFICER SHINABERY: We included a table to illustrate how the fees compare.

Illumifin fees amounted to about $14.9 million in savings over the life of the contract, which is a 23 percent discount compared to our current agreement. Wellcove's fees would have saved 13.1 million, making them a close second. Davies fees on the other hand would have cost 7.5 million more than staying with our current contract.

[SLIDE CHANGE]

CHIEF HEALTH DATA STRATEGY OFFICER SHINABERY:

Illumifin advanced to the contract negotiations in February, as the bidder with the highest number of total points, as I just mentioned. And I'm pleased to report that these negotiations are now complete and we've achieved several key wins for CalPERS and our policyholders. We negotiated a drop in fees from illumifin's initial bid. In addition to that, we requested to start the contract prior to the original January 2027 start date, since a new contractual -- the new contract has better terms. Illumifin agreed to a July 1st, 2026 start date, which amounts to nearly $2 million in additional savings.

When combining these outcomes, we project total savings to the program of 16.8 million. This represents a 25 percent discount compared to our current contract.

[SLIDE CHANGE]

CHIEF HEALTH DATA STRATEGY OFFICER SHINABERY: We

recommend that you approve Item 5a to issue an intent to award a five-year contract to illumifin to serve as the CalPERS TPA for its long-term care insurance program with and effective date of July 1st, 2026 through June 30, 2031. With illumifin, CalPERS will benefit from substantial cost savings, more favorable contractual terms, and enhanced technological capabilities, including improvements in data management and access.

Thank you for your time. I'm happy to take any questions or comments.

CHAIR RUBALCAVA: Thank you, Jared. Any questions from the Committee?

I do not see any, but I do want to thank you.

Oh, yes, President Taylor has a question, please.

COMMITTEE MEMBER TAYLOR: So thank you guys. Not -- I -- and I really appreciate the report. I actually don't have a question. I want to congratulate you guys on this contract. This was a really good win for us, especially on our long-term care. So hard work. I imagine you did really well getting through our RFPs and came out with, it looks like, the best savings that we could possibly get. So thank you very much for your hard work. Thanks.

CHIEF HEALTH DATA STRATEGY OFFICER SHINABERY: Thank you.

CHAIR RUBALCAVA: Thank you, President Taylor. We do have public comment. So Ms. Margaret Brown, please. Margarita Brown. Margarite Brown, excuse me.

MARGARITA BROWN: No relation to Margaret Brown.

I just had two questions. One is what is the split in enrollees between on claim and off claim?

CHAIR RUBALCAVA: You have three minutes. Just go ahead and make your statements and we can find the information, we'll try to see if we can get it to you.

MARGARITA BROWN: Okay. I would appreciate hearing back on that.

And the second is I would like to know what the impact is on our premiums of this savings. It's great that the savings is occurring, but we've been having large increases. We are scheduled for another increase on January 1st. So what is the impact to us of this change on our premiums?

CHAIR RUBALCAVA: We thank you for your comments and we'll take them. I'm sure the staff will take them into consideration, as we move forward.

COMMITTEE MEMBER COHEN: I do have a question for staff.

CHAIR RUBALCAVA: Controller Cohen, please.

COMMITTEE MEMBER COHEN: Thank you.

CHAIR RUBALCAVA: Whoops. Hold on.

COMMITTEE MEMBER COHEN: Perhaps you said it in your presentation, but was the premiums in the presentation?

CHAIR RUBALCAVA: No.

CHIEF HEALTH DATA STRATEGY OFFICER SHINABERY: No. This presentation was just about the selection of the TPA and not about the premiums.

COMMITTEE MEMBER COHEN: Okay. Thank you for the clarification. And so where we will we get that information? Is it on the website? Is it somewhere public?

CHIEF HEALTH DATA STRATEGY OFFICER SHINABERY: Are you interested in information about like what the current premium rates are and things?

COMMITTEE MEMBER COHEN: Yes, the current and then this -- with this new proposal that we're considering, or that will be in effect July on 1st of 2026. What's that cost differential is what I'm interested in.

CHIEF HEALTH DATA STRATEGY OFFICER SHINABERY: Yeah. So this won't -- this won't impact premiums. So the savings that are -- that we'll achieve through this, should the Board approve, ultimately will feed into the sustainability -- improve the sustainability of the Long-Term Care Fund. So it would essentially help

ensure that the premiums are more stable over time. It lessens the likelihood that we'll need future rate increases.

COMMITTEE MEMBER COHEN: So there's no cost benefit for the members.

CHIEF HEALTH DIRECTOR MOULDS: There is a cost benefit. It's the net dollar amount. It will translate into lower premiums over time. We could certainly -- we can certainly project those out and give you a rough estimate about what they would look like in future years.

COMMITTEE MEMBER COHEN: When you were doing the evaluation of the contract, did you -- did you -- did you cost that out?

CHIEF HEALTH DIRECTOR MOULDS: So to premium, no, because what we're looking -- the more savings, the -- we know that more savings is better. We didn't calculate the exact translation. It becomes a tricky calculation, because it's -- as Jared mentioned, it's relative to future premium, so it's all a projection. But again, we can -- we can certainly -- we can certainly project that out. Overall, it is a 23 percent reduction in our administrative fees over the course of the next five years, which, from our perspective, is a -- is a tremendous win.

COMMITTEE MEMBER COHEN: Yes, I agree it is a

tremendous win for the -- in the reduced administration -- administrative fees, but I just want to make sure that we're not reducing our fees and then producing more fees for the plan member.

CHIEF HEALTH DIRECTOR MOULDS: We would -- it would -- it would -- it will translate in -- it would be a dollar for dollar change in the overall premium to members going into the future. There's --

COMMITTEE MEMBER COHEN: Thank you very much. Thank you for answering that.

CHAIR RUBALCAVA: Thank you, Controller Cohen.

I do want to follow our President and talk -- congratulate you, Jared and Don for very good work. We have significant savings. And ensuring that there's a start date July 1 instead of January 1 is a big savings there too. And that's -- I commend you for that contract and everything else, the stronger contract terms. And, of course, as you stated, it improves the sustainability of the plan going forward in the long term, and that's what we're interested in. We want to get the services. I believe we have a motion from Vice Chair.

Oh, sorry.

VICE CHAIR PALKKI: Get it on the record. Yeah. So I'd like to motion that we approve the intent to award a five-year contract to illumifin to serve as California

Public Employees' Retirement System, CalPERS, third-party administrator for the -- for its Long-Term Care Insurance Program with the effective date of July 1st, 2026 through June 30th, 2031 with the caveat the final negotiations and satisfaction of all requirements.

COMMITTEE MEMBER MILLER: I'll second that.

CHAIR RUBALCAVA: And Mr. David Miller seconds. So now, we'll call the roll, please.

BOARD CLERK ANDERSON: Kevin Palkki?

VICE CHAIR PALKKI: Aye.

BOARD CLERK ANDERSON: Malia Cohen?

COMMITTEE MEMBER COHEN: Aye.

BOARD CLERK ANDERSON: David Miller?

COMMITTEE MEMBER MILLER: Aye.

BOARD CLERK ANDERSON: Nicole Griffith?

ACTING COMMITTEE MEMBER GRIFFITH: Aye.

BOARD CLERK ANDERSON: Jose Luis Pacheco?

COMMITTEE MEMBER PACHECO: Aye.

BOARD CLERK ANDERSON: Theresa Taylor?

COMMITTEE MEMBER TAYLOR: Aye.

BOARD CLERK ANDERSON: Yvonne Walker?

COMMITTEE MEMBER WALKER: Aye.

BOARD CLERK ANDERSON: Mullissa Willette?

COMMITTEE MEMBER WILLETTE: Yes.

CHAIR RUBALCAVA: Thank you. So the ayes have

it. The motion is adopted and we have -- we have awarded the contract to the incumbent. And good luck in moving forward with the implementation. And thank you, everybody, for your patience.

We will adjourn right now for lunch and for 45 minutes. We'll return at 12:45 and we'll continue with the rest of the agenda, which are the information items on the 2026 preliminary HMO premiums for health plans and the status of the PBM pharmacy benefit contract.

Thank you, everybody.

(Off record: 12:02 p.m.)

(Thereupon a lunch break was taken.)

(On record: 12:47 p.m.)

CHAIR RUBALCAVA: Good afternoon, everybody. We're reconvening the meeting; of the Pension and Health Benefits Committee. We're at Item 6, informational agenda tells. And the first item is preliminary 2026 health maintenance organization and preferred provider organization plan premiums with Don Moulds and Rob Jarzombek

(Slide presentation).

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Good afternoon, Mr. Chair and members of the Committee. Rob Jarzombek CalPERS team member.

This is an information item to update you on the

preliminary 2026 premiums for CalPERS Basic and Medicare plans. As a reminder, the health plan renewal strategy is an annual process, where the CalPERS team engages with the health plans and negotiates rates for our members.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: In this presentation, we will cover several items. We'll begin with a timeline for the rate development process, which we refer to as RDP. We'll provide a quick refresher on how we set premiums and talk through the waited averages. We'll then cover some general observations about the Basic and Medicare plans before walking through the individual plan details.

Finally, we will end with next steps.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: I'll start with the timeline. In November, you approved service area expansions for Kaiser Permanente and UnitedHealthcare's Harmony for 2026. Next month, we will present the proposed final premiums for your adoption at the Board off-site.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Let's briefly go over what makes up a premium and the process we use to determine what the

premium should be. This information might be well understood by some, but we want to walk through it again so everyone has the same foundation going into the presentation.

The premium can be broken down into three components, medical, pharmacy and administration. Medical is that cost of medical services provided. This includes inpatient, outpatient and professional services. Pharmacy represents the cost of outpatient prescription drugs filled at a local pharmacy or through mail order. And administration is the health plan's administrative fee and CalPERS administrative expenses.

To get the total per member per month, or PMPM, rate, we add the medical, pharmacy, and administration components together. Once we have that rate, we convert this to a premium by applying a family factor that takes into account the number of dependents in each health plan. We apply a family factor, because young adults -- I'm sorry, young dependents typically incur lower medical costs than adults. This changes the PMPM rate to a per subscriber per month or PSPM premium. This is the premium we'll be walking through today and discharged to members and employers.

Several years ago, we greatly improved how we set health premiums to enhance transparency with the plan's

proposed rate and improve our negotiating position. We use claims from the data warehouse along with financial information to create a baseline projection for each Basic plan. We then compare it with the plan's proposed rate. We require the plans to submit their proposal in specific categories using a standard methodology, so that we can conduct an apples to apples comparison to our projections. We also require them to submit an actuarial attestation of their proposals. Further, we engage an independent actuarial consulting firm to conduct a third-party verification and review.

Our approach using standardized methodology allows CalPERS to drill into significantly more detail with the plans to understand what's driving trends at the plan level. Finally, we risk adjust premiums for the Basic plans. We do not risk adjust the Medicare plans as this is done by CMS through their own process. Risk adjustment of the Basic plans allows us to price plans based on the value of their benefit design and network, rather than on the concentration of healthy or unhealthy lives in the plan.

This pushes the plans to compete on cost -- on the cost and quality of care, instead of on their ability to attract younger and healthier members. As you know, last year, the Board approved the full transition from two

risk pools, one for HMOs and one for PPOs, to a single risk pool for all Basic plans. This was necessary to stabilize the PPOs and is now in effect for 2025.

The last item on this slide is how we set premiums for public agencies and schools, as there is an extra step to that process. We start with the State premium calculated for the State of California and California State University members. Despite the fact that the -- that there are State employees in every county, the State, as an employer, uses the same pay scale, classifications, and benefit structure for everyone. Therefore, they use the same premiums regardless of where State employees reside.

We have three pricing regions for our contracting agencies, one in Northern California, and two in Southern California. Today, we're sharing the preliminary premiums for these regions in an attachment to this agenda item.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Now, let's take a look at the preliminary premiums, percent changes, and weighted averages.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: I'll start with the Basic plans.

Overall, the premium trends for CalPERS Basic plans are in line with California industry trends. This is based on a comparison of the trends applied to each component of the premiums against industry trends. For 2026 Basic -- for the 2026 Basic HMO premiums, the average increase is six and a half percent. For the Basic PPO premiums, the weighted average is about 12 percent.

As I shared earlier, CalPERS premiums have three components, medical, pharmacy, and administrative fees. CalPERS medical claim costs are in line with California trends. We evaluate each carrier's medical claim cost trends against our own, as well as in the context of large group rate filings with the Department of Managed Health Care. Our pharmacy trends are high, but in line with national and California specific pharmacy trends. Trends are very high for diabetes treatments and injectables for chronic, inflammatory conditions, for CalPERS and the rest of the industry.

CalPERS administrative fee trends are lower than industry trends. Since CalPERS has long-term contracts, our admin cost increases are shielded from cost pressures other plans face with respect to administrative costs. The other wildcard that can have a big impact on premium trends from plan to plan is recent claims experience. If the prior year's rate increase underestimated claims, this

year's rate increase would be larger than otherwise. Because of unusual claims Patterns we had recently, these source of fluctuations have had a larger impact in the past few years than they did historically. However, the good news is that outsized fluctuations seem to have settled as of this year.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Moving on to Medicare. Last year, the CMA changes to subsidies significantly impacted some plan premiums. Now, that the initial impact has been realized, some challenges and uncertainties of CM -- of the CMS changes still exist.

Our Medicare Advantage premiums have an average increase of just over seven percent. For context, in general, CalPERS Medicare premium trends are higher than industry trends for a couple reasons. The first reason is that CalPERS benefits are typically more comprehensive than many in the commercial and Medicare markets, which evidence tells us is critical to achieving good health outcomes. Medicare Advantage plans in the individual market tend to reduce benefit richness or covered benefits in order to be able to maintain low premiums.

The second reason is that CMS pays for most of -- most of the claims cost for Medicare members, so changes

in CMA revenue can be a material trend driver, which is the -- which is the case for both the medical and pharmacy components of the premium.

Now, for the Medicare Supplement plans. They have an average increase of about 13 and two-thirds percent. This is driven by the Inflation Reduction Act and increased utilization of medical services.

When we wrap things up and we put the Medicare Advantage and med sup plans together, the more efficient Medicare Advantage plans, Kaiser and Sharp, have an average increase of four percent. And the less efficient MA plan in the Medicare Supplemental plans have an average increase of 12 percent. This is a nearly eight point difference that is largely due to the change in CMS payments.

I mention this, so that Medicare members know they have lower cost options, if they prefer to not be in a higher cost and higher trending Medicare plan.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: This slide shows everything rolled up with the weighted average changes for each plan type. As a reminder, last year's Basic HMO premiums included an upward adjustment associated with the full transition to one risk pool and the Basic PPO premiums included a

downward adjustment. When compared to last year's rate increases without these adjustments, the 2026 HMO increase is similar to last year, and the 2026 PPO increase is lower than last year. Overall, we are seeing a 1.3 percent improvement on the rate increase for the total Basic program.

For Medicare, we are also seeing improvements this year with increases that are roughly half of what was experienced last year. CalPERS overall premium increase at this point is 8.21 percent, a 2.6 improvement -- percent improvement from last year.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Before we look at the individual plan slides, we'd like to talk about two key decisions impacting two of our lower cost narrow network plans. This is Blue Shield's Trio plan in Monterey County and UnitedHealthcare's Harmony expansion for 2026.

As background, part of CalPERS strategy to increase competition and bring lower cost options to members is to add new narrow network plans to our offerings and expand them to less competitive areas throughout California. This strategy has been in effect for several years and has had positive results on our program. These positive results are in the form of lower

monthly premiums for members who have enrolled in these plans and increased competition that forces the plans to compete on cost and quality. We have been thoughtful about where these new plans are introduced, as well as where we push them to expand. Each new offering and expansion, as you know, is brought to this Committee and to the Board to make the ultimate decision whether or not to move forward.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Trio is a high performance narrow network plan that is start -- that started with CalPERS in 2020 in six counties. It has expanded its footprint over the past few years to 21 counties to bring a low cost alternative to more of our members.

Trio entered Monterey in 2023 as a lower cost plan and now has about 30 percent of the Monterey membership. Medical costs in Monterey are about 40 percent higher than Trio's statewide average, which contributes an additional six percent to Trio's premium for 2026.

As we know and have discussed before, the high cost in Monterey County have been of increasing concern for many years, including leading up to this year's RDP. Our larger health plans in Monterey are better able to

absorb these high costs due to their large plan size. This is not the case for Trio. Besides the potential enrollment growth in Monterey, Blue Shield also projects that the high Trio premium increases would lead to membership losses in lower cost counties, further driving Trio's premiums up to the Access+ level in the next two to three years. All of this raises a concern about Trio's long term sustainability.

To address this issue, we recommend replacing Trio with Access+ in Monterey County. Access+ is better poised to absorb the cost of Monterey as it can spread those costs out over a much larger population. By exiting Monterey, Trio's statewide premium would improve by six percent while Access+ would experience a much smaller impact of less than a one percent increase to its premium.

Blue Shield is seeking the Department of Managed Health Care's approval for Access+'s entry to Monterey and the preliminary conversations have been productive. We'll walk through some of the details.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: This slide shows the pros and cons for changing the Blue Shield health plan offering in Monterey County. If we keep Trio in Monterey, for the short-term, there will be no disruption to the 6,000 members who are

currently enrolled. But in the long run, with the potential enrollment growth, the high Monterey costs will cause Trio's premiums to exceed that of Access+. This would effectively remove a low cost option for members and make Trio non-viable for our portfolio.

While replacing Trio with Access+ benefits, the non-Monterey Trio members, and is key to it's long-term sustainability, it does introduce premium increases for the Current Trio members in Monterey.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Here is a look at the likely plan choices public agency Trio members would make in Monterey, along with the premium impacts, as most of CalPERS members in the Monterey County come from a public agency or school. The range for these members would be from a negative -- actual premium decrease of about one percent to an increase of 13 and three-quarters percent.

I'll pause here to see if there are any questions?

CHAIR RUBALCAVA: I don't see any questions, so please continue.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Now, let's talk about UHC's Harmony

expansion for 2026. Harmony is a lower cost narrow network plan and started with CalPERS in 2022 in Southern California. In 2024 and 2025, UHC honored their commitment to expand Harmony into Northern California in areas where lower cost plans weren't prevalent while continuing to provide competitive pricing.

With, these service area expansions and continued good pricing, Harmony's membership increased nearly 60 percent in the early years and 40 percent last year. These figures were higher than projected and have caused additional uncertainty and premium volatility, which is typical when a plan grows this quickly.

Specifically, membership in Santa Cruz County increased from 200 members in 2024 to 1,200 members in 2025, a dramatic 500 percent increase. This is impactful as Santa Cruz is the second highest cost county in California and is driving costs for them statewide, much like Monterey is driving Trio's costs.

In November, the Board approved Harmony to further expand to four Northern California counties in 2026. Those counties are El Dorado, Nevada, Placer, and San Joaquin.

UHC is proposing to postpone Harmony's four county expansion for one year to give them time to stabilize from its rapid membership growth. We recommend

approving their proposal to delay their expansion so that they can stay a long-term, low-cost option for CalPERS and our members.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Now, let's go on to -- let's go through the individual plan slides, starting with the Basic HMOs.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: First is Anthem Select. This table shows the 2025 and the proposed 2026 premiums before and after risk adjustment with a total increase of about seven percent from 2025. The cost driver chart on the right shows the changes between 2025 and 2026 for each component of the premium.

The first bar is "Medical" cost and these changes contribute about a five percent increase to the premium.

The next bar is "Pharmacy" and changes this coming year contribute a four percent impact to the premium.

The third bar is labeled "Other" and includes overall changes on the administrative costs, both the plans and CalPERS. It also includes changes in the family mix of a plan's enrollment.

The fourth bar is changes in the "Risk

Mitigation", which has about a negative two percent impact. This bar shows in the negative, as it is less than what Anthem Select contributed to risk adjustment last year.

And a reminder regarding the risk scores, plans with a risk score of greater than one, with one being the average, have sicker than -- sicker lives and their premium is lowered with the impact of risk adjustment. Plans with risk scores of less than one have healthier lives and will see risk adjustment increase their premium. Also, risk scores fluctuate year to year and is a cost driver, regardless if it is an increase or a decrease. Risk scores do not main the same one year to the next.

Anthem Select has a risk score of less than one. It's in the table at 0.9565, meaning that the plan has healthier than average members in the Basic portfolio. Therefore, their 2026 premium is increased. That amount is shown in the table to the left in the fourth column. Again, the bar shows the negative, as it is less than what Anthem Select contributed to risk adjustment last year. So for setting the 2026 rate, these members have become sicker than they were last year, therefore, you see a negative bar. Adding this all together the light green bar shows an overall 6.78 percent increase?

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
CHIEF JARZOMBEK: Let's now look at Anthem traditional. This is a broad network -- broad network plan offered at many high-cost, low-competition areas of the state. Anthem Traditional is a plan that we have had concerns about its long-term sustainability in our program. We continue to closely monitor this plan to ensure it remains a viable product for CalPERS and our members. Trio's premium increase is close to five percent for next year

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
CHIEF JARZOMBEK: Now, to Blue Shield Access+. The top table shows the Access+ premium, if there are no changes to its service area, meaning that it would not go into Monterey County. The premium -- preliminary premium increase is about 12 percent. The bottom table shows the Access+ with a $7 higher premium to include Monterey County for 2026, which would be a 12.77 percent increase. As stated earlier, given the much larger membership, Access+ is able to absorb Monterey's costs much better.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION
CHIEF JARZOMBEK: Moving to Trio, the top table shows the 2026 premium if there were no changes to its service area, therefore so -- meaning remaining in Monterey County.

This would be a nine percent increase. The bottom table shows what Trio's premium would be if we excluded Monterey County for 2026, and this would be a three percent increase.

With this smaller plan size, the impacts on Monterey are much more significant to Trio than to Access+. The cost driver chart on the right shows the breakdown of the premium impacts by component, noting that the program change bar shows about a six percent downward adjustment for committing Monterey.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Health Net Salud y Más is a narrow network plan that provides services in six Southern California counties as well as in Mexico. Their proposed 2026 premium increase is just under four and three-quarters percent. Medical contributed about seven percent of the premium increase. Salud y Más continues to be our lowest plan -- lowest premium plan in our Basic program thanks to it's low cost narrow network and Southern California service area.

Their membership has been growing and members are starting to use more expensive providers. Pharmacy contributed about is 1.7 percent to the increase. And risk mitigation helped decrease their premium by 3.8

percent. Salud y Más had an average annual medical cost increase of seven percent since 2019, driven by the increased number of members with chronic conditions. The increase in medical costs resulted in a higher risk score, and therefore the plan received a downward risk adjustment impact in 2026 compared to 2025. However, despite the increased risk score, Salud y Más remains a very competitive and sustainable plan for CalPERS and our members.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Next is Kaiser Permanente. And they are the largest health plan in our portfolio, making up about half of the total basic membership. As you know, Kaiser is continuing to pursue expanding to additional zip codes in Monterey County, but has shared that they are not able to commit to expanding their coverage are by January of next year. This is driven by their continued negotiations in securing the necessary hospital contracts to do so. That said, Kaiser is committed to expanding in Monterey County and is regularly engaging to finish this important effort. We will keep you informed of their progress.

Kaiser's rate increase for 2026 is five percent. With the primary driver being medical costs and secondary driver pharmacy. Their population got slightly sicker

compared to last year, which is reflected in the negative risk adjustment bar. So for 2026, they are paying less into risk adjustment than they did in 2025.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Sharp's preliminary 2026 premium increase is five and a half percent. Medical accounts for more than four percent of the increase, and the pharmacy contributes almost three percent. The premium increase is offset by risk adjustment changes of one and two-thirds, as they got slightly sicker this past year.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Turning to UHC Alliance, the premium increase is mainly due to medical and pharmacy trends contributing to the nine percent increase.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: This slide shows UHC Harmony's premiums with and without the service area expansion. Both scenarios show a double digit premium increase from 2025. The top table shows Harmony premiums with just over a 12 percent increase without the four county northern -- the four county expansion in Northern California.

The bottom table shows Harmony premiums with the

expansion and about a 19 percent increase from 2025. The high premium increase is mainly caused by growing membership from the previous Northern California expansions. Again, as I mentioned, in particular, Santa Cruz County. All of these expansions have led to higher medical costs. These contributed to about seven percent of the premium increase.

In attracting healthier members, which lowers their overall member health risk, has resulted in a roughly five percent increase from risk adjustment. Given the high premium increases Harmony is facing, we recommend pausing their expansion for one year to allow UHC time to stabilize from its rapid membership growth.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Rounding out the HMO plans is Western Health Advantage. Medical, pharmacy, and risk mitigation each contributed about two percent to its premium increase, which is about six percent for next year.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Now, let's move on to the Basic PPO plans.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

CHIEF JARZOMBEK: As I mentioned previously, the transition to one risk pool last year has positively impacted the Basic PPOs. Specifically, the full transition to a single risk pool has helped moderate the 2025 PPO rate increase and slowed the decline in PPO membership. 2025's open enrollment migration came in better than expected with a total PPO membership decreasing by only three percent compared to the five percent reduction we projected.

The overall rate increase is projected approximately 12 percent and aligns with our previous forecasts.

In 2024, PERS Platinum experienced a higher-than-expected medical trend, largely driven by losing healthier members. In contrast, PERS Gold reported a more favorable medical trend. Overall, the total medical trend for the Basic PPOs remains within expectations.

Pharmacy costs continue to exceed projections for the second year. High pharmacy trend is driven by both increased utilization and rising unit cost, particularly in specialty and brand name drugs. In 2024, the unit cost for specialty drugs rose by over 20 percent, largely due to higher costs for oncology care and treatments for common chronic conditions.

Currently, specialty and brand name drugs account for over 90 percent of the total pharmacy cost. The PPO rate projection includes a four and five percent premium surcharge, which is the same as last year and that is to replenish the Health Care Fund. Finally, given differences between Blue Shield's and Anthem's provider discounts, some upward adjustment has been accounted for in the numbers before you. As more claims and utilization data becomes available, we will continue to refine our numbers and we'll update you in July with the final projection, with the hope that these numbers could see modest improvements next month.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Here are the 2026 preliminary Basic premiums. As you can see, there is still variation in the price points. PERS Platinum is now the highest cost plan in our portfolio surpassing Kaiser's out-of-state plan. The only other move is between Harmony and Sharp with Harmony becoming more expensive by $4.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Next, are the Medicare plans.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

CHIEF JARZOMBEK: So before we go into individual Medicare plan slides, I'd like to discuss some of the key issues impacting them. Many of the topics this year are continuations of last year's discussion.

First, we are experiencing increased utilization of medical services by Medicare members. This is something not unique to CalPERS and is impacting our Medicare Supplemental Premiums more than the Medicare Advantage premiums.

Next, are impacts from the Inflation Reduction Act. Last year, we talked about the changes the IRA has brought to CMS subsidies and it is a similar story this year. The subsidy changes impact CalPERS plans differently, and amongst our plans, we continue to have both winners and losers. Here are some of those details.

Plans that have integrated systems or have fewer members on high cost drugs are benefiting from the changes by receiving higher subsidy payments. This is intended to reward those plans that have more effective care management when it comes to providing pharmacy benefits.

Kaiser and Sharp are examples of plans that have efficient care management of their members, as well as fewer members on high cost drugs, as they have a greater usage of generics over brand drugs. As a result, we are seeing Kaiser and Sharp benefit from these changes and

both plans have low single digit premium increases this year.

Conversely, plans that are less efficient in their management of prescription drugs or have more members on high-cost drugs are receiving lower subsidy payments. All other Medicare Advantage plans, as well as our own Medicare Supplemental plan -- plans are examples here. Again, these plans are seeing high single digit or double digit rated increases this year.

As a reminder, the timing of one of the subsidies complicates our rate-setting process. CMS will announce the change in subsidies in late July again this year, which created -- which creates a timing issue to project the 2026 costs as we finalize our premiums mid-July.

To ensure that CalPERS is not hurt by this timing, we have gotten all plans to agree to reconcile any misestimations of their subsidies in their premium setting just as we did last year. I would like to publicly thank Kaiser, Blue Shield, and UHC for their continued partnership on this important item.

Another item I'd like to mention is something you are likely familiar with which are the CMS negotiated drugs. Starting in 2026, the prices of 10 drugs in the Medicare market have been negotiated by CMS. The list price of these drugs will go down significantly from their

2025 levels, but so will their rebates received. The net cost to CalPERS and others pay -- and other payors not known, but the expectation is that the net prices to CalPERS will be similar. This negotiated drug program was really intended to help Medicare beneficiaries who had high out-of-pocket costs, such as a 25 percent co-insurance. Unfortunately, even though it seems like this should be a cost savings to us, it's not actually expected to produce savings for plans like CalPERS.

The final topic on the high increases in CMS revenue -- the final topic is on high increases in CMS revenue few Medicare plans for 2026. This has been reported recently in the news. It is true that the average increase nationwide is about nine percent, much higher than in recent years. However, there are a few factors working against our plans.

First, the average growth rate in California is lower, and second, CMS has changed the rules around star ratings and these changes for 2026 have generally lowered the average star ratings, therefore lowering CMS revenue, and third, risk score model revisions are in -- are in effect for the calendar year 2026, are also applying downward pressure on CNS -- CMS revenue.

When we put all of this together, the increase in CMS revenue in California is not keeping pace with the

increase in cost to provide benefits. CMS revenue that does not fully offset rising costs will tend to result in higher premium trends for CalPERS.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Now, on to the Medicare Advantage plans.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Anthem's proposed preliminary premium is about a 17 percent increase from last year. More than half of the premium increase is due to pharmacy costs.

Blue Shield's nationwide Medicare Advantage plan started with CalPERS in 2022 with roughly 600 members. In just three years, it has grown to roughly 9,900 members. Most of the members in this plan are those who turned 65 and newly enrolled into Medicare. CMS payments are generally lower for the new Medicare members due to the lack of previous experience. This led to the high premium increase for Blue Shield.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Kaiser Senior Advantage is proposing a four percent increase. Kaiser is showing a medical increase of 24 percent and a decrease of 20 percent for pharmacy. The decrease in pharmacy, as we've been

discussing, are mainly due to in -- the increase in CMS subsidies based on the IRA changes.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Kaiser's Senior Advantage Summit plan was a new plan with CalPERS in 2023. It's preliminary premium is about a four and a half percent increase.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Sharp is proposing about a seven percent increase from last year. This product was introduced in 2021 and now has about 600 members this year compared to last year at about 400. The main cost drivers are medical at five percent and pharmacy at one and a half percent.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: UHC's Group Medicare Advantage Plan is a nationwide plan. UHC is proposing about a nine percent increase from last year. Close to four percent -- I'm sorry. Close to five percent of the premium increase is contributed by medical and four percent by pharmacy costs.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Next is our Medicare Supplemental plans.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: The overall rate increase for 2026 is projected at 13 and two-thirds percent. The key drivers for the current year's increase include an increase in the average age. So in the past few years, our population has -- was previously 74 years of age, and thousand it's 75 and a half years. Also, recent increased utilization in the past several years has increased about four percent when compared to previous years. The number of high-cost claimants has tripled since 2021, and this has contributed an estimated two percent increase in unit costs.

And lastly pharmacy. Similar to Basic PPO plans, we continue to observe rising utilization and unit costs in both specialty and brand name drugs, which significantly increases the total cost of care.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: This slide shows the 2026 proposed preliminary premiums for the Medicare plans.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: And for next steps, we continue negotiations with the plans and we are sharing the preliminary premiums with the Legislature, Department of Finance, and others, as required by statute. We will

present the final premiums to the Board in July for their approval.

This concludes the presentation and we're happy to take any questions.

CHAIR RUBALCAVA: Thank you, Rob. Now, we'll take questions from the Committee members.

No questions.

I just want to thank you for another great year of contract negotiating with the carriers. I know it wasn't -- every year is different, but -- we do have questions? Oh, I'm sorry. We do have now -- okay. Now, we have -- I'll let everybody speak first and I'll concluding remarks. We'll start with Mr. Frank Ruf -- Trustee -- Mr. Ruffino.

ACTING BOARD MEMBER RUFFINO: Mr. Chair, I can wait until the rest of the Board.

CHAIR RUBALCAVA: Okay. We'll start with President Taylor.

COMMITTEE MEMBER TAYLOR: So, yeah. Thank you, Chair Rubalcava. I just wanted to thank everybody for the work on this. I know we worked really hard. You guys worked really hard to get the costs down to the best of our ability. It's better -- it's better than last year, so this is a good thing. And you made some hard decisions with the Monterey and the Access+, and Harmony, and, you

though, staying their growth, but I think this will be better for our members in the long run. So we appreciate your hard work on this. So thank you very much.

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

CHAIR RUBALCAVA: Thank you, President Taylor.

Trustee David Miller, please.

COMMITTEE MEMBER MILLER: Yeah. I would echo President Taylor's comments. I just appreciate the work of all the team. I know this is, you know, really gritty work to be doing with. It's grueling. It can be very frustrating. And I also recognize for our members and stakeholders that, you know, seeing these increases as good as they are in a relative sense, and knowing how much work we put in and -- but it's still -- it's painfully expensive. And it just -- and I'm just hoping that, you know, as we do incrementally better, and we get better and better at negotiating and getting under the hood with these guys, that in the future, you know, we can be part of the solution on a -- on a larger scale, because even these kind of increases are just not sustainable in the long run for our members. It's just -- especially for our retirees.

And let alone, you know, I just think about the rest of the country for folks who don't have, you know, a

pension and a health care package like our members do, it's all part of a bigger picture where these health care costs and pharmaceutical costs are. Just -- I just don't see an end to that. And so, that's my rant for the day.

But I definitely appreciate the work of the team, and I think we're doing better and better, but it's still a real uphill battle. So I don't know. We'll see.

CHAIR RUBALCAVA: Thank you, Trustee Miller. We'll go to Trustee Jose Luis Pacheco.

COMMITTEE MEMBER PACHECO: Thank you. I also want to echo the same sentiment of your hard work and so forth in putting together these premiums. I just wanted to go back to the Monterey County slide, page 11 of 40. You mentioned that if we replaced the Trio with the access. It's going to be about 3,000 folks. Is that -- are those mostly single family? I'm just -- I wanted know.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: I don't have the breakdown between single and family. The 3,000 -- the 3,000 number -- actually, the 2,800 from public agency and school members, and then there's 3,400 State members, so a combined total of 6,000 --

COMMITTEE MEMBER PACHECO: Six thousand.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

CHIEF JARZOMBEK: -- members in Trio in Monterey County.

COMMITTEE MEMBER PACHECO: And would going from Trio to access, would they still be able to have access to the same hospital network and so forth?

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Yeah.

COMMITTEE MEMBER PACHECO: They won't -- there won't be -- they'll be continuity of care?

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: So the -- as we understand it, and this is what Blue Shield is working with the DMHC on, is just taking their current Trio network and what is their in Monterey in turning it into the Access+ network. So there wouldn't be any changes to the network with the potential to have maybe some additions to it. But for -- as what we understand it, it would just be converting what is there today into the Access+ plan.

COMMITTEE MEMBER PACHECO: And if there are any persons that are in like specialized services and so forth, and let's say -- let's say the Access didn't have it, but Trio had it, there will be some provision to -- you'll be -- still be able to have some continuity of care?

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Yes, Absolutely. What is our

understanding, and Blue Shield is working hard, so that there is no reduction in the network that is there for Monterey.

COMMITTEE MEMBER PACHECO: There's no reduction. Okay. Very good then.

CHIEF HEALTH DIRECTOR MOULDS: With one important qualifier here, which is -- which is that there is always the possibility that the network over time could be negotiated, but those -- the negotiate -- any changes would essentially be the same, were they to happen under Trio or Access+. So I don't want to -- I don't want to suggest that changes couldn't happen. The reason changes would happen would be efforts -- related to efforts to bring down costs in Monterey County. Any changes would be -- would be -- any changes on the HMO side would be overseen and require approval by the Department of Managed Health Care. So the time and distance standards that are part of California law would be in effect, the, you know, number of specialists, and primary care et cetera, all of that would be identical.

We typically use a very similar lens when we're looking at potential changes to the PPO. So I'm not -- I'm not foreshadowing any changes per se. I'm mostly just wanting to be crystal clear that they're always possible. They would be -- they would equally possible under Trio or

under Access+.

COMMITTEE MEMBER PACHECO: Well, thank you very much. As a -- as a resident that was -- that was born in Watsonville, I can attest how important that is. So thank you for your comments and I appreciate everything you've done. Thank you. That's all.

CHAIR RUBALCAVA: Thank you.

We'll go with Trustee Palkki, please.

VICE CHAIR PALKKI: Thank you, Mr. Chair. I just want to, first, thank you for all the work that you guys are putting into this. I do want to echo my colleagues' comments. I've been fortunate enough to travel to some other states and seeing that individuals that live in these other states have to literally drive to another state to get the care that they need tells me that there's a much bigger issue, and not just in California, but in the states, as a whole, as a nation. And I hope that being CalPERS we can utilize our voice at a much bigger platform to sort of as a society figure out how we can best serve everyone, when it comes to health benefits and taking care of our health and things of that sort.

So, again, thank you for everything you do. And anything we can do to utilize our voice at a much bigger platform, please do so. Thanks.

CHAIR RUBALCAVA: Thank you. We'll go to

Delegate Frank Ruffino, please.

ACTING BOARD MEMBER RUFFINO: Thank you, Mr. Chairman. You know, there is a well known saying that I think we all know, and we have heard, quote, "Nothing is certain except death and taxes." And that was attributed to Benjamin Franklin, by the way, way back in 1789. I think it might be appropriate to update that to today's standard. And it should, "Death, taxes, and health care premium increases."

(Laughter).

ACTING BOARD MEMBER RUFFINO: So, given that the premiums are projected to increase for both the employer -- employers and employees, the question is how are equity and affordability being weighted, particularly for lower income workers and retirees on fixed income?

CHIEF HEALTH DIRECTOR MOULDS: So, both important but big topics. Equity, as you know, is one of the four pillars of health care. It is one of our strategic objectives and something that we take incredibly seriously. We have -- I'm not going to go into all of the details of the health equity efforts that we've been making, because they are numerous, but it is absolutely critical that all of our members have access to high quality affordable health care, regardless of who they are, full stop. And that is something that we are -- we

are committed to and will continue to be committed to for the long haul.

So, Dr. Logan, periodically provides updates on the various pillars of that and the initiatives underway. We could talk for an hour about them right now. We're not going to, but just know that that commitment is there. Access is a challenge for a bunch of different reasons. One, as you rightly pointed out, is that there is a connection between cost and access. So one of the things that we know is that when costs go up, for people, their access tends to get compromised. That can be because of premiums, but it is more often because of cost sharing.

And so one of the things that we have endeavored to do here is to make sure that as we look to make health care premiums more affordable, that we do not do that by pushing overs indirectly back onto members. So there's a whole bunch of evidence out there that suggests that when you do that, people skip care that they need and they get sicker.

They -- conditions that are manageable or preventable are not well managed, are not prevented. And not only does that cause costs later on down the -- down the road, but it also just -- it gets in the way of what we're trying to do here, which is keep our members healthy. So that has always been a pillar of CalPERS

health care. It's wildly important. It's something personally that I've worked to ensure everywhere I've gone for most of my career. And it's critical to the way we think about this problem.

It limits the quick fixes that a lot of other large purchasers use to bring premiums down, but it is very shortsighted. I will also add that one of the things that's really special about CalPERS is that our members - and the health policy nerd term is - are extraordinarily sticky. What does that mean? It means that people who have CalPERS insurance tend to be on CalPERS insurance for a very, very long time. We have so many members who are born into CalPERS, and die in CalPERS, not because they die prematurely, but because they have retiree health care for the duration of their life. So those bets on long-term investments in health care are more beneficial to CalPERS than a lot of employers in the -- in the open market who have a connection to an employee for two or three years. So those are the -- those are a few of the ways we think about it.

Again, it limits the short-term moves that we can make to keep premiums lower, but we believe and evidence bears out that those are investments that are well worth making for the long haul.

ACTING BOARD MEMBER RUFFINO: And thank you, Mr.

Moulds, for your eloquent response. And I think although some of us will take for granted what you said, I think it was important for all of us in the room, and those who are watching, particularly, you know, our retirees who are on fixed income. You know, they hear exactly what you said, that still CalPERS does not take this lightly. And it's on the forefront every time we have to do this every year.

I want to ask you another question and I'm not necessarily looking for an answer, but I want to sort of think about it, reflect on this, on whether or not we have any specific innovations or reforms. Is CalPERS looking at pursuing or even exploring in the future to control health care costs growth beyond the annual rate negotiations that we do?

So like I said, I know -- you may -- please comment on it, but I'd like us to somehow -- and I also recognize that this is not unique just to us. This is a national dilemma, you know, the health care industry, and perhaps even internationally. You know, so I don't expect quick fix, but we -- we need to reflect on it. What can we do? And I think we should not let it -- leave it out to just to luck so to speak.

CHIEF HEALTH DIRECTOR MOULDS: Do you want an answer or --

(Laughter).

ACTING BOARD MEMBER RUFFINO: Please, if you have an answer. I'll definitely take an answer.

CHIEF HEALTH DIRECTOR MOULDS: I mean, again, I don't -- I don't want to give you a dissertation back. We have another -- a number of initiatives that have been underway now for some time that have shown progress, but have -- none of which have been silver bullets. One is addressing uncompetitive areas in California. So, you know, I've talked in the past about the fact that we pay about a 35 percent premium for health care in the north and we pay twice for our most expensive counties than we do in our least -- in our most efficient counties. None of that has to do with the quality of the medicine that our members are receiving. It is the same. If there's any relation, it is sometimes inversely related.

That has everything to do with the competitive environment and lack of competitive environment in some of these high cost areas. So when we talk about places like Monterey, like Santa Barbara, like Santa Cruz now, those high costs have to do with dysfunctional markets. We have been -- we have been working to try to add dress some of those anti- -- the anti-competitive nature of those markets. We work occasionally with the Attorney General's office to address some of that. We are looking increasingly at secondary ways of addressing that,

moving -- creating incentives to move members from high-cost sites of care within a county to lower cost sites of care that are at least clinically equivalent and often clinically superior alternatives. There's a lot of evidence suggesting, for example, that a lot of procedures when done outside of the hospital not only are much cheaper, but you get better outcomes.

We are looking increasingly at how we're thinking about primary care and its role. We are very interested, and Dr. Logan has spoken eloquently about this, we are looking at ways of increasing both the supply of primary care, the primacy of primary care in our offerings, and using it to drive better outcomes and lower costs.

I am, as you know, an ex officio member of the Health Care Affordability Board in California, which earlier this year set a premium -- sorry, health spending growth targets at ultimately three percent of -- of total cost. That's -- there are enforcement mechanisms there, so we are hopeful that we will see some savings there, when those are fully in effect. We have added financial alignments in all of the contracts that we have negotiated over the last couple of years. And, as Dr. Logan will talk about, we are hopeful that we will see them in our PBM relationship in the -- in the upcoming contract.

That creates a scenario where plans are rewarded

for keeping costs low and financially punished for not doing so. You would think that that would be standard issue. It is not. It is the rarity. It basically doesn't exist in the PPO market.

So all of those are tools that we are using to try to keep health care costs down. The challenge is that the underlying trend is in the wrong direction in the country and in California. And that is going to continue to put pressure in the opposite direction. We're going to be seeing massive changes at the federal level, in my view not for the better, for health care. There will, in all likelihood, be significant cuts to numerous public health programs, Covered California, the enhanced subsidies for members, Medicaid, et cetera. That will all have ripple effects through the commercial market.

So there's a lot going on in this space. We are doing what we can. We can always do better and we try to do better every day. It is a big task.

ACTING BOARD MEMBER RUFFINO: Thank you again.

CHAIR RUBALCAVA: Thank you.

ACTING BOARD MEMBER RUFFINO: Thank you again, Don. Am I on?

Just one final comment, Mr. Chair. Thank you, again, Don, for what you just said. And I am -- and I agree with you, those initiatives and some of them, you

know, should become our -- maybe some talking points, you know, to -- and don't take this as criticism in any shape or form, but we cannot rest -- we need to talk about these initiatives. We need to talk more and more and repeatedly, because you and I, we're in this business that we sort of know, we hear it, but the average person out there doesn't really know. And I challenge also the leadership of the various organizations who are here present in this room, and we're listening, you know, to take account of these issues and call CalPERS communication office, get the talking points. So that it's your chapter meetings. It's your gathering with your membership. Educate them on what's going on, what CalPERS is doing.

CalPERS is truly working really, really hard day after day during these negotiations. And although, you know, predecessor over here, you know, they're talking about sharpening the pencils. You can only sharpen so much until we breaks it, and we cannot keep that pencil going on our own.

So anyhow, I just want to thank you for your effort. And I want -- not withstanding all these comments, thank you for the great negotiation skills and the great job you guys have done.

Thank you, Mr. Chair and Don for allowing to

editorialize for a minute or two.

CHAIR RUBALCAVA: Thank you, Frank Ruffino.

Trustee Walker, please.

COMMITTEE MEMBER WALKER: Thank you. I just want to say that until I become a Board member, I didn't fully appreciate all the work that went into the setting -- getting the premiums, the negotiations, really setting up a plan to make sure that quality care is at the forefront of what we're doing. You know, when I first started in State Service, I remembered when they used to lower premiums by increasing our copays, right? And you made a decision we're not going to do that anymore. That's not who we are. That's not what we're going to do.

But I think that you guys do an outstanding job with the cards you are dealt. But I think fundamentally in our country, we have got to come to the decision that health care is a right. Like, we're playing around with insurance. We're not playing around with care. Like I think -- and we tend to not have those conversations. And I think we need to. I don't think it's going to change in the next four years, but, you know, the ground swell should start again some, because we do need to have the conversation about access to care, not insurance. And that access to care is a right. No matter where you live, no matter what your status is, health care should be a

right for all of us. And that should be the demand that we make as citizens, because until we do that, even with the exemplary work that you all are doing, right, you know, that is just playing around the edges.

And so, if we are serious about changing, you know, and really making an impact on health care, we will be having very different conversations and doing very different things.

CHAIR RUBALCAVA: Thank you, Board members, for your insightful comments, and thank you, staff, for all the work you do.

I wasn't going to speak much, but after Frank and Yvonne, I think we should acknowledge that CalPERS has different tools that most people -- most employers don't or more plan sponsors don't. I mean, we have a big database of information, because we have 1.5 million members and beneficiaries. And that information is used to our benefit. Whenever there's an issue -- proposal submitted, we have -- we do -- we have like our test premium that we can compare with them, the carriers. And we ask them, when they submit, to be -- act -- they have to do an actuarial attestation signed by an actuary, not an underwriter. And there's -- it's a complexity thing.

We heard Don speak earlier today about the contract terminations between insurance carriers and the

providers. That's a reality in this system, United States that we have to deal with. But one thing I think I want people to understand I think it was sort of alluded in other states in other locations, you know, plan design is very different, access is very different. We have a very rich plan here and we have Dr. Logan and others who are trying to improve on the outcomes or trying to link the primary care physician with a mental health -- the comor -- comor -- I cannot pronounce that word, but whenever there is more than one disease prevalent.

And we want to -- we want to understand what are the disease prevalent in our members, so we can attack those, those chronic diseases. And we try to do the value design. We want to give people incentive to see their primary care physician, to go to the -- to follow -- to be compliant with their medical instructions.

And so there's many things that have been mentioned and like the financial alignments that we got last year. I mean, that's -- in the HMOs. People -- we are -- staff has put -- made the carriers put money at risk. I try other experiences with other plan sponsors. They don't have the -- I don't want to say strength or the staff manpower to get those concessions. So I know this is a challenge. I know this is a burden. The price -- let's be clear, the premium is a burden on the employee,

and the member, on CalPERS, and on the employer. And it's a real challenge, but we going forward, and I comment, and thank our professional staff.

I talk too much, so we're going to our public comment.

Larry Woodson. I thought you retired.

(Laughter).

CHAIR RUBALCAVA: You know what I meant.

COMMITTEE MEMBER MILLER: It's good to see you.

LARRY WOODSON: I think I remember how to do this. Am I on?

CHAIR RUBALCAVA: Yes, you are. You have three minutes.

LARRY WOODSON: Okay. So Good afternoon. Larry Woodson, California State Retirees. Chairman Rubalcava and Board members, I thank you for the opportunity to comment. I also thank staff, the Health team, and Stakeholder Relations for holding the special stakeholders meeting for us. It gave us the opportunity to see the preliminary rates prior to coming into this meeting. There wasn't a lot of time to digest, but I o have a few comments.

First, it does seem like there's good news and bad news. Overall, the increases seem to be a little less. Rates are still too high. Kaiser rates are a

smaller increase, but their rates are still quite high. The MA plans are too high and those plans use capitation funding model and widespread upcoding, which we're all familiar with, and has been reported, and they are a real gold mine for the insurers.

Independent MedPAC estimated that MA insurers have reaped $217 billion in overpayments since 2007. And then other estimates a little different nature. They estimated MA plans cost 70 to 120 billion dollars more a year, are more costly than if the same services were provided by traditional Medicare.

So, turning to the biggest provider, UnitedHealthcare, they are almost double digit increases this year at 9.03 percent for Basic and 8.83 for Medicare Advantage. Those are too high increase. This is against the backdrop of the Fortune 500, which just came out, and showed UnitedHealth Group moved from number four to number three with revenues of $400.3 billion for 2024. Now, their profits shrunk a little bit, only 15.3 billion last year. That's still pretty darn high. And it's still, even with their reduction in profit, it puts them in the top 25 out of the 500, and it's trending upward. I saw the last quarter they made 500 -- $5 billion in profit, and then the first quarter of this year, six billion. So they're back up.

Am I out of time? In conclusion to -- in the words of former Board Chair Rob Feckner, go back and sharpen your pencils to UnitedHealthcare and a couple of other of these high rate increases, and lower your rates. They can afford it. Thank you.

CHAIR RUBALCAVA: Thank you. Thank you, Mr. Woodson.

Next, we have J.J. Jelincic to be followed by C.T. Weber.

J.J. JELINCIC: Joseph John Jelincic, Jr. from RPEA. The rates are too high. I was going to quote Rob Feckner, but I won't. But I must congratulate this Board, you have gotten what you want. You want more people in high cost plans and less people in low cost plans, and you're succeeding. When you decided to take health characteristics out of the evaluation for risk adjustment and to look at what the insurance companies were paying out, and ignoring health characteristics, you adopted a policy that says run up the premiums and we'll subsidize you.

Until you start looking at health characteristics for your risk adjustment, the risk adjustment is a farce.

Thank you.

CHAIR RUBALCAVA: Thank you. C.T. Weber, please.

C.T. WEBER: Hi. My name is C.T. Weber. Excuse

me.

My concern when I first signed up was the high cost of health care. Health care keeps going up. It's like a balloon and it's filled with helium, and the keep filling it. Then I heard the words of Frank and Yvonne, and I was, you know, heightened that -- you know, that the idea is getting out that health care cost is too high. And so -- and as long as we keep continuing to try to keep health care down under the current system, you know, the real problem is that we have privatized health care in this country. And so therefore, the competition and the concern for profit keeps driving health care costs up. And they'll always ask for more than they're going to get and they know that.

My other concern I think is that federal money, as long as it continues to subsidize the Advantage programs that they are using that money and it's going to make the amount of money available for Advantage health care that's taken extra money for their profit system, and it's going to wear down the money even faster, so that Medicare money is running out faster because of these Advantage programs.

I think, and just to put a little political pitch at the end here, is that I think what we really need is a universal, comprehensive, single-payer health care --

health plan not an insurance company, but with no copays, no deductibles, no payment at point of getting your service. So, yeah, health care cost is too high. And as long as you continue to fight to bring it down it's good work on what you're doing, but it's -- your fighting against the system that's built against that. Thank you.

CHAIR RUBALCAVA: Thank you.

There was other speakers for 6b, which is the pharmacy benefit manager, but I do have somebody on the phone. I'm not sure if that person wants to speak to the rates or to the benefit contracts. So do we know or can we can just wait for 6d.

We just wait for 6d. Okay.

STAFF SERVICES MANAGER I FORRER: Just wait for 6d, yes.

CHAIR RUBALCAVA: Okay. So we're going to wait.

So we'll -- thank you, Rob. Thank you, Don. It was very good. And one thing I forgot to mention, we have taken other actions, like supporting legislation to give the Attorney General more power authority to investigate these mergers into -- with private equity, and to providers, but we were unfortunately unsuccessful there. But thank you, Rob. It's excellent work. Thank you, Don. And now we'll -- stay there, Rob. I think you stay. You stay there, don't you, for the next item?

(Slide presentation).

CHAIR RUBALCAVA: And Dr. Logan, on the pharmacy benefit manager contract recommendation, please.

CHIEF CLINICAL DIRECTOR LOGAN: Good afternoon, Mr. Chair and members of the Committee. Julia Logan, CalPERS team member. As you know, we are working to complete our process of making our recommendation to the Board for outpatient pharmacy benefits for our PPO Basic and Medicare Supplement plan members, and many of our HMO Basic and Medicare Advantage plan members starting January 1st, 2026.

Today, I'll give you an overview of the -- our strategic considerations and status updates on the contracting process with our final recommendation to come in July.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: This slide highlights our current pharmacy benefit structure. Currently, our members receive medication through either the pharmacy benefit or through their medical providers under the medical benefit. Medications distributed under the pharmacy benefit are typically outpatient medications. These are primarily patient and caregiver administered.

Provider administered medications, such as infusions and some injections, are provided under the

medical benefit. Our members enrolled in Blue Shield HMO plans as well as Kaiser receive their pharmacy benefits through their medical plans and are fully funded. They don't use Optum. Our outpatient pharmacy benefit, through a self-insured arrangement, with OptumRx provides benefits to approximately 600,000 of our members, including more than 400,000 Basic members, both PPO and several HMOs, and 165,000 Medicare members.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: This slide illustrates what you are all very well aware, the critical importance of our pharmacy vendor from a financial perspective. It shows our total pharmacy spend over the past four years, as well as the total spend as a percent of premium. As you can see, it's an enormous amount of money, and a very significant percentage of our overall spend.

In 2023, CalPERS spent over $11.2 billion to purchase health benefits for one and a half million active and retired members and their families. Approximately 21 percent of our 11.2 billion spend in 2023 was for outpatient prescription drugs alone, which represents a two percent increase from '22 to '23, and an approximate 20 percent increase in pharmacy spending. There are several factors contributing to the overall increases in

cost, which -- I'm sorry -- to the overall increase in spend, which we've discussed previously and Rob just mentioned, including increases in cost and use of brand and specialty medications.

In 2023, 48 percent of CalPERS self-funded pharmacy spend was for specialty drugs, yet specialty drugs accounted for only about two percent of total outpatient drug utilization. I also want to underscore however that we look at pharmacy trend in the context of CalPERS overall goal of delivering the best possible care as cost effectively as possible. One of the things we look at is not just what the pharmacy trend is, but how our pharmacy spend impacts our medical spend.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: Over the past five years, we have made concrete improvements in the terms of our contract with Optum, including moving to a hundred percent pass-through of rebates and acquisition-based pricing. Our annual independently conducted market checks have also confirmed that we're getting pricing that is quite competitive with other purchasers of our size, but there are areas of the contract that we believe we can and should improve upon, including better assurances that we are indeed getting the full benefits of any rebates, improved transparency,

affordability, and predictability and clinical and financial accountability.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: Our three main objectives for this contract are to foster affordability for CalPERS and our members, promote better quality care, and ensure effective and safe medication access and use for our members, and ensure full transparency of the terms and arrangements between CalPERS and our pharmacy benefits vendor. Additionally, in terms of quality and access, we would like to support and reinforce the population health goals expressed through our Quality Alignment Measure Set or QAMS, so that a pharmacy vendor is working together with our plans and Included Health to improve quality.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: Just a brief overview of our process so far. We conducted a nationwide market scan of pharmacy benefit vendors in the fall of 2024 to assess the landscape of potential vendors and chose 16 entities with whom to enter discussions. These vendor discussions centered around their scope, approach, and capacity to provide pharmacy benefits for our members and included all of the big three pharmacy benefit managers, or PBMs, several mid-sized and smaller PMBs, a coalition, and a health plan.

Through multiple subsequent discussions with these vendors, as well as numerous data requests regarding pricing and financials, clinical aspects like formulary and utilization management, and operational aspects like transparency, and auditing, and data capabilities, we successfully narrowed the list to a small group of vendors with whom to enter contract negotiations.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: We have been evaluating vendors along three dimensions, first, financially including pricing, fees, rebates, and rebate guarantees, as well as the total cost of care guarantee that we are very interested in securing. We're also evaluating them from a clinical perspective, including formulary, and the management of high cost specialty and non-specialty drugs. Finally, we're evaluating them from an operational standpoint, including critical areas that I've mentioned, like auditing rights and transparency and flexibility, as well as transition and implementation plans.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: One of the main goals of the new pharmacy contract is to have it better aligned with our goals of financial sustainability and accountability, and to have the pharmacy vendor

accountable for some of that financial sustainability. We proposed an arrangement that's similar to what we achieved in our recent self-funded PPO contracts with Included Health -- Included Health -- I'm -- yeah, Included and Blue Shield of California. Namely, we expect the new pharmacy vendor to be subject to a cost trend guarantee over the life of the five-year contract that puts significant dollars at risk for controlling costs and quality.

While we are still in the process of our negotiations, we're very hopeful that the ultimate contract will literally have hundreds of millions of dollars at risk over the five years of the contract for cost and quality.

Part of those guarantees are based on the clinical quality guarantees. CalPERS has proposed quality guarantees that would have the PBM put $10 million at risk annually, five million for quality and our commercial plans, and five million for quality and Medicare, and to have the measures aligned with two of those in the quality alignment measures set, controlling high blood pressure and diabetes care, both of which are measures that have concrete pharmacy interventions and allow for our pharmacy vendor to have that direct impact on clinical outcomes.

In this way, the quality guarantee helps to

reinforce and support the quality efforts across our medical and pharmacy contracts, and will reinforce and support collaboration and patient care across the pharmacy and medical vendors. It's also worth highlighting that these guarantees are very innovative in the pharmacy industry, and we're holding them accountable in ways that they haven't been before.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: Negotiations with a small group of vendors have resulted in better contract terms and alignment with CalPERS goals and priorities, including significant money at risk for cost trend and quality, as I just mentioned. The vendors have also agreed to our clinical performance guarantees to be financially accountable for clinical outcomes of our members.

Also, the vendors have agreed to contractual language that give CalPERS greater protections around audit rights and other terms than we have had in the past, including improved language around formulary and utilization management customizations. We are still actively negotiating several key contractual areas including transparency and the ability to modify the terms of the contract. Achieving agreement in each of these areas with the vendors will be key factors in our final

recommendation.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: We are anticipating a certain level of disruption, regardless who -- of who we contract with. So let me explain why that is. First of all, there are several different types of disruption that we should review. There's the disruption associated with having a new and different formulary that excludes different drugs and puts drugs into different tiers, which can increase or decrease copays. This is generally the type of disruption that members care about the most.

There's also disruption in the pharmacy network, in other words, the pharmacies at which you get your medications filled, whether that be retail or mail order. We anticipate very little disruption in pharmacy networks. There's also the disruption that may result from drugs having a different set of criteria, like step therapy, that wasn't present in the -- that wasn't there in the present -- the present contract. Finally, there can be disruption associated with a new customer service interface, instead of staff who are new to CalPERS benefits.

All of these we know can be very frustrating and inconvenient, but some of them, like exclusions of drugs

that weren't previously excluded, are much more impactful to members. Knowing this is incredibly important for our members and we have done a careful disruption analysis, and have dug into this to the drug level. For drugs that would not be covered on a new formulary, members would be switched to a covered equally effective alternative. Most of these formulary changes are not clinically significant and include brand-to-generic switches.

And to mitigate member disruption, we have asked vendors to develop a comprehensive transition plan that includes providing telephonic access prior to our go-live date, a dedicated customer service team, obtaining all relevant member data for active prior authorization and open refills, and targeted outreach to members on specialty medications.

Additionally, under CMS rules, all Medicare members will receive their first fill of the year after the transition, regardless of whether the drug is excluded under the new formulary or not.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: Regardless of which vendor we ultimately contract with, we will require an implementation plan to ensure that the implementation of a new contract goes as smoothly as possible for our members. In addition to working closely with a vendor, we

will also be mobilizing partners internally here at CalPERS. For instance, we will have a dedicated team here at CalPERS to manage communication to members, so that members are informed every step of the way in advance of January 1st go-live date.

This internal CalPERS team will work very closely with the vendors CalPERS chooses to contract with to ensure members receive all necessary information and that the information is accurate or work with the incumbent in the event of formulary changes under a new contract.

Engagement between CalPERS and the vendor will start as soon as we announce the vendor we'll be contracting with in July. Both CalPERS and the vendor will be focused on open enrollment, which will be a critical opportunity to prepare members. And we will maximize communication strategies through our CalPERS team, the vendor's team, and our employer partners.

Please know that it's our number one priority to minimize the impact to members during implementation of this new contract. So let's talk about next steps. As I mentioned, we continued to negotiate several key contractual areas, including final financial terms, transparency, and the ability to modify the terms of the contract with the vendor. And as noted, reaching agreement in each of these areas with the vendors will be

key factors in our final recommendation. We will bring to you our final recommendation and contract for approval at the July off-site.

Implementation and any transition activities will begin immediately afterwards. Thanks for your attention and I look forward to the conversation.

CHAIR RUBALCAVA: Thank you, Dr. Logan.

Do we have questions or comments from the Board?

Mr. Kevin Palkki.

President Theresa Taylor, please.

COMMITTEE MEMBER TAYLOR: Did you change your mind?

VICE CHAIR PALKKI: I'll yield the floor to the President.

COMMITTEE MEMBER TAYLOR: Ah. So I always, as usual, want to thank you guys for all the hard wok you did on this. I want folks to understand that we were really looking for solutions that were out of the box, including looking at mid-market folks, combining PBMs. I think we've talked about this before, but to find a really good solution to the pharmacy question, which has been a big driver of our costs. So I did want folks to know that and would we ended up with were the two large -- anyway, so that we have the -- we've done really well. And I just want to tell you how I appreciate it. But again, I think

I want to also state that this is problematic moving forward, because even if whatever gets approved and we have five years more to go what does that do for costs in the future, right?

So we have to figure out a way, whether that's, you know, all these other things we've thought about. And I think the Governor even thought about doing some sort of drug manufacturing here in California. We've got to figure out something to control these costs. So I do appreciate the work you've done on this though.

CHIEF CLINICAL DIRECTOR LOGAN: Thank you. And if I could just add to that. I think a lot of what we've built into this new model contract with the pharmacy benefits vendor has a lot of those protections in it. We have a cost trend guarantee, so the trend of pharmacy can't go above a certain amount, or else the pharmacy benefits vendor is accountable for that. There's the cost trend guarantee, and the quality guarantee, and the ability to work with the medical -- with our plans. And Included Health is really important in terms of cost and quality over time.

COMMITTEE MEMBER TAYLOR: I hope that works.

CHAIR RUBALCAVA: Thank you, President Taylor.

Trustee David Miller, please.

COMMITTEE MEMBER MILLER: Yeah. Thank you.

There we go. Yeah. Thanks very much.

Again, kind of like my comments the last time, I'm kind of also reminded of Director Walker and C.T.'s comments, that in this big picture where -- and I've taken some heat in the past for saying I would like to see a world without pharmacy benefit managers some day. But in the bigger picture, the system that we're having to work with, you know, we ended up with two of the -- the two big gorillas. But I think, you know, the progress we're making with -- even with them and with the system, and with undertaking this -- you know, this grueling effort, and turning over all the rocks and looking at all -- we started with a large net and we really made every effort to make sure that, you know, we had all the possibilities that might yield kind of break-through improvements there.

I think we're still in the realm of incremental improvements here, but until some things change in the bigger, broader marketplace, and how things work certainly in this country, I think we're doing the best we can do with a difficult situation. And I'm really impressed with the progress that we've made and work that the team has done. And I just hope that we can continue to move the needle and eventually get more of a break-through beyond just the needs of just our members -- or our focus, but it's a bigger problem for the country, and it's a bigger

problem for people who, you know, don't have a system like ours supporting them.

Everybody should have access to this. I agree that health care should be a right, not a privilege for people. And I think this helps move us further toward access and affordability for our members. But I hope that in the long run, we have a better solution for everybody.

CHAIR RUBALCAVA: Thank you, Mr. Miller.

Jose Luis Pacheco, Trustee.

COMMITTEE MEMBER PACHECO: Thank you, Chairman Rubalcava and thank you, Dr. Logan, for your comments and so forth. I always appreciate the rigor you put into understanding this material and providing us perspective. I think the membership and the public appreciate that.

So my question is regarding back to the transition and implementation. I believe you mentioned -- actually, the pharmacy distribution -- disruption. You mentioned that the member experienced change with the customer service interface with the members with respect to the final vendor selection. You also mentioned that there might be -- there will be like webinars and a dedicated team. Can you elaborate that -- on that? Is there going to be a -- is there going to be a combination between the vendor and CalPERS or CalPERS doing most of the work or the vendor doing most of the work, if you can

give us some understanding of that.

CHIEF CLINICAL DIRECTOR LOGAN: Yeah. Thank you for the question. So we actually have already started on our communication plan. And so it's a -- it's a CalPERS-wide communication plan and approach that obviously requires not just the health team, but across the organization stakeholder relations, the Contact Center, really an all-hands-on-deck approach, because we want to be able to have a joint message across the board.

That being said, we can't do it alone, so we have engaged the finalist vendors on their implementation and any transition plans that would be needed. And so we've already started those conversations and made sure we've built in provisions into the contract to build up that customer service capacity prior to go-live and go-live, and even post go-live to make sure that transition is as smooth as possible.

And it doesn't just include the pharmacy vendor and us, it's also all of our health plans, Included Health, our PPOs. It's really everybody and we have a very long communication plan that breaks that all down by plan and who's sort of on first for each plan within Rob's team. So it's incredibly extensive. And we've built on the learnings that we just had with the HMO transition and then the PPO transition. We learned an incredible amount

and are applying those lessons learned to this contract as well.

COMMITTEE MEMBER PACHECO: That's excellent then. And I just want to make sure that I didn't hear the -- you'll be also partnering with the retiree groups as well.

CHIEF CLINICAL DIRECTOR LOGAN: Yes. That is actually on the list. Also, we have a number of webinars that are set and communications that are set to go out to those various groups, yes, and a retiree roundtable that we're planning for as well.

COMMITTEE MEMBER PACHECO: As well as maybe an article in the PERSpective and so forth?

CHIEF CLINICAL DIRECTOR LOGAN: Yes, sir. Yes.

COMMITTEE MEMBER PACHECO: Okay. I just wanted to get an understanding of the whole process -- it is -- it is -- it appears to be a full faceted sort of approach. And I appreciate that. And again, I appreciate all the efforts you put into this. Thank you.

CHAIR RUBALCAVA: Thank you.

Mr. -- Trustee Kevin Palkki.

VICE CHAIR PALKKI: Thank you, Mr. Chair. Just really quickly without reiterating what my colleagues have said. With prescription drugs, the research that goes behind that is obviously a process in itself. Is the -- is the -- there's a lot of concern about research funding,

lately. And I'm wondering if that is correlated with -- with the probability of prescription drugs rising, the cost of them rising in that. Is that --

CHIEF CLINICAL DIRECTOR LOGAN: Yeah. So R&D, so the research and development that goes into making a drug is, I don't know exactly the number, but billions, tens, 20, 30 billion dollars just to make one drug. And it takes -- they have to go through phase one, two, and three trials. And so, that is incredibly costly and time-consuming. So you're absolutely right that R&D cost is built into the launch price of a particular drug. And so, yes, we're all paying for that R&D. And some part of that R&D I think we should obviously pay for. It's just sort of the debate lies in kind of that profit margin that does exist.

VICE CHAIR PALKKI: Yeah. I was thinking about that just recently. And it seems to me one of those -- the things where R&D is very beneficial to us, but to what cost are we willing to have that R&D.

When it comes to access facilities, is there a large amount of manufacturers overseas and is there -- obviously, all the conversations with manufacturers being overseas and coming to the U.S., is there -- is there a lot of -- is there talks out there about bringing -- is there talks out there about bringing in manufacturers that

are local like California or even other states?

CHIEF CLINICAL DIRECTOR LOGAN: Yes. So there -- federally, there are certainly talks. I know that you -- I'm sure you're all aware about the maximum fair price that Trump is -- that the administration is working through, but at the same time is working -- has talked about tariffs on pharmaceuticals. So there's a lot of conversation about that at the federal level. There's also conversation about that at the State level, because we have been talking to our colleagues at HCAI who have been working on CalRx and manufacturing insulin in California, and the potential for other drug manufacturing in California.

So certainly that conversation is happening here and then that wider conversation at the federal level.

VICE CHAIR PALKKI: Thank you. Appreciate it.

CHAIR RUBALCAVA: Thank you, Dr. Logan. Thank you, Vice Chair Palkki.

We will now proceed to the public comment. Catherine DeLou and a Brynnen Lopez.

Please.

CATHERINE DeLOU: Good afternoon. Thank you. My name is Catherine DeLou. I am the HR manager with Tahoe City Public Utility District, a CalPERS contracting agency in the Lake Tahoe basin, where the CalPERS PPO plan are

the only options available to us.

I first want to thank the Committee and the CalPERS staff for the hard work I know it takes to provide the prescription drug and network or health care options for the various public agencies and retirees across the state.

I am here, however, today to express my concern about recent network access and prescription drug coverage issues with the Blue Shield of California PERS Gold PPO plan in the -- both the Lake Tahoe and Reno, Nevada regions. Our district has received multiple reports from employees, retirees, and their families that hospital networks, providers, prescription drugs that had been accepted under the PERS PPO plan for the past 20 years are no longer covered under the plan as of 2025.

These changes have made it increasingly difficult for our members to access the care that they need without traveling long distances or incurring significant out-of-network costs.

Given our geographic location near the California Nevada border, many of our employees rely on providers and care in both states especially in Reno, which offers the most comprehensive health care services in our area. The current network limitations of the PERS Gold plan are particularly challenging in rural and mountainous regions,

where provider options are already limited.

I ask that the Committee consider an extension of the rural designation for organizations such as ours that are covered only under the PERS PPO plans. This designation plays a vital role in supporting access to affordable and timely health care for members in geographically underserved areas. Alternatively, I ask that the Committee explore allowing additional PPO plan options with wider or multi-state networks that better meet the needs rural and border area members.

Thank you very much for that opportunity.

CHAIR RUBALCAVA: Thank you for raising your concerns.

Brynnen Lopez.

BRYNNEN LOPEZ: Good afternoon. My name is Brynnen Lopez. I am the HR and Risk Manager for Truckee Sanitary District. Similar to Catie that was just up here seeking, we are in a rural area in the Sierra Nevada mountains. We are located about 20 miles from Reno and also have limited access to providers in our area. We have been very thankful that CalPERS has provided us a rural county designation for 2025, and also has continuity of care provisions in place that our employees have been able to access as needed. However, we are continuing to experience increased network limitations in our area, as

providers are continuing to drop Blue Shield as coverage options.

We are limited on providers in the area already. We have one rural access hospital located in our Truckee area, and the closest level one trauma center is in Reno, so we continue to have challenges. Having the potential of also losing the UC system and network, whether that be temporary or not, that also puts further detriment and burden on the membership that we have.

In addition, to having challenges with the health coverage and network availability that we have only being able to access Region 1 basic PPO plans. We are experiencing similar benefit challenges with pharmacy through Optum as well. While I am pleased to hear that we are looking at a new PBM to start in January of 2026, we are also having challenges with the current coverage with Optum and formulary challenges.

So, I, too, am here to ask you, on behalf of myself and a couple of other rural districts that weren't able to make it with Catie and I today, to please consider offering more coverage opportunity and/or extending the rural county designation into 2026 to assist in less disruption to our membership and their care in the area.

Thank you.

CHAIR RUBALCAVA: Thank you very much for

bringing your concerns to the Board and to staff.

That concludes public comment on this item. We still have another comment -- we also have some public comment on 6d. But next, will be the summary of committee direction.

CHIEF HEALTH DIRECTOR MOULDS: Mr. Chair, I did not take any committee direction.

CHAIR RUBALCAVA: I have one. I understand -- Mr. Ruffino was asking about maybe some talking points outlining the rate development process, and perhaps you can always also add what cost mitigation efforts CalPERS has taken.

CHIEF HEALTH DIRECTOR MOULDS: Happy to do that.

CHAIR RUBALCAVA: Thank you.

Next, we have public comment, 6d. We somebody on the phone, I believe. How many.

STAFF SERVICES MANAGER I FORRER: Yes, Mr. Chair. We have Michael Friedman on the line to speak to Item 6d.

CHAIR RUBALCAVA: Yes. Please continue.

STAFF SERVICES MANAGER I FORRER: Go ahead, Mr. Friedman

MICHAEL FRIEDMAN: Yes. Can you guys hear me?

CHAIR RUBALCAVA: Yes. Please continue.

MICHAEL FRIEDMAN: Okay. I'd actually like to piggyback on what the last commenter was saying about the

lack of coverage. I am analyst. I work at Napa State Hospital. I was in PERS Platinum for 12 years. And obviously you know that was Anthem. You guys switched it over to Blue Shield touting it as a great victory for I don't know what, cost savings?

Nothing will change. Your premiums will go -- will stat the same. Everything will stay the same. You can -- I'll give you the phone numbers of my co-workers when I told them at the time somehow we're going to get screwed on the back end of this, and lo and behold six months later with no notice I find out from my provider -- from a number of my providers at UCSF, three of whom I'm seeing for very serious chronic conditions that all of a sudden Blue Shield is dropping them or they're separating from Blue Shield, whatever. I don't know anything about the technical aspects of it. But without UC in the network, like this coverage is horrible. Like that's the main reason to have it. That's why people pay more for it.

And I don't understand like when you guys switch over to Blue Shield, did you have -- if I knew something like this was going to happen -- did you guys really have no idea that they were going to do this or something like this?

Anyway, so I also have a question. Given the

fact that those sharpened pencils that you guys have been talking about 45 minutes ago, which they now feel like they're kind of in my back, are you guys going to be able to provide UC coverage in any of your other plans? And I also don't want to -- that's a -- that's not a rhetorical question. Is there anyway people like me beyond this one year pathetic continuum of care, which for -- as I'm sure you guys all know for chronic conditions, don't do much. They help for a year and that's it.

And is there any contingency plans you have for people to stay in UCSF or -- or that's where I go, but the UC system in general. I assume it's the whole thing that's being dropped. And also, the fact that there was no notice from Blue Shield. The only way I found out was from my providers. Like is that legal? Like how does that work?

So I'm done. So I hope I got my questions across. Like is there anything you guys can do or is there a different plan to move to, even if I have to wait until next January to do it for open enrollment?

I'm done. I don't know --

CHAIR RUBALCAVA: We appreciate -- we appreciate your comments.

MICHAEL FRIEDMAN: Okay.

CHAIR RUBALCAVA: We heard your questions and

concerns. Staff is working on these things every day.

CHIEF HEALTH DIRECTOR MOULDS: We're also, Mr. Chair, happy to reach out to all three of the commenters.

CHAIR RUBALCAVA: Thank you, please.

Next caller please.

STAFF SERVICES MANAGER I FORRER: Yes, Mr. Chair. We have Dolores Ridgeway.

Go ahead, Dolores.

DOLORES RIDGEWAY: Hello.

CHAIR RUBALCAVA: Yes, please continue.

DOLORES RIDGEWAY: My name is Dolores Ridgeway and I'm calling to request an extension of free credit monitoring for the data breach of CalPERS members.

CHAIR RUBALCAVA: Thank you for your comment about credit monitoring extension. We got it. Thank you

DOLORES RIDGEWAY: Yes. Do you know if that will be granted, the free credit monitoring?

CHAIR RUBALCAVA: Everything is being taken under advisement and I can't give you an answer at this point, but thank you for calling.

DOLORES RIDGEWAY: Well, thank you very much for YOUR time. Have a good day.

CHAIR RUBALCAVA: Thank you for commenting.

Any more calls?

One more. Please, next call.

STAFF SERVICES MANAGER I FORRER: Yes, Mr. Chair. We have Terry Battenburg.

TERRY BATTENBURG: Hello.

STAFF SERVICES MANAGER I FORRER: Go ahead. Go ahead, Terry.

TERRY BATTENBURG: Hi. I'm Terry. I am a State of California employee and I'm speaking about the Blue Shield UC Health issue. I live with a chronic disease. I was on the hone with my specialist, my UC Davis specialist, this morning. I have a team of doctors that I have put together over 10 years to help me manage a serious chronic health condition. This potential dropping of UC Health can -- will have a devastating impact on the way I manage my disease. It is completely not reasonable to expect people with this amount of notice to put together teams of doctors that they have worked with over a decade.

So, in addition to adding on to what a previous caller said, really we need some creative thinking about all the ways that the thousands of us can continue to work with our UC Health doctors, open enrollment, looking at other options. This kind of act of this scale will do harm. And I'm very concerned. I am doing everything possible with all of the continuity of care. I'm working with a case manager who just left a message on my phone as

I'm making comments. The paperwork is extensive. It's not a guarantee and there's no way that I'm going to be able to find the same level of specialist that I have. I have the specialist for my disease that's in the Sacramento region.

So this is a serious issue. This will harm people. And I urge each of you to be using your most creative problem-solving skills to help those of us who will be harmed.

Thank you for your time.

CHAIR RUBALCAVA: Thank you for expressing your concerns. We care about your health and the health of each and every one of our members and beneficiaries.

That concludes our public comment. And with that, we adjourn the meeting. Thank you, everybody.

(Thereupon California Public Employees' Retirement System, Pension and Health Benefits Committee open session meeting adjourned at 2:36 p.m.)

CERTIFICATE OF REPORTER

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

That I am a disinterested person herein; that the foregoing California Public Employees' Retirement System, Board of Administration, Pension and Health Benefits Committee open session meeting was reported in shorthand by me, James F. Peters, a Certified Shorthand Reporter of the State of California, and was thereafter transcribed, under my direction, by computer-assisted transcription;

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

IN WITNESS WHEREOF, I have hereunto set my hand this 22nd day of June, 2025.

JAMES F. PETERS, CSR
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