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 16, 2026

8:32 A.M.

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

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APPEARANCES

COMMITTEE MEMBERS:

Ramon Rubalcava, Chair

Kevin Palkki, Vice Chair

Monica Erickson

Troy Johnson

Fiona Ma, represented by Patrick Henning(Remote)

David Miller

Theresa Taylor

Yvonne Walker

Mullissa Willette

BOARD MEMBERS:

Michael Detoy

Lisa Middleton

Gail Willis, PhD(Remote)

STAFF:

Marcie Frost, Chief Executive Officer

Kim Malm, Deputy Executive Officer

Donald Moulds, PhD, Chief Health Director

Prashant Yerramalli, General Counsel

Robert Carlin, Senior Attorney

Rob Jarzombek, Chief, Health Plan Research and Administration

APPEARANCES CONTINUED

STAFF:

Julia Logan, MD, Chief Clinical Director

Renee Salazar, Deputy Chief Counsel

ALSO PRESENT:

J.J. Jelincic, Retired Public Employees Association

Robert Norton, Amador County Unified School District

Larry Woodson, California State Retirees

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PROCEEDINGS

CHAIR RUBALCAVA: Good morning, everybody. Welcome to the Pension and Health Benefits Committee. We're going to start -- call to order and then roll call, please.

BOARD CLERK LEMUS: Ramon Rubalcava.

CHAIR RUBALCAVA: Present.

BOARD CLERK LEMUS: Kevin Palkki.

VICE CHAIR PALKKI: Good morning.

BOARD CLERK LEMUS: Monica Erickson.

COMMITTEE MEMBER ERICKSON: Here.

BOARD CLERK LEMUS: Troy Johnson.

COMMITTEE MEMBER JOHNSON: Here.

BOARD CLERK LEMUS: Patrick Henning for Fiona Ma.

ACTING COMMITTEE MEMBER HENNING: Here.

BOARD CLERK LEMUS: David Miller.

COMMITTEE MEMBER MILLER: Here.

BOARD CLERK LEMUS: Theresa Taylor.

COMMITTEE MEMBER TAYLOR: Here.

BOARD CLERK LEMUS: Yvonne Walker.

COMMITTEE MEMBER WALKER: Here.

BOARD CLERK LEMUS: Mullissa Willette.

COMMITTEE MEMBER WILLETTE: Here.

CHAIR RUBALCAVA: Thank you.

We will now recess into closed session to address

Items 1 through 3 -- 1 through 3 from the closed session agenda and we will reconvene in open session afterwards.

It will probably be an hour and a half at least, so it will be about 10 a.m. So thank you for your patience and understanding.

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

(Thereupon the meeting recessed into closed session.)

(Thereupon the meeting reconvened Open session.)

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

CHAIR RUBALCAVA: Good morning. We are back in open session for the -- and we'll continue with the rest of the Pension and Health Benefits Committee open session agenda.

Please call the roll.

BOARD CLERK LEMUS: Ramon Rubalcava.

CHAIR RUBALCAVA: Yes. Hi. Here

BOARD CLERK LEMUS: Kevin Palkki.

VICE CHAIR PALKKI: Good morning.

BOARD CLERK LEMUS: Monica Erickson.

COMMITTEE MEMBER ERICKSON: Here.

BOARD CLERK LEMUS: Troy Johnson.

COMMITTEE MEMBER JOHNSON: Here.

BOARD CLERK LEMUS: Patrick Henning for Fiona Ma.

ACTING COMMITTEE MEMBER HENNING: Here.
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COMMITTEE MEMBER MILLER: Here.
BOARD CLERK LEMUS: Theresa Taylor.
COMMITTEE MEMBER TAYLOR: Here.
BOARD CLERK LEMUS: Yvonne Walker.
COMMITTEE MEMBER WALKER: Here.
BOARD CLERK LEMUS: Mullissa Willette.
COMMITTEE MEMBER WILLETTE: Here.
CHAIR RUBALCAVA: Thank you. Good morning, Board members. Because we are not all present in the same room and Board members are participating from remote locations and not -- are not accessible to the public, Bagley-Keene requires the 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 either that, one, they are alone, or two, if there are one or more persons present with them who are at least 18 years old, the nature of the Board's relationship to each person.
At this time, I will ask each remote Board member to verbally attest accordingly. Please conduct a roll call attestation. Thank you.
BOARD CLERK LEMUS: Dr. Gail Willis.
BOARD MEMBER WILLIS: Yes. Good morning. I do

attest to the fact that I am alone. Thank you.

CHAIR RUBALCAVA: Thank you.

BOARD CLERK LEMUS: And Patrick Henning.

ACTING COMMITTEE MEMBER HENNING: I am still all alone.

(Laughter).

CHAIR RUBALCAVA: And we feel for you. We wish you were here. Thank you. So now we'll proceed to the action -- sorry executive report, Mr. Don Moulds and Kim Malm, please.

DEPUTY EXECUTIVE OFFICER MALM: Great. Thank you. Good morning. Kim Malm, CalPERS team.

In March, I shared that we kicked off the 2026 benefit verification cycle. This process is now conducted annually to prevent oaf payments due to unreported deaths. In March, we sent approximately 14,000 letters to retirees that met specific risk criteria, such as age, benefit amount, length of time since they made contact with CalPERS and the last time they saw their health care Provider. We sent them reminders in April and in May informing retirees that they were -- if we did not receive their information by July 17th deadline, the August 1st warrants would be held.

To date, a total of 326 deaths have been identified in the last couple of months, 233 of them in

California, and 103 in 21 other states. The unreported deaths have led to almost $3 million in overpayments. The team has successfully collected over $1.4 million of those overpayments, or about 46 percent. The benefit verification project continues to be an important tool as we continue to try and reduce overpayments.

Next, I wanted to mention the recent wildfires in Southern California that affected some of our retirees. In late May, the team began tracking those potentially impacted and conducted outreach to 254 retirees who still received paper checks, in those areas. We are offering them the opportunity to change to direct deposit or have their checks sent somewhere else so they would continue to receive those.

Although only two retirees took us up on that offer to do direct deposit, I am proud of the team that proactively reached out to over 250 retirees. I also wanted to share the training we have recently been providing for employers and retirees on working after retirement. On June 2nd, CalPERS hosted a webinar for employers focusing on hiring retired annuitants by membership type or State, school and public agency, introducing a new questionnaire to help employers ensure compliance when hiring retired annuitants. The event drew over 1,500 employers and received positive feedback from

the participants. The recording of this presentation was posted on our YouTube page yesterday.

In addition to the webinar, we conducted five hiring retired annuitant focus session, classes attended by 208 participants, both virtual and in person. These sessions were also designed for employers. However, they did not just cover the questionnaire like the webinar did. Instead, they addressed important considerations and rules related to hiring a retired annuitant.

We're currently developing a video that aims to inform both employers and retirees about the rules and restrictions associated with post-retirement employment and it's scheduled for completion on July 1st. Once finished, it will be accessible on the CalPERS website, on the "Retired Annuitant" page under "Working After Retirement" section.

Next, I'd like to give you an update on our CalPERS Benefits Education Events. We hosted an in-person CBEE in Anaheim on April 10th and 11th with almost 1,500 attendees and a 98.6 percent satisfaction rating for that event. We had five people retire on the spot. We just hosted an in-person CBEE in Redding on June 5th and 6th with 351 attendees, with a hundred percent satisfaction rating for the event. While the Redding event does not attract the number of attendees like Anaheim does, since

they are approximately three hours away from our closest regional office, it's very well received and appreciated that we go to that area. We had three people retire at that event.

Our next in-person event will take place on July 10th and 11th in Santa Clara and the remaining schedule for 2026 is just one virtual CBEE in August -- for August 12th and 13th.

To close, I'd like to share some significant progress the Call Center has made recently. With several strategic changes, the Call Center achieved its first 100 percent day on May 12th. That means they answered every single call that came in that day. This milestone was unprecedented for our Call Center.

Leadership improvements, including initiated -- initiating immediate use of detailed reporting on actual traffic data, instead of daily averages, revealed a consistent surplus of agents at the end of the day and created a roadmap for better scheduling options. Team surveys led to the introduction of a 45 minute lunch option for improved lunch coverage and shift flexibility ability, as well as lunch overtime program, resulting in 21 hours of additional call coverage.

Finally, calls are now prioritized first thing in the morning instead of workflows that are sent through the

system to address peak call volumes in the morning more effectively. These scheduling changes have significantly impacted service levels resulting in an average improvement of 29 percent over the last four months. The dedication of the Contact Center team and leadership has been instrumental in driving these enhancements.

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

CHAIR RUBALCAVA: Thank you, Ms. Malm. Do we have any questions or comments from the Committee members?

Vice Pres -- Vice Chair Palkki, please.

VICE CHAIR PALKKI: Thank you from the bottom of my heart. That hundred percent means a lot to not just me but every single active member out there. And for that, I just -- I truly, truly, truly applaud like every single one of you for that action.

(Applause).

VICE CHAIR PALKKI: So, I mean, I just a few minutes ago I spoke about excellence and pushing for excellence and just moments later thank you for this report, so...

DEPUTY EXECUTIVE OFFICER MALM: You bet. We will be absolutely be passing this on to the team. Thank you so much.

VICE CHAIR PALKKI: Thank you.

CHAIR RUBALCAVA: Thank you, Ms. Malm.

Oh, I'm sorry. President Taylor.

COMMITTEE MEMBER TAYLOR: Kim, I want to thank you as well. But everything that you reported out on, you're always doing excellent on your staff that help us and our members. Chef's kiss always.

But I've worked in a Call Center and there are two big Call Centers and I've never heard of a hundred percent, so that is amazing.

DEPUTY EXECUTIVE OFFICER MALM: Right.

COMMITTEE MEMBER TAYLOR: That's -- I just -- yeah.

DEPUTY EXECUTIVE OFFICER MALM: Thank you.

COMMITTEE MEMBER TAYLOR: Yeah. The 95 percent that you guys maintain is amazing, because we don't have that. So thank you very much.

DEPUTY EXECUTIVE OFFICER MALM: They work really hard so thank you.

COMMITTEE MEMBER TAYLOR: I don't know how you're doing it and how you're keeping those folks happy. So don't lose them.

DEPUTY EXECUTIVE OFFICER MALM: We have great leadership and management over the area and great team members that come every day and take those calls. So thank you for recognizing them all of you.

COMMITTEE MEMBER TAYLOR: Thank you.

CHAIR RUBALCAVA: Thank you. Thank you, Ms. Malm.

Now, we'll proceed with Don Moulds.

CHIEF HEALTH DIRECTOR MOULDS: Great. Mr. Rubalcava, members, I want to begin my comments with a review of today's discussion of rates. I'll start with the positive. The rates you'll be hearing about today are a continuation of an encouraging trend. Today's overall rate increase, which is 4.98 percent, is over three percent lower than the rate we brought you last year. This is -- will be the third year in a row now that rates have -- increases have gone done. And this is the first time since the COVID years that annual trend is under five percent.

We still think that we can and should be doing better, but today's rates are a reflection of a number of important improvements to the CalPERS Health Program, a better PPO contract that includes a first ever trend guarantee, a pharmacy contract that has already resulted in far better trend than we are seeing in drugs nationally, and reserves that are fully funded this year. I'll add that we are doing this at the same time that we're adding critical benefits, like the family building benefit that Dr. Logan will be talking about in a bit, and

at the same time we're making big investments in quality.

Second, on the agenda is a recommendation that we remove UnitedHealthcare's two Basic plans offerings, their Alliance and Harmony plans from our program beginning in 2027. The decision to bring this recommendation to you is not one made lightly. But as Rob is going to walk through, we really had no other option. The rates United was seeking were exorbitant and unsubstantiated and would have undercut affordability for our members and employers in both the short and the long term.

Moreover, recommending them to you would have sent the wrong message to the rest of the health plans with which we contract. I'd like to thank UnitedHealthcare, particularly their representatives in California for the important partnership that we had with them for many years. It's regrettable that we were not able to reach agreement on a reasonable rate.

The team has been working hard over the last few months to ensure that our members will continue to be able to see their current providers through other plans. We're going to continue to work to make sure that disruption is as minimal as possible. You're going to hear more about that too in just a minute.

We continue to focus on advanced primary care as a key part of our health strategy to improve access,

quality, equity and affordability for our members. The model is patient centered, team based, integrates behavioral health, and emphasizes prevention care coordination, and support for members with complex needs.

We know primary care access and workforce capacity are real challenges in many parts of the state. To help guide our next steps, we've done market research and we'll be fielding a five-county member access survey this summer. Currently, we're expanding access through community based clinics, including federal qualified health centers. In Shasta County, as you know, we've partnered with Shasta Community Health Center, which brings together a network of about 115 primary care and specialty providers and meets Medical Home standards, along with aligned quality measures consistent with CalPERS's approach.

Looking ahead, we're also exploring a more direct role in bringing online community-based primary care clinics in areas with access gaps. This would likely include partnerships with existing dedicated clinics and repurposing existing build to create primary care clinics dedicated to carrying for CalPERS members. This builds on models used by other employers with on-site clinics and it's informed by our analysis of our own claims data showing where members are underusing primary care and

relying more on emergency and hospital care than is necessary.

We're currently looking at potential sites and actively evaluating vendors. Julia will be sharing more details in her primary care and behavioral health updates in July. And we plan on bringing a formal recommendation on this to the Board in September.

I also want to provide an update on the evaluation of the CalPERS health regions used to price premiums for public agencies and school health contracting employers. As we've mentioned in previous Committee meetings, health care market dynamics shift over time, sometimes rapidly, and it's a best practice to periodically evaluate our regions, which CalPERS did last in 2018. At this time, the Board approved the three large regions we have today.

Since then, costs have further stratified and our three regions have significant cost variation within and between them, as we discussed with you in March. We're now looking -- now looking to define regions and corresponding premiums that allow CalPERS to compete more effectively on lower cost parts of the state and more accurately reflects the cost of care in higher cost areas.

In April, we conducted an online survey of public agencies and schools. The CalPERS team has been modeling

various options for how to configure new regions. We are analyzing options that strike a balance between the cost of health care per county, rate disruption, and member and administrative burden. We will return to you in July with options to consider, showing each map and its corresponding cost and premium impacts. We have begun and will continue to communicate about this project to our employer partners and other stakeholders and upcoming Board meetings and our ongoing employer leadership dialogues, but also directly with employers in a webinar specifically about regions in August, and at the Education Forum in November.

All of these activities are informing the development of the work and our ultimate recommendation to you. We look forward to returning with more detail about the survey results and specific regional models next month.

That concludes my comments. Happy to answer any questions, before I turn things over to Dr. Logan to talk about the new family building benefit.

CHAIR RUBALCAVA: Thank you.

Any comments on the Committee?

I would like to thank you, Don and your shop, because something I mentioned earlier. Your shop is very innovative and that's one thing that I think has allowed

us, being a big purchaser of health care, to come forward with all these amazing advances.

And the importance of primary care, I'd just like -- I was going to do it later, Dr. Logan, but I think part of -- one thing that reflects it is how we're taking the lead in the importance of primary care is the past initiative where we merge primary care, so there could be an encounter on mental health screening. But most recently, Dr. Logan was a coauthor of an article about how we coalesce around primary care with other purchase -- large purchasers here in California. And I want to commend her for that excellent job, so thank you. So I, too, want to applaud, Dr. Logan and our staff.

(Applause).

CHAIR RUBALCAVA: Thank you.

I think the -- thank you, Don. I think the next action is our action consent items. Do I have a motion?

COMMITTEE MEMBER MILLER: I move approval.

VICE CHAIR PALKKI: Second.

CHAIR RUBALCAVA: Move and second.

Let me get my little talking points here. Okay. I have a motion and a second.

Any discussion on the motion?

All in favor say aye?

(Ayes.)

CHAIR RUBALCAVA: Oh, do we need a roll call?
BOARD CLERK LEMUS: (Nods head).
CHAIR RUBALCAVA: Roll call. We need a roll call. Sorry about that folks. Roll call, please.
BOARD CLERK LEMUS: Kevin Palkki?
VICE CHAIR PALKKI: Aye.
BOARD CLERK LEMUS: Monica Erickson?
COMMITTEE MEMBER ERICKSON: Aye.
BOARD CLERK LEMUS: Troy Johnson?
COMMITTEE MEMBER JOHNSON: Aye.
BOARD CLERK LEMUS: Patrick Henning?
ACTING COMMITTEE MEMBER HENNING: Aye.
CHAIR RUBALCAVA: Thank you.
BOARD CLERK LEMUS: David Miller?
COMMITTEE MEMBER MILLER: Aye.
BOARD CLERK LEMUS: Theresa Taylor?
COMMITTEE MEMBER TAYLOR: Aye.
BOARD CLERK LEMUS: Yvonne Walker?
COMMITTEE MEMBER WALKER: Aye.
BOARD CLERK LEMUS: Mullissa Willette?
COMMITTEE MEMBER WILLETTE: Yes.
CHAIR RUBALCAVA: Okay. Thank you. And that's for actions 3a and b -- 3b together.
Okay. Now, we're going into the informational consent items. I did not receive any indication from

anybody we going to hold it.

So now, we'll go into the next action item, which is the approval of Preferred Provider Organization Fertility Benefit Design change, which is the implementation of State legislation, SB 729.

Dr. Logan and Rob.

(Slide presentation).

CHIEF CLINICAL DIRECTOR LOGAN: Good morning, Mr. Chair members of the Committee. Julia Logan, CalPERS team member. This is Agenda Item 5a, approval of the Preferred Provider Organization Fertility Benefit Design Change. This is an action item. I'm very excited to share how we will support our members in building their families today.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: Today, I'll walk through Senate Bill 729, our research findings and our recommendation for your approval.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: As you are aware, Senate Bill 729 was passed into law in 2024 and requires health plans regulated by the Department of Managed Health Care, or the DMHC, to cover the diagnosis and treatment of infertility. This requirement applies to CalPERS HMO Basic plans effective July 1st, 2027.

To comply with this law and provide our members

with the best possible benefit, we will implement a family building benefit for our HMO plans. While this law does not apply to our PPO plans, we recommend implementing these benefits for our PPO Basic plans also to ensure that all Basic members have equitable benefits.

We've designed our family building benefit based on DMHC's guidance, which was last updated in February. This is a new benefit for many purchasers and health plans. And DMHC continues to update their guidance as the health care system works through the challenges and questions related to the benefit. We've been in regular contact with DMHC on this and they've been really great partners.

The really significant piece of all of this is that this law and our benefit provide equal family building access to heterosexual couples, LGBTQ+ couples and single parents.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: So what will this family building benefit cover? We will cover a comprehensive suite of benefits to diagnose and treat infertility, including: fertility related testing; in vitro fertilization, or IVF, including three attempts to retrieve sperm or eggs and unlimited embryo transfers; medications; counseling as needed to ensure that members

understand their family building options; five years of cryopreservation and storage; surrogacy - and I wanted to just pause on this one a little bit. Because while it's part of SB 729, it's not something that has traditionally been included by many fertility providers. Because surrogacy arrangements are complex, it's important to note that we do not cover compensation to a surrogate for carrying a pregnancy nor all associated, non-medical, or uncovered legal costs.

Coverage is limited to eligible medical fertility services and medications. Essentially we will cover fertility services for a surrogate that we would cover for the member. We will also cover Basic adoption support for members who need resources to adopt a child, like information and referrals.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: Over the last several months, we've been gathering information from our health plans and fertility vendors to better understand what a family building benefit could look like. Based on our research, we believe using a fertility vendor is the best option for our members, and there are a few reasons for that. First, is experience.

Fertility vendors specialize in infertility care and typically have much deeper experience in this space,

including services like surrogacy support that I just mentioned. There are also set standards for the providers and their networks and require reporting on outcomes and key data points. This allows them to offer performance guarantees and gives us clear data to monitor utilization, outcomes and costs, once the benefit is implemented. And you may know that the fertility industry itself has historically been rife with some unscrupulous actors, exploiting the anxieties of prospective parents pushing unproven and often risky treatments. Vendors are able to navigate this complicated space and put needed guardrails around the networks and standards.

The second is access. The vendors we spoke with all have statewide networks, so members across California can access care. They also provide patient care advocates who help guide members through the process, finding providers, navigating treatment options and helping with billing. That kind of support can make a big difference from members going through what can be a very complex and emotional journey.

The third is affordability. Vendors consistently came in with the most competitive pricing. Vendors have experience and data in this area, which helps them predict utilization and price the benefit accurately allowing for predictability and rate setting. We were also able to

secure performance guarantees related to quality and cost by going through a vendor.

Finally is equity. Having a single vendor administer the benefit would create a more consistent experience for our members. Even when benefits are technically the same across plans, how they're implemented can vary. Using one vendor helps standardize, access, services and support so members have a much more equitable experience regardless of their health plan.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: Based on the reasons on the prior slide that we just talked about, we also believe that Progyny is the right vendor for us to partner with. Progyny is a leading fertility vendor with over ten years of experience in California, and currently covers more than 540,000 lives in our state.

They're committed to taking care of each and every member that needs this benefit and will provide them with high quality equitable care. They're able to provide the comprehensive suite of family building benefits, including all necessary medications and support for adoption.

Excuse me.

Progyny has high standard for its network and provides superior access to high-quality reproductive

endocrinologists and infertility specialists statewide. Ninety-two percent of HMO and PPO members live within 50 miles of a provider. They've also committed to addressing underserved markets and to continuously monitor and adjust their networks as needed. We know that many of our members have been waiting for this benefit for a long timing, so Progyny will expedite setting appointments and begin taking calls before July 1st, 2027, so that members can access care as soon as the benefit is effective.

And finally, Progyny provided the most competitive costs and performance guarantees related to cost, quality and safety for four and a half years. They really committed to meeting our high standards on price, equity and quality.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: So how much will this cost? We've worked hard to develop the most cost effective solution. For 2027, the projected impact is $2.91 per member per month, which amounts to an average premium increase of 0.3 percent for our Basic members. Because this benefit is starting mid-year in 2027, we'll see the second half of the cost associated in 2028's premiums.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: Let's talk about

current implementation plan. Our approach is to require all HMO plans, except Kaiser, to offer the benefit through Progyny. We've used our market leverage to negotiate a nonbinding memorandum of understanding with competitive pricing and terms. Each health plan will contract with Progyny using these agreed upon terms, and Progyny will manage the full family building benefit, including prescription drugs. Because we have negotiated a very competitive arrangement that provides the best value for our members, we're working with the Department of Managed Health Care to ensure compliance with State regulations.

For Kaiser, we believe it makes the most sense for them to administer the benefit themselves. Their care model, as you know, is fully integrated, including pharmacy, which allows members to move seamlessly through care with their primary care team and their specialist team together. Kaiser members will access services through Kaiser fertility clinics, consistent with how they manage their other benefits.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: While we worked on the HMO family building benefit, we also considered the implications for our PPO members. Based on our research, we recommend approval of the family building benefit for our Basic PPO plans. Implementing this benefit for both

HMO and PPO plans at the same time ensures parity and equity for all our members across all our Basic plans.

Many members, as I mentioned, have been waiting years for this benefit and some may switch from a PPO to an HMO to access it, knowing it becomes available on July 2027. Vendors and other employers we've spoken with have seen this kind of movement when the benefit is only offered in certain plans. Implementing it across our Basic program simultaneously eliminates that risk. And PPO members would not need to choose between and disrupt their regular non-infertility-related care to access infertility-related care.

Finally, by implementing this benefit at the same time across our Basic program actually led to better pricing from vendors. Progyny estimates that rolling this out across all plans together will reduce costs by about 10 percent compared to launching it for HMOs only.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: So on to next steps. Upon the Committee's approval of the PPO benefit, we will work with our health plans to lay out the necessary implementation activities to ensure a smooth rollout for our members. We will also communicate the changes to our members ahead of open enrollment. And as a reminder, this is an action item, so it will require a

Committee vote, specifically to add fertility benefits for the PPO. That's my presentation and I'm happy to answer any questions.

CHAIR RUBALCAVA: Questions or comments.

Any comments of questions from the Committee, please.

Well, I do want to again commend the -- Dr. Logan and the staff for an admirable job in implementing this new legislative benefit. And excellent job and I'm very happy with the due diligence your staff went through to choose the final vendor. And it's a beautiful thing and expanding to PPO. I do have a question. I know that the California Department of Managed Health Care provided the guidance. Do we expect -- and that took some time. Do we expect anymore amendments to the guidance in the future or after it's implemented or anything like that?

CHIEF CLINICAL DIRECTOR LOGAN: Yeah. So that's always possible, minor tweaks along the way. For large group plans in California, it got rolled out in January. And so there -- a lot of the kinks and the questions have been essentially worked out. So I think -- I anticipate that by July of 2027, we'll be -- we'll have a very clear idea of what the benefit will be and we already do, essentially.

CHAIR RUBALCAVA: Okay. And when -- I know

there's going to be a robust communication program to promote the family building benefit. When do we think we will start to see some of that -- in open -- before open enrollment, we can see some of it?

CHIEF CLINICAL DIRECTOR LOGAN: In open enrollment.

CHAIR RUBALCAVA: In open enrollment.

CHIEF CLINICAL DIRECTOR LOGAN: Yes.

CHAIR RUBALCAVA: Because it doesn't -- effective date is July 1, so...

CHIEF CLINICAL DIRECTOR LOGAN: Yes.

CHAIR RUBALCAVA: Okay.

CHIEF CLINICAL DIRECTOR LOGAN: We're already drafting the language for that.

CHAIR RUBALCAVA: Sounds good. July 2027. Okay. Thank you very much. I think, at this point, it's an appropriate time to take a lunch break. Is that okay?

CHIEF CLINICAL DIRECTOR LOGAN: Did you want to vote before we --

CHAIR RUBALCAVA: Oh, I'm Sorry. I'm so sorry.

(Laughter).

CHAIR RUBALCAVA: Details, yes. This is a historic vote actually on a historic benefit. So, of course, we want to take a vote. So do I have a motion?

COMMITTEE MEMBER MILLER: So moved.

VICE CHAIR PALKKI: So Chair Rubalcava, I would like to motion to approve the family building benefit for our PPO Basic plans effective July 1st, 2027.

CHAIR RUBALCAVA: Thank you, Vice Chair.

COMMITTEE MEMBER MILLER: I'll second it.

CHAIR RUBALCAVA: Mr. David Miller was second.

And now we'll call for a -- we have a motion and a second. Any discussion on the motion?

Seeing none.

All those in favor say aye?

(Ayes).

CHAIR RUBALCAVA: Oh, we have roll call. Sorry. Roll call vote, please.

BOARD CLERK LEMUS: Kevin Palkki?

VICE CHAIR PALKKI: Aye.

BOARD CLERK LEMUS: Monica Erickson?

COMMITTEE MEMBER ERICKSON: Aye.

BOARD CLERK LEMUS: Troy Johnson?

COMMITTEE MEMBER JOHNSON: Aye.

BOARD CLERK LEMUS: Patrick Henning?

ACTING COMMITTEE MEMBER HENNING: Aye.

BOARD CLERK LEMUS: David Miller?

COMMITTEE MEMBER MILLER: Aye.

BOARD CLERK LEMUS: Theresa Taylor?

COMMITTEE MEMBER TAYLOR: Aye.

BOARD CLERK LEMUS: Yvonne Walker?

COMMITTEE MEMBER WALKER: Aye.

BOARD CLERK LEMUS: Mullissa Willette?

COMMITTEE MEMBER WILLETTE: Yes.

CHAIR RUBALCAVA: Great. We have a successful motion and looking forward to implementation. Thank you, everybody.

And now we will have a lunch break. We'll be back at 12:45. Thank you, everybody.

(Off record: 12:03 p.m.)

(Thereupon a lunch break was taken.)

AFTERNOON SESSION

(On record: 12:48 p.m.)

CHAIR RUBALCAVA: Good afternoon. We're reconvening the Pension and Health Benefits Committee. And the next item of business is Information Item -- Agenda Item number 6a, the preliminary 2027 plan premiums. Don Moulds and Rob Jarzombek, please. Thank you.

(Slide presentation).

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: All right. 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 2027 premiums for CalPERS Basic and Medicare plans. This is annual process where the CalPERS team engages with health plans and negotiates rates for our members and employers.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Here is today's agenda. We'll begin with a timeline for the rate development process, walk through the process by which we set premiums, and look at the weight averages for Basic and Medicare plans. Next, we'll discuss several recommendations given the unique landscape we're in this year. We'll then go through individual plan slides and end with next steps.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Starting with the timeline, last November, the Board approved service area expansions for Kaiser Permanente into northwestern Nevada and Blue Shield's EPO plan into the remaining California zip codes that do not have an HMO option. You also approved a product change for Blue Shield's Medicare Advantage plan. Next month, we'll present the proposed final premiums for your adoption at the Board off-site.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Let's start by going over the process we use to set premiums each year. This information might be well understood by some, but we want to walk through it again, so everyone has the same foundation here today. As an active purchaser of health benefits, CalPERS sets health premiums annually through our rate development process and we negotiate methodically to achieve the most competitive premiums possible. The negotiation process that we follow to set premium is quite detailed and data driven.

Here are the key steps. To begin, we create a baseline premium projection for each health plan by using information from our data warehouse and financial

reconciliation processes with the plans. In doing this, we require the plans to use a standardized methodology to allow for a detailed analysis of trends at the plan level. For example, there are multiple factors that impact pricing, such as changes in enrollment, geographic mix, provider contract negotiations and the health status of members, among others.

We require plans to report all changes in uniform categories, so we can compare their projections to each other, as well as to CalPERS projections. This approach enhances transparency and improves our negotiating position. Next, we compare each plan's premium proposal against actual cost and utilization trends using claims data from our data warehouse. This includes: utilization trends, such as emergency room visits, hospital stays, and office visits; cost trends, such as the cost for services and pharmaceuticals; and any benefit, design or service area changes.

We also compare the health plan's trends with industry trends, such as large group rate filings with the Department of Managed Health Care and other State entities. We then meet with each plan individually to walk through their data and assumptions and talk through the differences between our projections and their proposal. CalPERS negotiating position is greatly

enhanced thanks to our comprehensive data warehouse, transparent invoicing processes, and standardized methodology to identify trends at the plan level.

All of these improve our ability to project plan premiums independently from the health plans and help conduct focused negotiations with each plan. Additionally, we require each health plan to submit an actuarial certification for their projections to certify the accuracy and validity of their projections. We also engage an independent actuarial consulting firm to conduct a third-party verification and review of all rate projections.

This comprehensive strategy enables CalPERS to negotiate efficiently and avoid unwarranted premium increases from being passed on to members and employers. Once we determined -- once we have determined the premiums are reasonable and align with our projections, we apply risk adjustment to the Basic plans. We do not risk the adjust 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 on the concentration of healthy or unhealthy lives in a plan. This pushes the plans to complete on the cost and quality of care, instead of on

their ability to attract younger an healthier members.

The last item on this slide is how we set premiums for public agency and schools as there is an extra step to that process. We start with the State premium calculated for the State of California and CSU members. Despite the fact 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.

In contrast, we have three pricing regions for our contracting agencies, one in Northern California and two in Southern California.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Here are the 2027 Basic plan premiums and weighted averages. Overall, we're seeing a lot of positives this year, such as: improved pharmacy pricing, thanks to our strong contract with CVS; the improved funded status of the Health Care Fund allows us to be less conservative in pricing the PPO plans; our new PPO and PBM contracts include performance guarantees for controlling costs that insulate CalPERS from significant losses; and we're largely seeing positive pricing from Kaiser this

year.

We are not showing UnitedHealthcare Alliance or Harmony plans on this slide, as we are recommending removal of UHC's Basic plans from our portfolio going forward. Additionally, we are recommending adding the Sutter Health Plan to our program, and that premium is included in the chart. We will talk about this in detail in the recommendations section of the presentation.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Here are the Medicare premiums. The Medicare Advantage premiums have an average increase of just over one percent, which is seven percent better than last year. This is because the premiums for Kaiser's Medicare Advantage plans are experience -- experiencing a decrease next year. It's also worth noting that our integrated plans, such as Kaiser and Sharp, are showing dramatically lower premiums than the broad network Medicare Advantage plans. And as we've previously discussed, CMS subsidies for pharmacy costs have been changing in recent years and this has impacted plans differently.

In general, the subsidy changes tend to benefit the integrated plans like Kaiser and Sharp, but not the other plans. For the Medicare Supplemental premiums, they

will remain flat for 2027. This is because the medical costs for the PERS Platinum Med Sup plan are slightly below our projections due to lower-than-projected utilization.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: This slide shows everything rolled up with the 2027 weighted average changes for each plan type and a comparison to last year's increases. The Basic plan weighted average is 5.8 percent, the Medicare weighted average is 0.51 percent, and the overall program average is 4.98 percent. This year's premiums are a significant improvement on last year's and are a continuation of a three-year run of lower year-over-year increases. Projections for national and State 2027 premium trend are just starting to emerge, but ours should be significantly lower than either.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Now, let's take a look at our recommendations. And the first is about UnitedHealthcare's Basic plans. UHC's Alliance Basic plan joined CalPERS -- joined the CalPERS Health Program in 2014 and UHC Harmony joined in 2022. Both have served CalPERS and our members well, as UHC has regularly

received high member satisfaction scores and achieve high clinical quality outcomes for members. Unfortunately, UHC's Basic plans came in with extremely high and unsubstantiated rate increases for 2027. Despite negotiation, UHC was unwilling to bring rates down sufficiently. So in support of CalPERS mission to provide affordable, equitable, accessible and high quality health care, we are recommending removal of UHC's Basic plans. This recommendation is for 2027 and is not retrospective.

We are also recommending CalPERS enter a new contract with Sutter Health Plan. These two recommendations clearly show that CalPERS is an active purchaser and will move to protect members and employers from inappropriately high rate increases. We are also recommending a product change for UHC's Medicare Advantage plan. This product change will separate UHC's medical and pharmacy plans which will result in higher reimbursements from CMS. This is the same product change we approved for Blue Shield's Medicare Advantage Plan last November. Our two other recommendations impact the Basic PPO plan. We propose reducing the surcharge by half and adding the family building benefits to these plans at the same time they're added to the HMO plans, which you approved earlier.

We'll talk about the surcharge reduction when we

go through the individual plan details later in this presentation. Let's walk through our first recommendation.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: UHC's rate submissions were significantly higher than our rate buildup and where we expected their rate to be. We met with UHC multiple times at various levels and they were unable to justify the discrepancies. We worked closely with UHC so that they understood our projections and instructed them to submit an additional submission in April. Unfortunately, there was not much movement with any of their submissions. UHC's final rate submissions were not reasonable and not at all close to our projections. The proposed increases -- the proposed increases would have equated to an additional $167 million that CalPERS members and employers would have had to pay in premiums next year.

Given the unsubstantiated premium increases on their Basic plans, we considered viable options to remove them from our program at the end of 2026, while ensuring our members still have access to the providers they're seeing today.

Let's look at the UHC Basic plans, so we all understand who is in them and what access they provide.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: UHC Alliance is in 26 counties throughout California. It is the only mid-priced plan that provides members access to the Sutter Health system here in the greater Sacramento area. These are the counties of Sacramento, San Joaquin, Stanislaus, Solano, Placer and Yolo. It includes a large number of State employees, as the State employer contribution for health typically covers the entire premium for a single person.

Other HMO plans, such as Anthem Traditional, Anthem Select and Blue Shield Access+ provide access to the same providers in the Alliance Network, but Alliance is the only mid-priced plan in the area that includes access to the Sutter Health system. There are just over 80,000 members in this plan.

Harmony is a narrow network plan in 10 counties. All of the providers in Harm -- in the Harmony network are also available through other HMO plans. Harmony's current enrollment is 13,500 members. Given we were unable to come to agreement on UHC's premium increases, we recommend removing their Basic plans from our program.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Let's talk about the transition plan for

Alliance, as this is where we have the greatest potential for member disruption. As I mentioned, the majority of members in this plan are State employees, as only about 20 percent of their members come from a public agency or school. There is high enrollment in the Sacramento air -- Sacramento area in particular, with the majority of those members assigned to clinicians at the Sutter Health System.

So solving the Sutter issue was a high priority. Therefore, we reached out to the Sutter Health Plan to explore potentially adding them to the CalPERS Health Program. Let's not -- now talk more about who the Sutter Health Plan is and our recommendation to add them to our program.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: The Sutter Health Plan is a fully integrated health plan that started in 2014. It operates in a coordinated way across its clinicians and hospitals, similar to other integrated plans in our program, like Kaiser and Sharp. Plans with this kind of integrated structure often achieve stronger clinical outcomes, because care is better coordinated. In addition, it receives high ratings on quality and service through NCQA, which is the National Committee for Quality Assurance.

The Sutter Health Plan serves about 115,000 Basic members across 16 counties, and has a network of 8,000 clinicians and 33 hospitals. For CalPERS, we are recommending a six-county service area as this largely matches the service area that UHC Alliance has with the Sutter Health System. Those counties are Sacramento, San Joaquin, Stanislaus, Solano, Placer and Yolo.

We recommend entering a two-year contract with Sutter Health Plan as this will align with the end dates of all of our other HMO contracts. The contract with Sutter Health Plan will contain the same strong terms and conditions that we have in all other HMO contracts. Also, for this arrangement, members will continue to have their outpatient pharmacy benefits provided by CVS through the CalPERS contract, which is how this is set up for UHC Alliance and Harmony members today.

UHC Alliance member joining the Sutter Health Plan next will see a rate increase of 7.9 percent over what they are paying in UHC premiums this year. So there's definitely a lot of positives about contracting with the Sutter Health Plan. However, we want to acknowledge that there is no exact fit that fully replicates the experience UHC Alliance members in particular have today.

There are a couple of considerations to discuss.

The first will effect members in combination plans. This is where one member of the family is in a Basic plan and another is in a Medicare plan. This creates a challenge for the approximately 800 families, or about 1,800 members, who are in UHC combination plans and receive services through Sutter Health System.

Through conversations with Sutter Health Plan and a potential Medicare Advantage plan they recently began partnering with, we quickly realized that creating a Sutter-based medical -- Medicare Advantage Plan for January 1st, 2027 was unwise. Having one in place for a 2028 start or beyond is much more realistic. Without a Sutter-based Medicare plan, current UHC combo members receiving services through the Sutter Health System will have to find a new plan with both a Basic and Medicare product.

However, this is not a unique challenge. Neither Health Net Salud y Más or Western Health Advantage Basic plans have a corresponding Medicare plan. And for years, the same was true for Blue Shield, Anthem and Sharp.

Another area of potential membership disruption is behavioral health. Currently, UHC Alliance members use the Optum behavioral health network. However, Sutter Health Plan contracts exclusively with lie Carelon for Behavioral Health Services. We are working closely with

Sutter Health Plan to determine the current provider overlap, which Sutter puts at 80 percent.

Specifically, we are working with Sutter to identify high impact providers in critical areas, so they can potentially add them to the network to ensure as high a level as possible in continuity and better access for members. We raise these issues as we want to be transparent about the areas that could cause member disruption. We strive to make transitions like this as seamless as possible, but that will not be the case for some members.

I'll pause here for questions.

CHAIR RUBALCAVA: Thank you, Mr. Jarzombek. Just -- sorry, Rob. Thank you.

Any comments from the -- or questions from the Committee?

Trustee David Miller.

COMMITTEE MEMBER MILLER: Yeah. Thank you for the presentation. Just more comments. Just really impressed with the work. I think it's -- you know, as much as our members liked their coverage, the fact that the provider just would not work with us -- and really I'm seeing those numbers, that it's just -- they just were not being reasonable. And I think we've -- we're making the right decision here. And I think we will make the right

decision based on staff's recommendations ultimately.

I am really pleased to see Sutter coming in. I know just anecdotally a lot of our members have been very happy with Sutter, and in particular, the behavioral health coverage through Sutter. So I'm hoping that ultimately that can be issues of the coverage can be resolved, because I think they've developed quite a reputation for doing a good job with behavioral health coverage. So I hope that that will work out to our advantage as well. Thank you.

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

CHAIR RUBALCAVA: Thank you, Mr. Miller.

Any more questions or comments?

Before you proceed, Mr. Jarzombek, I do have a comment or a question. In the presentation on how CalPERS sets premiums, you mentioned -- you talked about applying risk adjustment, what have you. But one thing that CalPERS prides itself upon is considering -- making sure quality care, and we have some incentives, and we develop some quality alignment measure sets. So there's -- where there's a percentage of premium at risk.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Yes. And I'm actually going to get that in a slide here.

CHAIR RUBALCAVA: Oh, you were. Okay. Then I'll wait.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Okay.

CHAIR RUBALCAVA: I will wait. Okay. Thank you. Please proceed then.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Okay. So slide 14.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Now, let's talk through how we are going to support members through the transition and the next steps for exiting UHC's Basic plans.

Starting in July, we'll begin our communication campaign to both members and employers informing them of the upcoming removal of UHC Alliance and Harmony plans. We will encourage members to compare and select the best plan for themselves and their families during open enrollment. While we will do our best to map the most appropriate plan for members as part of CalPERS administrative transfer process after open enrollment, there may be specific clinician or facility preferences that we can't predict or know. Therefore, we will strongly recommend that members use our online tools to help ensure they will be in the right plan come next year.

Let's talk more about the criteria we use when setting up the administrative transfer process.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: When there is a plan termination or exit from a service area, we need to determine the plan for members to be transferred into, should they not make an active plan choice during open enrollment. For the UHC Basic plan's exit, we're looking at this from two key angles to ensure we transfer members to the plan that makes the most sense for them.

The key criteria are provider continuity and premium impact. We look at provider continuity to ensure the member and their family can continue with the same provider relationship they have today where possible. For this, we strive for a match with the medical group associated with the assigned primary care physician. We also look at the premium impact to members. We want to transfer members to the lowest priced plan that allows access to their provider. With the unique service areas that Alliance and Harmony both have, there will be multiple admin plans for -- admin transfer plans for each plan.

There will be at least two for Alliance as the Sutter Health plan will be available in six counties in

greater Sacramento -- in the greater Sacramento area. There are other counties in Alliance service area to cover. For Harmony, there may be even more admin transfer plans, as we want to be mindful of the key criteria I just mentioned.

Another potential change for the non-Sutter UHC members is with outpatient pharmacy benefits. This is because any UHC Basic members moving to Blue Shield Access+ or Trio will no longer receive their outpatient pharmacy benefits through CVS. This is because Blue Shield provides its own pharmacy benefits with a slightly different formulary than what UHC members receive from CVS today.

We take these criteria into consideration and are finalizing the administrative transfer plans now. We will share them at the July off-site. The migration of the UH -- of the UHC members will cause small fluctuations in the premiums for Anthem Select and Blue Shield Access+, as they will receive the majority of these members. We will update you on any premium changes in July.

And like with all admin transfer plans we determine, we will still encourage members to do their own review of costs and network

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

CHIEF JARZOMBEK: Here are the next steps for the Sutter Health Plan. First, we need to come to agreement with Sutter Health Plan on the many terms and conditions we have in our contract. I'm please to report that we have made good progress. Our goal is to have agreement on all terms and conditions by the end of June, so we are ready to formally recommend adding the Sutter Health Plan at the July off-site.

And of course, we are preparing our implementation activities to bring on Sutter Health Plan. A key item of this is our communication campaign, which I'll go through in detail in the next couple of slides. We've already begun reaching out across the enterprise to the many business areas that are Needed to support this new plan, which includes resources from IT to make updates to the myCalPERS system.

We're also developing resources for our team members in the Call Center, regional offices, and health teams, so we can all answer questions and inquiries that will come in.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

CHIEF JARZOMBEK: Member support in open enrollment is always important. And with the exit of UHC's Basic plans, its even more critical this year. Therefore, we're using

our targeted member letters as a way to explain the situation, provide information and resources, and help members make an informed decision.

Impacted members will receive an -- impacted members will also receive an email and the custom message on their health plan statement and on the myCalPERS page. In addition, to the targeted member letters, we communicate through a variety of channels from July through October. This includes emails about what is changing, how to make a plan change, factors to consider when shopping for a new plan, and reminders when open enrollment is beginning and ending. We encourage our members to utilize the available resources when evaluating their options so they can make an informed decision for themselves and their families.

In addition to targeted letters, members will also receive an email and a custom message on their health plan statement. And in September, we'll host our annual member webinar, where we'll explain all of the health plan changes in detail and allow members to submit their questions for live answers.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: For our employers, we extensively communicate health plan changes to ensure they have what

they need to assist their employees with any questions or concerns. We start communicating in late June with a circular letter that provides an overview of open enrollment resources and what to expect. In July, they have the opportunity to request open enrollment health fairs with our health plans. And through October, we send emails and employer bulletins with helpful resources and reminders. And just as we do for members, we hold an annual webinar for employers in September where we provide details on upcoming plan changes and where they also have the opportunity to submit their questions.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Next, an update on QAMS, or the Quality Alignment Measure Set. We adopted the QAMS incentive structure for the Basic HMO plans in 2024. We now have the data and have assessed the plan's performance for that year. For 2024, one percent of each HMO plan's total gross premium is at risk for performance on the QAMS, if the plan does not meet the 66 percentile nationally.

The total amount at risk for QAMS increases by one percent per year up to four percent in 2027. Our goal is to not collect any penalty dollars as we would greatly prefer that our plans improve the clinical quality outcomes for our members. With the assessment now

complete, all plans, with the exception of Kaiser, owe CalPERS a penalty for their 2024 performance. We are in the process of collecting $11.9 million, which will be used to lower premiums. Each Basic HMO plan's 2027 premium has been reduced by $1.13 per member per month. Next month at the Board off-site, Dr. Logan will present the plan specific QAMS results for 2024.

The final item to discuss before walking through the individual plan slides is the potential MCO tax. In the State's proposed budget for next fiscal year, the Governor included a managed care organization tax to generate funding for Medi-Cal. As background, recent federal legislation signed by President Trump changed the rules to now apply the MCO tax equally to Medicaid and commercial plans, which includes CalPERS. The idea here is to tax managed care organizations and use that revenue to allow the State of California to draw down additional federal matching funds.

The tax would apply to fully insured or flex-funded Basic plans. It would not apply to self-funded Basic plans or Medicare plans. The Tax is roughly $9 per member per month and equates to about $95 million.

The timing with this is challenging, as the State's budget needs to be approved by July 1st and is

rarely approved ahead of time. Our rate-setting process and applicable statutes require our rates to be made public 30 days in advance of their approval by the Board. We'll continue to monitor this at the State and federal levels. We have instructed the health plan to not include any funds for this potential tax in their 2027 premiums. However, if passed, it will impact 2028 premiums.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Now, let's go through the individual plan slides starting with basic HMOs. The premiums we're showing you reflect the new family building benefits mandated by SB 729 for CalPERS HMO plans effective July 1st, 2027 and the same benefits you approved earlier for the Basic PPOs effective the same time. Because this benefit is starting mid-year 2027, we will see the second half of the cost associated in 2028's premiums.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: The first plan to go through is Anthem Select. To orient everyone to the information on these individual plan slides, I'll walk through this first one in greater detail. The table on the left shows the 2026 and the proposed 2027 premiums before and after risk adjustment, which is 11.38 percent increase. The cost

driver chart on the right shows the breakdown on the premium impacts by component.

The first bar is medical cost and they contribute about ten percent to the premium increase. The next bar is pharmacy and it contributes about four percent to the increase. The third bar is labeled "Program Changes" and includes the net premium impacts of 0.22 percent. This is from adding the fertility benefits as well as the premium offsets from the 2024 QAMS performance measures. The fourth bar is for risk mitigation impact, which has a negative 2.5 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 risk scores, plans with a risk score of greater than one, with one being the average, have sicker lives and their premium is lowered with the impact of risk adjustment. Plans with risk scores less than one have healthier lives and will see risk adjustment increase their premium. Anthem Select has a risk score of less than one. It's 0.9715, meaning the plan has healthier than average members in the Basic portfolio. Therefore, the 2027 premium is increased by $50.75. That amount is shown in the fourth column in the table on the left.

Again, this bar on the chart on the right shows,

in the negative, that it is less than what Anthem Select contributed to risk adjustment last year. So in 2026, they'd have a less healthy population than in 2025. Therefore, you see a negative bar.

Adding all this together, the light green bar shows an overall 11.3 percent increase. I'll pause here in case there are any questions on how to interpret this information

Okay. Now, let's look at Anthem Traditional.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: This is a broad network plan offered in many high-cost, low-competition areas of the state. Traditional's 2027 premium increase is about seven and a half percent, and is largely driven by medical costs.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Next is Blue Shield Access+. Access+ has a premium increase of 11 percent. In addition to general rising medical costs, this plan is also impacted by the costs in Monterey. As a reminder, the Board approved swapping Trio with Access+ in Monterey starting this year. Access+ now serves more than 70 percent of the HMO members in Monterey and provider costs have increased beyond Blue Shield's initial projections. The additional

Mont -- the additional Monterey costs contribute approximately 1.6 percent to the premium increase statewide for this plan.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: And now to Trio. Trio is one of the low premium plans available in 20 counties. The proposed 2027 premium increase is just under three and three-quarters percent.

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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Next is Health Net Salud y Más, which is a very narrow network plan that provides services in six southern California counties as well as in Mexico. Their proposed 2027 premium increase is about eight and a half percent. Medical costs contribute just under seven percent to the premium increase and pharmacy contributed a little over two and a half percent. Salud y Más continues to be our lowest premium Basic plan thanks to its low cost narrow network and Southern California service area. Their membership has been growing and increased by eight and a half percent in 2026.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Next is Kaiser Permanente which is the

largest health plan in our portfolio and makes up about half of the total Basic membership. The proposed 2027 premium increase is just under two and a half percent. While Kaiser has the lowest premium increase of Basic plans, we do need to continue working with them in the coming years to ensure their medical trend remains low and consistent with where they were previously able to maintain it. As a fully integrated system, they should have a consistently low medical trend.

The health status of Kaiser members also decreased, which means they're contributing less to risk adjustment than the previous year. There are two additional tables on this slide, as Kaiser has different rates for their current out-of-state plan and their new Kaiser Permanente Nevada plan. The premiums for these plans are both set on their book of business rates in those areas and not on the CalPERS specific membership as is done when setting their in-state premium.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Moving to Sharp. Sharp's preliminary 2027 premium increase is 6.44 percent. Medical accounts for about five percent of the increase, while pharmacy contributed about two and three-quarter percent.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Next is new Sutter Health Plan that we recommend adding to our Basic program for next year. The plan will be available to CalPERS members in six Northern California counties, which again are Sacramento, San Joaquin, Stanislaus, Solano, Placer and Yolo. And they will provide members with access to the Sutter Health System.

As I mentioned earlier, UHC Alliance members joining the Sutter Health Plan next year will see a rate increase of 7.9 percent above what they are paying in UHC premiums for 2026.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Rounding out the Basic HMO plans is Western Health Advantage. Their increase is just over six and a quarter percent and is primarily driven by medical costs.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Now, let's talk about the Basic PPO plans and our recommendation to reduce the surcharge by half. There has been a reserve funding shortfall for our PPO plans since 2021. That year, the fund balance fell below 90 percent of actuarial reserves and continued to

decrease through 2023. This was mainly due to a combination of premium buydowns for plan years 2020, 2021 and 2022, and the unexpected high health care costs for a couple of years post-COVID.

After a few years of premium surcharges, we've seen great improvements in the PPO fund. As we reported in April's Finance and Administration Committee, the funded status has increased to 81 percent at the end of 2025, and we expect it to reach the required 90 percent reserve benchmark in 2026. Therefore, we recommend reducing the premium surcharge for the 2027 Basic PPO plan premium by 50 percent, with the goal of fully eliminating the surcharge for 2028. Limb

Eliminating the surcharge over two years mitigates the risk of large premium swings and destabilizing member migration, that would be more likely to occur, if CalPERS were to eliminate the surcharge over a single year. The premiums shown here reflect the reduced surcharge. These premiums also reflect the cost of the new family building benefit, which has a 0.3 percent impact for 2027. The overall rate increase is projected at seven and -- 7.34 percent for the Basic PPO plan.

Medical costs continue to be the main driver at nine and a half percent, with the PERS Platinum experience

being higher than expected. This is primarily driven by the migration of healthier members out of the plan. In contrast, PERS Gold reported more favorable medical trends. Pharmacy costs performed within expectations.

The 2027 premium is offset by the reduced surcharged amount. Specifically, the surcharges have been reduced in half. For PERS Platinum, it's going from four percent to two percent, and for PERS Gold from five percent to two and a half percent. Risk adjustment also helps moderate the PPO rate increase by offsetting the healthy members who exited the PPOs.

And as you know, 2025 was the first year of our new contracts with Blue Shield and Included Health. These contracts include new total cost of care performance guarantees. And the preliminary results are that both entities will owe money to CalPERS. We continue to complete the complex data analyses to ensure the claims data we are using in this very important calculation are both accurate and complete. The official calculation will be performed once we have full rent out from the 2025 plan year, which is expected to occur in the coming months. We look forward to reporting back to the Board the final impact of the performance guarantees on both the total cost of care and clinical quality measures.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: This slide shows the 2027 Basic plan premiums and the placement in our program. It also reflects the removal of the UHC Basic plans and the addition of the Sutter Health Plan. The Sutter Health Plan comes in right above Kaiser Permanente, which dropped two places below Anthem Select and Blue Shield Access+. Blue Shield Trio also dropped one place just below Sharp. I'll pause here for any questions before moving on to the Medicare plans.

CHAIR RUBALCAVA: Trustee Walker, please.

COMMITTEE MEMBER WALKER: Thank you. Rob, I don't remember you saying the zip codes that the Kaiser Nevada is going to cover.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: I don't have those with me, but we are posting them online tomorrow and will be on -- ready in our open enrollment resources and plan changes for next year.

COMMITTEE MEMBER WALKER: Great. Yeah. Because that's the question I get a lot and I just want to make sure we're there. Thank you.

CHAIR RUBALCAVA: Thank you. Please continue.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Okay.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: So now let's talk about Medicare. The impacts of the Inflation Reduction Act are starting to take effect and we see this positively benefiting the well-managed Medicare Advantage plans that have their own networks. Kaiser's MA plans are seeing a decrease in premium. And Sharp continues to be a much lower cost option in our program.

By contrast, the Medicare Advantage plans of UHC, Blue Shield and Anthem are significantly more expensive. And as we've previously discussed, CMS subsidies for pharmacy costs have been changing in recent years and this has impacted the plans differently. In general, the subsidy changes tended to benefit integrated plan, like Kaiser and Sharp, but not the other plans. This is because they're able to control their prescribing habits better and use less brand named drugs and more generics, which helps keep costs down.

For the Med Sup Plan, it's a higher priced plan, because it uses the broadest PPO network available and includes all providers who participate in original Medicare. These benefits are richer in the -- the benefits are richer in the Med Supp plans, which also necessitate a higher premium. All of this highlights the

variety of Medicare plans in our portfolio, which is something we'll be digging into in the coming year.

We should have high-performing plans that manage costs well, while achieving the best clinical outcomes for members. Therefore, we plan to evaluate what types of Medicare Advantage plans make the most sense to include in our portfolio. We will likely return to you with options and recommendations, so that we are containing costs, maximizing payments from CMS, and improving quality for members.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Anthem's proposed is premium just over eight and a quarter percent from 2026. The majority of this rate increase is driven by medical costs.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Blue Shield's nationwide Medicare Advantage plan started with CalPERS an 2022 with about 600 members. In just four years, it has grown to roughly 13,000 members today. To help make their premiums more competitive, Blue Shield has used their own reserves to reduce the premium by roughly 31 percent for 2026, and 17 percent for 2027. The proposed 2027 premium increase is about 15 percent. Eleven percent of the premium increase

is due to medical and pharmacy costs. The reduced Blue Shield investment has contributed 6.3 percent to the premium increase, which is shown in the other column in the cost drive chart.

The program change column reflects the premium savings by separating the medical and prescription drug coverage into two plans. As I've shared earlier, this is because with separate medical and pharmacy plans. The pharmacy risk score is calculated differently than when combined and receives a higher CMS reimbursement. With this product change, the only impact to members is that they will have two ID cards, one for medical and one for pharmacy benefits. Everything else, such as copays and formularies will remain the same.

Taking learnings from transitioning Medicare members from Optum to CVS last year, we are working with Blue Shield to ensure the communications sent to members are clear and don't cause any unnecessary alarm.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Moving on to Kaiser. Kaiser Senior Advantage is proposing a six and a half percent decrease. Kaiser Medicare plans are community rated with the CalPERS Medicare rates blended across all Kaiser regions. The premium differences between the Kaiser Senior Advantage

Plan in California and the out-of-state plan are driven by the California specific benefits, which include over-the-counter drug benefits, meals delivery and transportation.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Kaiser Senior Advantage Summit plans have a similar premium reduction for 2027. The Summit plans utilize the same Kaiser California and out-of-state care delivery system with the only difference being the richer benefit design, where members pay less out-of-pocket costs when utilizing services.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Moving to Sharp. They are proposing a 10 percent premium increase from last year. This product was introduced in 2021 and now has about 800 members. The main cost driver is pharmacy, which is close to seven 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 an 11 percent increase from 2026. The medical cost increase is the largest driver for this plan. Their premium increase is offset by

the product change we are recommending for them too.

Again, the only impact to members is that they will have two ID cards, one for medical and one for pharmacy benefits. And like with Blue Shield's product change, we will work with UHC to ensure the members sent -- to ensure the communications sent to members on this are clear.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Now, PERS Medicare supplemental premiums. These will remain flat for 2027. This is because the medical costs for the PERS Platinum Med Sup Plan are slightly below our projection due to lower-than-projected utilization. Therefore, we are still collecting enough in premiums to cover the cost of services for 2027.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Here are all the Medicare plans in our portfolio and their ranking by premium.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: For next steps, the CalPERS team will finalize the contract terms with Sutter Health Plan, with the goal of having a signature-ready contract should you

approve adding them to our Program. We will actively continue preparations for the exit of UHC's 2 Basic plans, as well as the implementation of the Sutter Health Plan. We are also providing the preliminary premiums to stakeholders, the Legislature, and Department of Finance.

In July, we'll then present the final premiums to you for your -- for the Board's approval. This concludes our presentation, and Don and I are happy to take any questions.

CHAIR RUBALCAVA: Thank you, Mr. Jarzombek.

Now, we have an opportunity for questions and comments from the Committee. We'll begin with President Taylor.

COMMITTEE MEMBER TAYLOR: Thank you, Rob and Don for going over this, as well as Dr. Logan for the beginning -- for the fertility addition of our care. This is a lot of information and I appreciate all the information that you gave us. I had a couple of questions on -- wait, wait, wait. Let me get there. Okay. So the Blue Shield Medicare PPO is at 14.82 percent. And part of that you said that they're breaking out their pharmacy or was I listening to the wrong one?

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: That one applies to this one. And so this was part of the product change the Board approved

last November. And it's ordered to get more revenue from CVS. When you split out the pharmacy from the Medicare plans, the pharmacy plan is rated differently and it generates more dollars from CVS. So it has that reduction of that product change of like negative 2.5percent.

COMMITTEE MEMBER TAYLOR: And then you had said that they are recovering some cost from the previous year, is that what this rate increase is?

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: So they were buying down their rate for a several years actually.

COMMITTEE MEMBER TAYLOR: Oh, okay, like we did, yeah.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: And so that -- like we did. And so that 6.34 percent is actually a snapback that's happening when you don't continue to buy it down year over year, which we're, of course, familiar with. So that is -- that's what happens.

COMMITTEE MEMBER TAYLOR: Always a bad idea. It hurts in the end.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: It hurts in the end, yes.

COMMITTEE MEMBER TAYLOR: So -- and my concern is that I don't want to -- this is kind of what happened to

Blue Shield before. Okay. We -- they started to get higher, and higher, and higher priced, and sort of priced themselves out of a whole bunch of lives. So I just -- I'm hoping that this is not what we're seeing again.

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Right. And so this is an example of why we want to look at the Medicare offerings in our program. We have such a difference. There's nearly a two-to-one price difference with some of these like Blue Shield, UHC, and Anthem compared to Kaiser and Sharp. And so that's part of the work we want to do in the coming year is to understand what is the right type of Medicare Advantage Plan for our portfolio --

COMMITTEE MEMBER TAYLOR: And then --

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: -- for our members really.

COMMITTEE MEMBER TAYLOR: Well, and then if you look at Blue Shield for Access+ for the HMO, they're still one of the highest increases. I think they are the highest increase for the HMO. So that's where I'm getting a little concerned, the HMO and the EPO. And then you -- than you look at the Medicare Advantage Program and it's -- I'm really concerned about this turning into what it was before.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

CHIEF JARZOMBEK: Okay.

COMMITTEE MEMBER TAYLOR: And a whole bunch of lives have moved back over to Blue Shield, including myself. And I think that's a big concern.

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Okay. That's something we'll definitely be keeping an eye on. Don.

CHIEF HEALTH DIRECTOR MOULDS: I was just going to add, and I'm -- I think you're right to focus on the Shield premium and that concern. It's always something that we've gone an eye on. On the Medicare side, I just wanted to remind you that this is still a relatively new and very small MA plan. So it's got 12,000 lives in it. We haven't had it in the book. Part of what's going on I think is that they're trying to find their bearings and a new environment. So we're working with them.

COMMITTEE MEMBER TAYLOR: Okay.

CHIEF HEALTH DIRECTOR MOULDS: I think the change to the adjustment in the way that they disaggregate pharmacy and medical was really critical to the CMS revenue piece. But, you know, the ones that we've had for much longer periods of time have been working with CMS and understand the rules, and how to do this in a way that is, you know, more of a front-end learning curve when you're -- when you're starting out with a -- with a plan

in CalPERS book.

COMMITTEE MEMBER TAYLOR: All right. Thank you. And I just -- the last thing I wanted to state -- I appreciate all of the information you guys, because I think everybody else's rates look pretty good. I mean, Anthem is not great either, but they tend to be really high anyway. I just want to make sure that the Sutter Health Plan, when implementation comes, there's lots of communication out to our members. As I said earlier, I'd like to have a copy of it, so we can get it to my union and make sure that they can post it on their update or wherever and whoever else wants that to happen as well. So thank you.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Yes. That's absolutely part of our open enrollment communications is do doing newsletters for any organization that would like to help us spread the message to your constituents. So that's definitely something that's on our list of things to do

COMMITTEE MEMBER TAYLOR: All right. Thank you so much.

CHIEF HEALTH DIRECTOR MOULDS: We had also the same conversation in the stakeholder meeting with the retiree groups who were there. We're going to be working with them to get stuff out into their newsletters as well.

COMMITTEE MEMBER TAYLOR: Okay. Great, Thank you.

CHAIR RUBALCAVA: Thank you.

Trustee Walker. Yvonne Walker.

COMMITTEE MEMBER WALKER: Thank you. So I just want to say I really appreciate the work of the team. You guys do, I think, incredible work. And as hard as it is to go through another year of change, I think we're making the right choice -- well, I'm making the right choice. We haven't voted yet, but I am.

(Laughter).

COMMITTEE MEMBER WALKER: So I'm making the right choice. It is absolutely right to drop UHC and go to Sutter. So I thought that that was a very good decision. And I hope it opens up doors further into the future. And it will be interesting. It will be interesting. And I do appreciate that these rates are so much better than they've been since I first came on the Board. So that is a plus too. And I appreciate all of the innovations that you go for, you try to get.

When we got -- when I saw the building family, it added a lot of stuff that I didn't think was going to be there, right? And so I just like that we're -- you know, we're on -- we're ahead of the curve on a lot of things. And I'm hopeful that that's where we will remain.

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

CHAIR RUBALCAVA: Thank you.

I'll call on Vice Chair Palkki.

Whoops. I hit the wrong one. Hold on.

Okay.

VICE CHAIR PALKKI: Just something to look for in the future. Obviously, I know we're still --

J.J. JELINCIC: Mic.

VICE CHAIR PALKKI: Thank you. I know we're still settling contracts and things of that sort, but it would be good to do a spotlight with Sutter upon completion of that, similar to what we did with the other agencies.

CHAIR RUBALCAVA: Thank you.

Any more comments or questions?

Okay. I do have a couple comments. First, I also want to thank and congratulate the team, Don, for another great year of negotiating rates, that rate-setting process is complicated, but I do think we have all the pieces that make us the innovative leader, the data warehouse and the other calculations your folks are doing, the requirements for high performance and quality and standards. And I'm pleased that this, as Don mentioned, that we have a third year of reasonable rate increases.

I'm also very pleased that Kaiser is a very reasonable increase. But being an integrated system, I would hope -- I mean, they're moving down the -- if you look, you stack all the premiums. They're moving closer to the bottom third, bottom half, but they're still higher than PERS Gold, which is a PPO. And would think an integrated system would have lower rates. That's my view.

I also want to -- want to -- I mean, you said it, Rob, if not this meeting, some other meeting, that now we have HMO or an EPO in every county in the State, which is a big accomplishment. And I'm glad that Blue Shield Trio is expanding throughout Northern California. We always want quality networks and that's something I'm pleased we're moving forward with in this -- in this program.

So I look forward to the Medicare program report backs on the high performance. I also want to join with our Chief Health Director Don Moulds in thanking UnitedHealthcare for the years of service they've given our members, both in Alliance and in the Harmony plan. I was very happy when we were able to add Harmony, but unfortunately we couldn't move it beyond -- really beyond Southern California. But anyway, but we have to look forward to working with Medicare UnitedHealthcare. So thank you.

Anybody else on the Committee?

No questions. I guess not.

So thank you, Mr. Jarzombek, for your great presentation.

So now, we're going to comment --- public comment. We have J.J. Jelincic on 6a.

J.J. JELINCIC: J.J. Jelincic, RPEA.

I'm glad to see the lower cost -- the lower increases, but lower increases still mean higher costs. It's sort of reminds me of the politicians who talk about inflation. If you're a Democrat, it's going up. If you're a Republican, it's going down. It's just that you define different periods.

But in any case, the issue is not the rate of change, the issue is the cost. And the costs are too high. Rob Feckner isn't here, so on his behalf, I will say tell them to sharpen their pencils. It didn't work for him. I don't think it will work for me.

Most of my members are in Medicare. And although we do have a number in the Basic plans. Let me point out you get what you reward. You continue to reward companies with high premiums by subsidizing their premiums and you continue to hit low-cost plans with surcharges. I'd point out that Sharp, Trio, Salud y Más and Kaiser would all be negative this year except for the surcharge this Board chooses to put on their premiums.

As I said, my members are by and large in Medicare, but we have an interest in the Basic plans, because as basic plans go up, costs go up, and that eventually transfers to Medicare. So we do have a concern. It's not a direct one, but, you know, it leads to higher costs for us.

Last year, you dropped a plan, and I forget which plan it was, because they wanted a 49 percent premium. That struck me as reasonable, struck you as reasonable. This year, you're dropping UHC for having asked for an extremely higher plan, but I notice you're not telling us this time what that plan increase was. And I'm just wondering if you could release it as you did a year ago?

Thank you.

CHAIR RUBALCAVA: Thank you for speaking to the Board.

Next, we have Larry Woodson.

LARRY WOODSON: Good afternoon. Larry Woodson. Thank you for the opportunity to speak again. And I want to thank the health team for the special session that we had this morning. It gave us a glimpse of -- and some good explanation of the new proposed rates. This is the first time in 10 years that I've been commenting on rates that I can surprisingly say I'm pleased, at least with the rate increases and overall. I mean I agree with Mr.

Jelincic, they're too hard to start -- too high to start with, but until -- just speaking for myself, until we get a single payer plan not-for-profit in this country, it's going to remain to be high.

I'm happy to see that UnitedHealthcare is being removed as an HMO plan, due to especially high rate proposals. Although they remain as an MA plan and are jacking up those rates by nearly 11 percent. The MA is a big money maker for them, due to capitation method. And recently, they just climbed from third to second in the Fortune 500. So they're doing quite well, even without us.

It's good to see the zero percent change in Platinum and Gold Supplemental plans. However, I agree with the Board member's comment about Blue Shield and Anthem, Ms. Taylor. It's just really, really too high. And I hope, you know, maybe between now and July, the team can get those done a little bits.

And let's see, we have been -- we've heard measures they're taking to minimize disruption to those members affected by UHC cancellation. And I'm really impressed with their efforts and we talked a lot about that in this session. I hope they're more effective, and I think they will be, than the PBM transition from Optum to Caremark.

And then lastly, I hope they can take action to lessen the harm PE is doing to our health care system. And more on that when I speak to Item 6c at the end.

Thank you.

CHAIR RUBALCAVA: Thank you, Mr. Woodson. Now we -- any -- nothing on the phone, right?

BOARD CLERK LEMUS: (Shakes head).

CHAIR RUBALCAVA: Okay. Now, we'll proceed to Summary of Committee Direction.

CHIEF HEALTH DIRECTOR MOULDS: Thanks, Mr. Chair. I have, I think, two potentials and you can tell me whether they are Committee direction, but I think they are. So the first is to -- is to schedule a future spotlight with the Sutter Health Plan?

CHAIR RUBALCAVA: That is correct.

CHIEF HEALTH DIRECTOR MOULDS: Yeah. And then the other one would be to work with outside groups to reach critical audiences, so the retiree groups, some of the labor groups, if they're interested in sharing our materials in their newsletters and so forth.

CHAIR RUBALCAVA: Thank you. Member communication is always going to be very important to this Committee. Thank you very much.

Now, we'll move on to public comments, 6c and we'll start with Mr. Robert Norton.

ROBERT NORTON: Good afternoon, Chair and members of the Committee. My name is Robert Norton and I am the Chief business official for Amador County Unified School District and Amador County Office of Education. Our Superintendent Jared Critchfield and our Board of Trustee Member Shane Crowe is here in attendance and we're behind this message here. We are here today to be a partner with you and to deeply thank you for your willingness to listen and consider the unique challenges currently facing our rural public servants and their families.

We are here today to identify a critical problem challenging our community. CalPERS current regional structure group -- groups Amador County into Region 1, alongside high cost metropolitan areas like San Francisco and Sacramento. This creates a rural penalty, giving us the highest cost relativity in the state, despite our vastly different rural economic reality.

Compounding on this structure are our limited plan options. Our Educators and staff are restricted to just two plan options, the CalPERS Gold and the CalPERS Platinum. To make matters worse, our only local hospital in Jackson, California is the only in-network plan that is available to our folks is the higher cost Platinum plan. So if they want to go to your local hospital, they have to go there, which is also a Sutter Hospital. And with the

expansion of the Sutter plans that I'm seeing here today, one of the counties not noted in those six was Amador County. So I would request from the Board, if we're -- or at the Committee, if we could look into that as we move forward there.

So this leaves our staff with a painful false choice. They can either choose the Platinum Plan, which places a massive financial burden on our families and to not -- or just to have the local hospital, or they can choose to, the more affordable Gold plan, which then forces our folks to bypass our local hospital and drive 60 miles out of the county just to see an in-network doctor.

So this access gap is causing real-world damage. Our staff are missing precious time out of the classroom to go have sick days, burning through gas money, sick leave, and most heart breaking cases, completely delaying necessary medical care, because the travel is simply too overwhelming.

Right now, our members do not have sustainable affordability, nor do they have competitive choice. Your Committee is conducting a vital evaluation of regional structure over the next three meetings in July, August and November. This is why we are advocating now. We urge you to look at Amador County during this review, decouple us from the metropolitan rates that were referenced -- or

looking at the 2018 -- or the model that was done, there were two different models that would have put us in a much more one-to-one cost relatively ratio. Expand our plan options to where we don't just have two within our county. With this Sutter Health one, it would be amazing if we could add that.

And use your negotiating power to ensure our local hospital is included in more affordable tiers that were referenced earlier today. To help illustrate this human cost of this crisis, I'm presenting you with a letter containing 21 deeply personal stories of our teachers, staff detailing how these plans and offerings have severely impacted them, since we joined CalPERS in October of 2025.

In here, you'll read about a single mother forced to delay her own care, a new teacher facing immediate financial ruin, and an employee who incurred an $8,000 out of pocket network bill. We ask that you live out your core values of quality, respect and accountability by looking at the faces behind these statistics. Let's work together to fix this structure and ensure that those who serve our students can afford to take care of their own families.

Thank you for your time, leadership and thoughtful consideration of this.

CHAIR RUBALCAVA: Thank you for your comments.

Next, we have Larry Woodson.

LARRY WOODSON: Hello again. Larry Woodson. CSR has a long history of expressing concern regarding the harm PE is doing to health care. And as you know, I documented that extensively in my report on the dangers of private equity, which you and the Exec staff received last year. As noted in that report, there's been an explosion of PE acquisitions of health care in the last 15 years, hospitals, nursing homes, rural health, doctors practices, and so on, dialysis clinics and more. They create huge debt for all and typically strip assets which results in harm to patients and lower quality outcomes.

I cited the most egregious example being Cerberus Capital's acquisition of a health system in Massachusetts, renaming it Steward Health and expanding it from six to 37 hospitals in ten states. Over a ten-year period, they went into such debt that six are now closed, 31 others in bankruptcy.

I pointed tout that CalPERS has invested nearly half a billion dollars in 2012 in a Cerberus fund that led to these failures. When I mentioned that at the March Retiree Roundtable, Mr. Orlich stated that that particular found was not used for acquisition of Steward. And subsequently, I find that he is likely correct, even

though, AI says differently. But I consider that a moot point, since CalPERS currently shows seven active funds in Cerberus for over a total of two and quarter billion dollars, including three new funds after the collapse of Steward. They continue to feed millions to the PE company that has bankrupted 37 hospitals.

In the same vein, a March 5th article in the New England Journal of Medicine titled, "PE's Transformation of American Medicine: Implications for Health Equity," documents how recent in years PE firms have gained increasing control over U.S. health care infrastructure, undermining the progress in health equity by curtailing access to affordable high quality care for rural populations, older people, and people with low incomes.

It also documents how other firms are causing hospital closures elsewhere. At the January networking session, I asked Mr. Gilmore if he was at all concerned about PE's harm to health care. And he said, it's mainly a lot of anecdotal situations. I asked Mr. Orlich the same question at the Retiree Roundtable and his response is no more harmful than many other factors.

It's time for this organization to -- that prides itself in ESG policies to wake up and put guardrails on PE acquisitions of health care. Now, in closing, I will say, Mr. Rubalcava came up to me before this meeting and said

that CalPERS is no longer investing in PE companies that acquire health care, which was the first I've heard of this, and that's great news. If that's so, I'm not sure Mr. Gilmore and Orlich heard that message. I would like to hear more about how that was decided and is being implemented.

Thank you very much.

CHAIR RUBALCAVA: Thank you.

Perhaps I should have said something earlier, but it is our practice not to respond to public comment, but we welcome the comments.

Thank you.

Any more comments?

So with that, the meeting is adjourned. Thank you, everybody.

(Thereupon California Public Employees' Retirement System, Pension and Health Benefits Committee open session meeting adjourned at 2:01 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, 2026.

JAMES F. PETERS, CSR
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