

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, SEPTEMBER 15, 2026
1:15 P.M.

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

A P P E A R A N C E S

COMMITTEE MEMBERS:

Ramon Rubalcava, Chair

Kevin Palkki, Vice Chair

Monica Erickson

Troy Johnson

Fiona Ma, represented by Patrick Henning

David Miller

Theresa Taylor

Yvonne Walker

Mullissa Willette

BOARD MEMBERS:

Michael Detoy

Lisa Middleton

STAFF:

Marcie Frost, Chief Executive Officer

Kim Malm, Deputy Executive Officer

Donald Moulds, PhD, Chief Health Director

Prashant Yerramalli, General Counsel

Yesenia Croft, Chief, Health Account Management Division

Emily Zhong, Supervising Health Actuary

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

ALSO PRESENT:

Aparna Abburi, Sutter Health Plan

Ariana Adame, City of West Sacramento

Peter Bergamo, Sutter Health Plan

Robert Bixler, MD, Sutter Health Plan

Sara Granda

Joe Heim

J.J. Jelincic, Retired Public Employees Association

Stacey Peterson, City of Roseville

Frank Ruffino, California State Retirees

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P R O C E E D I N G S

CHAIR RUBALCAVA: Good afternoon, everybody.
Thank you for your patience. We will begin. I call to
order the Pension and Health Benefits Committee. And the
first order of business is --

BOARD CLERK LEMUS: Ramon, may we have a moment?

CHAIR RUBALCAVA: Sorry?

BOARD CLERK LEMUS: Okay. We're good.

CHAIR RUBALCAVA: Can you hear me?

Okay. First order of business will be roll call
please.

BOARD CLERK LEMUS: Ramon Rubalcava.

CHAIR RUBALCAVA: Present.

BOARD CLERK LEMUS: Kevin Palkki.

VICE CHAIR PALKKI: Good afternoon

BOARD CLERK LEMUS: Monica Erickson.

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.

1 COMMITTEE MEMBER WALKER: Here.

2 BOARD CLERK LEMUS: Mullissa Willette.

3 COMMITTEE MEMBER WILLETTE: Here.

4 CHAIR RUBALCAVA: Thank you. And now the agenda
5 calls for us to go into closed session. The agenda says
6 it will be about two hours, I must -- I'm afraid.

7 (Laughter).

8 CHAIR RUBALCAVA: So I thank you again for your
9 patience, as we enter --

10 CHIEF HEALTH DIRECTOR MOULDS: Mr. Chair, I think
11 we can do your best to -- I think we can probably shorten
12 that, I mean, subject to discussion, et cetera.

13 CHAIR RUBALCAVA: Yes, of course.

14 CHIEF HEALTH DIRECTOR MOULDS: But we will -- we
15 will work on that.

16 CHAIR RUBALCAVA: Okay. It will be less than two
17 hours. Hopefully an hour.

18 CHIEF HEALTH DIRECTOR MOULDS: I think that's an
19 excellent target.

20 CHAIR RUBALCAVA: We'll shoot for an hour folks.

21 (Laughter).

22 CHAIR RUBALCAVA: Thank you for your patience.

23 (Off record: 1:16 p.m.)

24 (Thereupon the meeting recessed
25 into closed session.)

1 (Thereupon the meeting reconvened
2 open session.)

3 (On record: 2:30 p.m.)

4 CHAIR RUBALCAVA: Good afternoon. We are back in
5 open session of the Pension and Health Benefits Committee.
6 I thank you for your patience. And we will continue with
7 the remainder of the open session agenda. Please call the
8 roll.

9 BOARD CLERK LEMUS: Ramon Rubalcava.

10 CHAIR RUBALCAVA: Present.

11 BOARD CLERK LEMUS: Kevin Palkki.

12 VICE CHAIR PALKKI: Good afternoon.

13 BOARD CLERK LEMUS: Monica Erickson.

14 COMMITTEE MEMBER ERICKSON: Here.

15 BOARD CLERK LEMUS: Troy Johnson.

16 COMMITTEE MEMBER JOHNSON: Here.

17 BOARD CLERK LEMUS: Patrick Henning.

18 ACTING COMMITTEE MEMBER HENNING: Here.

19 BOARD CLERK LEMUS: David Miller.

20 COMMITTEE MEMBER MILLER: Here.

21 BOARD CLERK LEMUS: Theresa Taylor.

22 Yvonne Walker.

23 COMMITTEE MEMBER WALKER: Here.

24 BOARD CLERK LEMUS: Mullissa Willette.

25 COMMITTEE MEMBER WILLETTE: Here.

1 CHAIR RUBALCAVA: I believe President Taylor is
2 present. We'll just -- she'll come in when she comes in.
3 Okay. We'll proceed with the execute report. Don Moulds
4 and Kim Malm, please.

5 DEPUTY EXECUTIVE OFFICER MALM: Good afternoon.
6 Kim Malm, CalPERS team member. Open enrollment season
7 kicked off yesterday. And while Don will be providing
8 those updates, I do want to share that our Call Center
9 received over 7,100 calls from our members on opening day.
10 The average wait time for our callers was approximately
11 nine minutes. In comparison to last year, we received
12 almost 7,800 calls and the wait time was over 17 minutes.
13 So the team was able to reduce that wait time by eight
14 minutes this year. I want to thank the entire team,
15 including our managers for answering the calls and
16 supporting our members during this important time.

17 I'd also like to share some updates on the
18 Customer Services and Support projects. First, our 2026
19 Benefit Verification cycle concluded in August. As I
20 previously reported to you, we sent approximately 14,000
21 letters to members that had met specific risk thresholds,
22 such as age, benefit amount, length of time since last
23 contact with CalPERS, and when they last interacted with
24 their health care provider.

25 This year, we found 426 unreported deaths across

1 California and 32 other states. Through this cycle, we
2 identified 4.3 million in overpayments and have received
3 2.7 or 63 percent of those overpayments. In the last
4 three years, we've identified about four and a million
5 dollars on average of overpayments each year and we've
6 successfully collected 80 percent.

7 The Benefit Verification Project continues to be
8 a very important tool, as we continue our efforts to
9 reduce overpayments.

10 Next, I'd like to provide you an update on our
11 effort over the past year to increase myCalPERS member
12 self-service registration. Our goal was to reach members
13 who had not yet signed up for a myCalPERS account, so we
14 could improve communication, reduce undeliverable mail,
15 and help prevent fraud. Over the past year, in
16 partnership with Public Affairs, we've sent targeted
17 emails, member education bulletins, provided online
18 tutorial videos, and our Call Center has assisted those
19 who have called.

20 We requested that our employers, through our
21 employer leadership dialogues and employer education
22 bulletins encourage their employees to register for a
23 myCalPERS account as well. I'm happy to report that we've
24 increased registrations by over 84,000 accounts from this
25 time last year. This is an increase of almost six

1 percent. Today, 65 percent of our active members and 88
2 percent of our retirees have a myCalPERS account.
3 However, about 36 percent of our members are still not
4 registered. We remain committed to our engagement
5 efforts, including encouraging our employers to promote
6 registration at the time of hire.

7 We're also focused on assisting our employers and
8 members with understanding the laws surrounding working
9 after retirement. We're tackling this from a few
10 different angles. First, we've notified our employers
11 that we are cleaning up our data by automatically removing
12 retired annuitants who have shown zero payroll for 12
13 months or longer. Before this change, we had over 17,000
14 active retired annuitant appointments in our system. The
15 first batch ran on September 1st. There are almost 800
16 members that were separated due to having no payroll
17 reported for the last 12 to 18 months and there were over
18 5,200 additional retired annuitants separated because
19 there was no payroll reported for 19 months or longer. A
20 totaling of 6,000 inactive appointments were removed,
21 resulting in approximately 11,000 remaining active retired
22 annuitant appointments.

23 Second, we have many implemented a new internal
24 tool affectionately called Computron, in our Employer
25 Division. I've mentioned this to you before. This AI

1 tool was developed by our team members and assists in
2 comparing employer's memorandums of understanding, or
3 MOUs, with CalPERS law, and quickly identifies any issues.
4 When employees -- employers requested these reviews
5 previously, it took our team about 30 days to read all of
6 the documents, analyze them against the PERL, and then
7 identify if there were any pay compliance issues.

8 Now, Computron will perform the first pass to
9 check for compliance in about an hour's time. Then our
10 team reviews the results for accuracy. It also drafts the
11 memo that we send back to the employer regarding any
12 issues found. This has significantly reduced our time to
13 respond to the employer by 14 days. We encourage our
14 employers to reach out to us for review of their MOUs,
15 which will help prevent future overpayment issues. It's
16 best to find these early and not when the members are
17 ready to retire.

18 Lastly, on the retired annuitant front, building
19 on our initial efforts from 2023, in November we'll be
20 brining and agenda item for your approval of the proposed
21 regulations defining limited duration for post-retirement
22 appointments. We took the feedback stakeholders raised
23 during the 2023 regulatory push and directly incorporated
24 adjustments to address those concerns.

25 In July and August of this year, we met with

1 retiree, labor, and employer stakeholder groups to preview
2 these updated documents. By providing better tracking and
3 clear rules, we're protecting our employers and retirees
4 from accidental infractions. We'll also be bringing
5 regulations to you in November to clarify how a retiree's
6 normal retirement age is determined and evaluating whether
7 the retiree has had a bona fide separation from service
8 before returning to work as a CalPERS covered employer.

9 Currently, the normal retirement age is set at
10 the highest age across all benefit formulas a member has
11 earned service in, regardless of how much time they've
12 spent in each formula. For example, if a police officer
13 spends 30 years in the safety three percent at 50 formula,
14 but one year in a miscellaneous formula, two percent at 55
15 as a cadet, their normal retirement age would be set at
16 55, not at 50. This causes confusion for employers and
17 retirees, as they would naturally assume the normal
18 retirement age would be set at 50, since that's the
19 formula for which most of the retiree service was earned.

20 It leads to bona fide separation violations,
21 which require reinstatement from retirement and impose
22 costly penalties for retirees. We do not think that was
23 intended when the regulation was adopted. Most recently,
24 this has resulted in negative consequences for CalPERS
25 retirees, when employer audits identify violations,

1 particularly involving peace officers who return as
2 retired annuitants to support seasonal events, where
3 additional Law enforcement is needed to help ensure public
4 safety.

5 This regulation change would propose an 80/20
6 rule where if the member earns their service credit in one
7 formula, up to 80 percent of their service time or more,
8 that formula determines their normal retirement age. This
9 ensures that normal retirement age reflects the formula
10 that represents the majority of the member's career
11 contributions. Again, you will see this regulation
12 package in November.

13 Finally, our team has been preparing and
14 executing educational training for our members and
15 employers. Coming up later this month, September 29th and
16 30th, we'll be hosting our Third Annual Funding Your
17 Retirement Futures webinar. This webinar is focused on
18 helping members understand the three key pieces of
19 retirement planning, their CalPERS pension, Social
20 Security and supplemental retirement savings. Together,
21 these three components can help members build a more
22 secure and well-rounded retirement plan.

23 We partnered with the Social Security
24 Administration, the California 457 program, and CalHR's
25 Savings Plus Program to provide members with information

1 and resources across each of these areas. We offer two
2 versions of the webinar, one specifically for State and
3 CSU members, and another for public agency and school
4 members. Members can register for an upcoming webinar
5 directly through their myCalPERS account. Following each
6 webinar, the recordings are also posted to our
7 myCalPERS -- or sorry, CalPERS YouTube channel for members
8 to view at their own convenience. As of Friday, we
9 have -- over 1,900 registrations for these four upcoming
10 sessions.

11 Moving on to our CalPERS Benefit Education
12 Events, or CBEEs, we hosted the first two of this fiscal
13 year. We hold five every fiscal year, three in person and
14 two virtually. In August, we holded -- we hosted a
15 virtual session with over 1,800 attendees and an overall
16 satisfaction rating of 98 percent. As was mentioned at
17 the July off-site, we hosted an in-person event in Santa
18 Clara. We had 975 attendees with a 98 percent overall
19 satisfaction rating. We offered two classes in Spanish
20 for the first time at the CBEEs, Retirement Planning
21 Basics and the new Health into Retirement classes. They
22 were well received and attendees mentioned they were very
23 happy to receive this critical information on their
24 benefits in the preferred language to help them understand
25 their benefits. In addition, five members submitted their

1 online retirement application at the event.

2 We have two upcoming in-person CBEEs scheduled in
3 early 2027. We'll be in San Diego January 8th and 9th,
4 and we'll be in Sacramento, February 26th and 27th. We're
5 excited especially about Sacramento, because that's one of
6 our biggest attended fairs of the year.

7 Lastly, we're preparing for the Annual Employer
8 Education Forum scheduled for November 2nd through the 4th
9 in Anaheim. There are 806 employers currently registered,
10 which is trending higher than last year. Public Affairs
11 does an amazing job organizing this event. This forum
12 this year consists of 37 sessions, 24 CalPERS exhibits,
13 and 11 health plans. Numerous areas of CalPERS
14 participate with Customer Services and Support Branch
15 having a major presence. This forum is our largest
16 employer event and is a valuable opportunity to strengthen
17 collaboration and support with our employer partners. We
18 look forward to seeing everyone there.

19 To close, I'm really proud of our continuous work
20 for measurable improvement and performance in support of
21 our many members who are the reason and our mission. This
22 concludes my comments and I'm happy to take any questions.

23 CHAIR RUBALCAVA: Thank you, Ms. Malm.

24 I don't see any comments from the Committee.

25 Trustee Vice chair Palkki.

1 VICE CHAIR PALKKI: I just want to really quickly
2 thank you for the work that you're doing on the retired
3 annuitants. I know it's been a huge concern amongst the
4 school employees, especially when it comes to bus drivers,
5 things like that, where they require a specialized license
6 to drive the buses. So again, thank you and the team for
7 the work you're doing on that and hopefully there's an
8 easy resolve in the near future, but I know it's tough
9 right now, so thank you.

10 CHIEF HEALTH DIRECTOR MOULDS: We'll get into the
11 details more of that in November, Mr. Palkki, but thank
12 you.

13 VICE CHAIR PALKKI: Yeah. Thank you.

14 CHAIR RUBALCAVA: Thank you.

15 Now, we'll hear from President Taylor.

16 COMMITTEE MEMBER TAYLOR: Thank you, Mr.
17 Rubalcava.

18 So Kim, all of that stuff is amazing and I can't
19 wait to hear about it more in November. And there was one
20 in particular. And I've forgotten and I didn't write it
21 down. But what I do want to say is I heard you had your
22 second perfect day. And as an ex-phone rep, oh, my gosh.
23 I'm just going to tell you that's amazing. So
24 congratulations to you and your team.

25 DEPUTY EXECUTIVE OFFICER MALM: Thank you. The

1 team has just done an amazing job and Thor Dunn, the
2 Division Chief that's made the changes has mad and impact.
3 And so we're crossing our fingers for open enrollment.

4 COMMITTEE MEMBER TAYLOR: There you go. Well, I
5 know. Thank you though.

6 DEPUTY EXECUTIVE OFFICER MALM: Thank you.

7 CHAIR RUBALCAVA: Thank you, Ms. Malm. Now,
8 we'll go back to Mr. Don Moulds.

9 CHIEF HEALTH DIRECTOR MOULDS: Great. Good
10 afternoon, Mr. Chair and members. I have a few topics for
11 my remarks today. I'll start with news we've recently
12 communicated to impacted members regarding our Anthem
13 Select plan and Aspire Health, which is the primary
14 medical group for much of Monterey County. Anthem and
15 Aspire's contract will end effective December 31st, 2026
16 and there will be no further negotiations between the two
17 parties.

18 Because Anthem does not contract with any other
19 medical groups in Monterey County, there are unable to
20 operate a Basic plan in the county effective January 1st,
21 2027. Therefore, Anthem Select will be unavailable in
22 Monterey County starting next year. We've been working to
23 ensure Anthem members are aware of this change going into
24 open enrollment. We sent email communications, updated
25 our website, provided employers with information and

1 discussed it in the employer and member open enrollment
2 webinars we just held. Members will receive letters from
3 Anthem in October. Any members who don't make a plan
4 choice during open enrollment will be administratively
5 transferred into Blue Shield Access+ HMO as the provider
6 network overlaps considerably so. Most members will be
7 able to continue to see their current care teams.

8 The other bit of unfortunate news I want to share
9 is that earlier this month, Health Net announced that they
10 will be pulling out of California's commercial insurance
11 market starting in February of next year. Health Net
12 administers our Salud y Más plan. Health Net has agreed
13 to continue administering Salud y Más for CalPERS through
14 the end of 2027, so members will be able to continue using
15 that plan as usual through the end of next year.

16 Salud y Más operates in the seven most Southern
17 California counties and in Mexico, and has about 13,000
18 CalPERS members. We will be working with our other plans
19 to keep disruption for those members to a minimum and
20 we'll be back to you over the course of 2027 as our
21 strategy for ensuring that evolves.

22 On a lighter note or a better note, as Kim
23 mentioned open, enrollment is going on now. It started
24 yesterday, September 14th, and runs through Friday,
25 October 9th. This is the annual time members can change

1 their health plans and add or remove dependents. We've
2 sent a lot of advanced communication to help members
3 prepare and will continue over the next four weeks. And
4 my gratitude to Kim and the team -- her team for all they
5 do during open enrollment.

6 There's a lot of information about open
7 enrollment on our website for both members and employers.
8 There's also a dedicated webpage to guide UnitedHealthcare
9 Alliance and Harmony HMO members with information they
10 need to know, including the administrative transfer plans
11 should members not make a plan change during open
12 enrollment.

13 There is also information about our new Sutter
14 Health Plan. They are here with us today as a
15 continuation of our health plan spotlight series. You'll
16 be hearing from them next.

17 Two open enrollment webinars are available to
18 watch on the CalPERS YouTube channel. They provide a lot
19 of information to help guide health plan choices. And
20 once again, we created a Spanish version of our open
21 enrollment newsletter that's also on the website. It's
22 crucial for members to explore their options and shop
23 health plans. In some cases, members can save hundreds of
24 dollars a month and continue to see their same doctors.
25 Weighing your options can save you a lot of money and it

1 helps keep pressure on our plans to make their offerings
2 as competitive as possible. We encourage everyone to take
3 advantage of the tools and resources available and make
4 the best choices for you and for your family.

5 Next, an update on our federal advocacy efforts.
6 This week, we submitted two federal comment letters
7 jointly with Covered California. The first was submitted
8 to CMS in response to their request for comment on the
9 Medicare physician fee schedule proposed rule. The letter
10 called for continued access to telehealth services and
11 supported payment reforms that strengthen comprehensive
12 and coordinated primary care. The second letter was
13 submitted in response to the U.S. Health and Human
14 Services Agency's Request for Information on their
15 proposed vaccine recommendations. In this letter, we
16 emphasize that federal vaccine recommendations should
17 continue to be grounded in the best available scientific
18 evidence communicated through trusted health care
19 providers, and accompanied by clear guidance on coverage
20 an implementation.

21 Speaking of vaccines, last week, we hosted the
22 CalPERS annual vaccine clinic here at Headquarters, in
23 partnership with Kaiser Permanente and Safeway. Proud to
24 share that we successfully helped get more than 650 shots
25 in arms. It was a great turnout and important effort to

1 help protect our CalPERS team. So that concludes my
2 remarks. I'm happy to answer any questions.

3 CHAIR RUBALCAVA: Thank you, Mr. Moulds. I don't
4 see any comments from the Committee, so we'll proceed with
5 the action consent items.

6 VICE CHAIR PALKKI: Move approval

7 CHAIR RUBALCAVA: We move -- have a -- Mr. Vice
8 Chair Palkki moved.

9 COMMITTEE MEMBER TAYLOR: Second.

10 CHAIR RUBALCAVA: Second by President Taylor.

11 So I guess we're on -- all in favor say aye?

12 (Ayes.)

13 CHAIR RUBALCAVA: Any opposed?

14 Any abstentions?

15 So I the ayes have it.

16 So we move on to information consent items.

17 Nobody gave anything to withdraw, so we'll proceed to one
18 of our highlights, which is our health spotlight. We'll
19 be hearing from the President of Sutter Health Plan, our
20 newest introduction to the CalPERS menu.

21 Thank you very much. Ms. Moulds, you'll be then
22 doing introductions I presume

23 CHIEF HEALTH DIRECTOR MOULDS: Yep.

24 CHAIR RUBALCAVA: Thank you.

25 (Slide presentation).

1 CHIEF HEALTH DIRECTOR MOULDS: Thank you, Mr.
2 Chair. This item is a continuation of our health plan
3 spotlight series. Today, we're featuring our new Basic
4 HMO health plan for 2027 Sutter Health Plan. I have the
5 pleasure to introduce Aparna Abburi, Executive Vice
6 President, Population Health and Health Plan Services and
7 CEO of the Sutter Health Plan; Robert Bixler, their Chief
8 Medical Officer; and Peter Bergamo, their Chief Growth
9 Officer. Their presentation will provide an overview of
10 the plan, how they align with our strategic goals of
11 exception -- our goal of exceptional health care and how
12 they're supporting members through the transition. So
13 I'll go ahead and hand it over to you Aparna

14 LEGISLATIVE AFFAIRS DIVISION CHIEF ASHLEY:

15 APARNA ABBURI: Thank you, Don. Good afternoon,
16 Chair and members of the Committee.

17 COURT REPORTER: Microphone.

18 COMMITTEE MEMBER WALKER: You're not on.

19 APARNA ABBURI: Sorry about that.

20 CHAIR RUBALCAVA: Now, you can go. Please
21 proceed.

22 APARNA ABBURI: Will redo. Thank you, Don. Good
23 afternoon, Chair, Vice Chair, and members of the
24 Committee. Thank you for this opportunity to be here and
25 introduce our Sutter Health Plan. It is truly an honor

1 and a privilege that CalPERS is placing in our
2 organization the trust to serve your members. We
3 recognize that this partnership care is an important
4 responsibility that is to help your members and their
5 families access high quality affordable care through a
6 transition that is frictionless, coordinated and centered
7 on their needs.

8 Today, Dr. Bixler, Pete and I will be briefly
9 describing our share priorities with CalPERS, the clinical
10 and service model behind our offering, and the work
11 underway to prepare for 2027. We look forward to your
12 questions as we wrap up our presentation.

13 If you go to the next slide.

14 [SLIDE CHANGE]

15 APARNA ABBURI: Just quick introduction. I'm --
16 as Don said, I serve as EVP of Population Health and
17 Health Plan Services for Sutter Health, as well as the
18 President and CEO of Sutter Health Plan. In this role, I
19 lead our efforts to advance valuable-based care models
20 across Sutter Health that improve health outcomes, expand
21 access, and reduce costs for people and communities we
22 serve in Northern California.

23 Dr. Bixler, who's our Chief Medical Officer and a
24 practicing Board certified family medicine physician with
25 Sutter Medical Group. Some of you may recognize him if

1 you have access coverage from Sutter Health. He continued
2 work in direct patient care. It keeps him closely
3 connected to the patient experience. He also brings deep
4 experience and evidence-based medicine, population health,
5 utilization management, and health care affordability.

6 Pete is our Chief Growth Officer. He leads the
7 health plan's product, market positioning, sales, growth,
8 and retention strategies. Pete has also served as the
9 Plan's Interim CEO and previously led Operations giving
10 him a broad view of what are the strategic priorities and
11 the practical details required to deliver a strong member
12 experience.

13 So let's jump into the priorities and how this
14 partnership is a really strong alignment between CalPERS
15 strategic goals as well as Sutter Health Plan's goals.
16 CalPERS has clearly stated four priorities, quality,
17 access, affordability, and equity. Sutter Health Plan
18 shares these priorities as well, and they're reflected in
19 the way we design our coverage, organize care, and support
20 our members.

21 As you may know, Sutter Health Plan is a
22 wholly-owned subsidiary of Sutter Health, an organization
23 that has over a hundred years of deep history in Northern
24 California and serving our communities. On quality, our
25 goal is to provide high quality coverage connected to

1 award winning care through our Sutter doctors and our
2 hospitals. And we believe in helping members receive the
3 right care, at the right time, in the right setting from
4 the right providers with meaningful support throughout
5 their health care journey. Sutter Health Plan has been
6 NCQA accredited since 2019, demonstrating a sustained
7 commitment to quality and member experience.

8 For measurement year 2025, several of our
9 clinical quality measures performed at or above the 90th
10 percentile across preventive care, chronic disease
11 management, and behavioral health.

12 On access, we want to connect members with
13 Sutter's trusted doctors, clinicians, and hospitals close
14 to home. Access is not just about the size of the
15 network, it is about whether members can navigate that
16 network, find an appropriate provider, receive timely
17 care, and understand where to turn when their needs
18 change.

19 On affordability, we believe that better care
20 coordination between the health plan and the delivery
21 system can reduce fragmentation and help avoid unnecessary
22 cost. When care and coverage really operate with shared
23 information in line objectives, we have greater
24 opportunity to support preventive services, manage chronic
25 conditions, coordinate transitions, and help members use

1 the most appropriate setting of care.

2 Around equity, for Sutter Health Plan, that means
3 working to improve health and wellness in the communities
4 we serve and helping members obtain appropriate care
5 regardless of where they begin their health care journey.

6 These priorities really come together in a
7 connected experience, comprehensive coverage for physical,
8 behavioral, and preventive health needs, and the
9 personalized care management and a sustained commitment to
10 quality and member experience. Members should not need to
11 understand the organizational boundaries between a health
12 plan, a medical group, and a hospital to receive
13 coordinated care. Our job is to make sure that those
14 connections work on their behalf. That is the central
15 promise of our model, bringing care and coverage to
16 together around the member.

17 Now, I'm going to turn the presentation over to
18 Dr. Bixler to explain how that model supports members
19 directly.

20 DR. ROBERT BIXLER: Thanks, Aparna.

21 Good afternoon everybody. We can go to the next
22 slide.

23 [SLIDE CHANGE]

24 DR. ROBERT BIXLER: So as both the Chief Medical
25 Officer and a practicing physician, I see health care

1 through two complementary lenses. The first is the
2 individual experience of each patient sitting in my exam
3 room. The second is the broader responsibility of a
4 health plan to an entire population to receive
5 appropriate, coordinated, and affordable care.

6 The slide shows how we bring those perspectives
7 together for CalPERS members. Sutter Health Plan's
8 network is anchored by the Sutter Health Care delivery
9 system and supplemented by our provider network. It
10 includes approximately 8,000 clinicians and 33 hospitals.

11 However, an integrated approach is more than just
12 the number of physicians and it's more than just the
13 number of hospitals in our network. Its values come from
14 connecting our members with the services they need across
15 the continuum of care. That begins with the annual
16 preventative care visits. Preventative care provides an
17 opportunity to identify health risks sooner, close
18 important care gaps, and help members stay healthy rather
19 than waiting for a condition to become more serious.

20 For members managing ongoing conditions, our
21 disease management programs can provide targeted support
22 and reinforce the clinical care plan. For members with
23 more significant or multiple health needs, our complex and
24 transitional care management programs help coordinate care
25 across providers and settings. After a hospitalization or

1 other significant episode post-acute care navigation helps
2 members understand and move through the next stage of
3 their recovery.

4 Access also increasingly includes virtual
5 options. On-demand video visits provide an additional
6 venue for members to connect with care, while our Virtual
7 Pharmacy Ambulatory Care Clinic -- a big long name. We
8 call VPACC, a little bit easier. But this is a very
9 powerful program that adds pharmacy expertise for
10 medication related needs. The goal is not to direct every
11 member into the same pathway. The goal is to connect each
12 member with the right level of support based on that
13 individual's needs.

14 From a physician's perspective, a medical
15 decision may take place during a visit, but the patient's
16 success often depends on what happens before and after
17 that visit. Our integrated model is designed to help
18 close those gaps and support a more continuous health care
19 experience.

20 Let's go to the next slide. We can show how that
21 care management infrastructure behind that experience
22 looks.

23 [SLIDE CHANGE]

24 DR. ROBERT BIXLER: So case management is one of
25 the clearest examples of how an integrated health plan can

1 provide meaningful support to members. Our approach
2 combines four elements who supports the member, what
3 support is provided, how we identify the coordinated --
4 and coordinate that support, and the impact that we're
5 working to achieve. Let's start with the who. Our care
6 management model uses an interdisciplinary team.
7 Depending on the member's circumstance, that team may
8 include nurses, social workers, a dietician, pharmacists,
9 a health coach, a chaplain, health care coordinators, and
10 program support staff.

11 The range of expertise is important because a
12 member's health is rarely defined by a single diagnosis.
13 Clinical needs may insect with medication needs,
14 nutrition, behavioral health, mobility, family
15 circumstances, or challenges navigating the health care
16 system.

17 The second element is the what. Our model
18 includes both complex care management and transitional
19 care management. Our complex care management is
20 proactive. It's intended to support members with
21 significant or ongoing needs before those needs result in
22 avoidable complications.

23 Transitional care management is responsive. It's
24 responsive to the changes in the member's condition or the
25 care setting. A common example is a period following the

1 hospitalization when a member may be managing new
2 instructions, medications, follow-up appointments and
3 recovery needs.

4 The third element is the how. We use predictive
5 modeling that considers hospitalization, readmission risk,
6 and condition-specific risk indicators. The purpose is to
7 help identify members who may benefit from additional
8 outreach and support early. We also use a single
9 documentation and care management platform called Compass
10 Rose. That provides a common foundation for the care
11 management team and supports coordination across the
12 member's needs.

13 The final element is the impact. Our focus on
14 reducing avoidable admissions and readmissions, reducing
15 unnecessary emergency department use, and managing the
16 total cost of care, and improving patient satisfaction.
17 Care management does not replace the treating physician.
18 It complements the clinical relationship by helping the
19 member navigate across visits, providers, medications, and
20 care settings.

21 Ultimately, whole person care means seeing more
22 than a diagnosis. It means understanding that the
23 member's clinical needs, the practical barriers that may
24 affect care, and the support required to help that person
25 achieve the best possible outcomes.

1 I'll now turn the presentation over to Pete
2 Bergamo who will discuss the member service experience,
3 the service area, and implementation readiness.

4 Pete.

5 PETER BERGAMO: Thank you, Dr. Bixler. If we go
6 to the next slide.

7 [SLIDE CHANGE]

8 PETER BERGAMO: A connected clinical model must
9 be matched by a responsive and reliable service
10 experience. When a member contacts Sutter Health Plan,
11 the interaction may be prompted by a routine question, but
12 it may also come at a stressful time when a member is
13 trying to understand coverage, find a provider, or
14 navigate and immediate health care need. Our objective is
15 to make every interaction clear, accurate, and helpful.

16 Members services is staffed by dedicated Sutter
17 Health Plan employees, who handle inbound telephone calls
18 and emails and also make outbound outreach to our members.
19 SHP member and provider services are within one overall
20 department. That structure makes it easier for the two
21 teams to coordinate when a member's question also requires
22 engagement with a physician, medical group, or another
23 provider. The goal is to reduce handoffs and avoid asking
24 the member to navigate the organizational structure on
25 their own.

1 The results shown on this slide reflect that
2 commitment, as each member, each measure represents a
3 member interaction. Customer satisfaction reflects
4 whether members feel that we serve them well. Call
5 quality reflects whether representatives provide accurate
6 and effective service. And first call resolution reflects
7 whether we addressed a member's need without unnecessary
8 transfers or repeat contacts.

9 For CalPERS members, Sutter Health plan is
10 applying the service model to a dedicated support
11 experience. We understand members going through a health
12 plan transition will have questions. Our commitment is to
13 provide clear answers, connect members to the appropriate
14 resource, and remain accountable until the issue is
15 resolved.

16 If we go to the next slide.

17 [SLIDE CHANGE]

18 PETER BERGAMO: For Jan year 2027, Sutter Health
19 Plan will be available and eligible to CalPERS members in
20 six Northern California counties: Placer, Sacramento, San
21 Joaquin, Solano, Stanislaus, and Yolo. Our approach is to
22 connect the coverage offered by Sutter Health Plan with
23 Sutter network of physicians, clinicians, and hospitals
24 supplemented by additional provider relationships where
25 appropriate. For members, this means the health plan,

1 member service team, and care delivery network are working
2 from a shared commitment to help them navigate care.

3 The geographic footprint also gives us an
4 opportunity to understand the needs of the communities we
5 serve. Although, the six counties are connected through
6 the Sutter network, they are not identical. Their
7 populations, provider resources, and access needs can
8 differ. Our responsibility is therefore both regional and
9 local. Regional in the consistency of coverage and
10 support we provide, and local in how members experience
11 access to care in their communities.

12 Most importantly, our intention is for the
13 service area map to represent more than geographical
14 coverage. It should also represent a connected system of
15 care that members can navigate with confidence. That
16 brings me to the final slide and work underway to prepare
17 for the 2027 transition.

18 [SLIDE CHANGE]

19 PETER BERGAMO: CalPERS made an active choice to
20 change health plans and place its trust with Sutter Health
21 Plan. We are grateful for that opportunity and are taking
22 the transition very seriously. Our implementation work is
23 organizing around four priorities: open enrollment
24 readiness, primary care physician continuity, behavioral
25 health coordination, and digital readiness.

1 Sutter Health Plan is scheduled to participate in
2 46 open enrollment events with an anticipated attendance
3 of over 28,000 of CalPERS members. Our team has
4 participated in 11 events since September 1st. These
5 events give us an opportunity to answer questions directly
6 and help members understand their options.

7 Beginning September 1st, we also launched a
8 dedicated CalPERS phone line staffed by top performing
9 Sutter Health Plan Call Center agents. In the first two
10 weeks, the call centers handled 550 calls, with 68 percent
11 of the calls related to benefit questions, provider
12 availability, and general enrollment. We also launched
13 the CalPERS member website, providing access to plan
14 documents, marketing materials and key forms.

15 In addition, Sutter Health has initiated a
16 provider outreach campaign to existing patients. The
17 purpose is to ensure individual -- impacted individuals
18 have timely information, as they review their 2027 health
19 plan choices through a letter and outbound phone call. As
20 of yesterday, 9,300 outbound phone calls had been made to
21 the head of households. Thirty-six percent have been
22 answered with a dialogue and an additional 56 percent have
23 been -- a voicemail has been left for those individuals.
24 We have 1,600 households left to connect and will do so
25 with the remainder of this week.

1 Our second priority is primary care physician
2 continuity. Sutter Health Plan has established auto
3 assignment logic designed to match members with their
4 existing primary care physicians. Members can retain
5 existing primary care physician, even when that physician
6 panel is now closed. Existing medical and pharmacy prior
7 authorizations will also carry through the transition.
8 These steps are intended to reduce avoidable disruption
9 and provide greater continuity for members with
10 established care relationships or active treatment needs.

11 Our third priority is behavioral health
12 coordination. Sutter Health Plan is working with CalPERS
13 to identify and understand high-volume United-Optum
14 providers who are not currently participating in the
15 Carelon network. This will help us and address -- help us
16 identify and address priority network apps. We are also
17 partnering with Carelon to establish transition processes
18 for members with greatest needs. Behavioral health
19 continuity is an important part of whole person care and
20 has received focused attention within this implementation.

21 Our fourth priority is digital and data
22 readiness. Sutter Health Plan and CalPERS have
23 successfully transferred and ingested 834 eligibility
24 files. We have completed and validated provider and
25 medical group test files, and we have defined the

1 requirements for the data warehouse integrations.

2 Together, these activities demonstrate progress across
3 member provider clinical and technical dimensions of the
4 implementation. We know readiness is not defined solely
5 by completing an implementation checklist. It will be
6 defined by what our members experience.

7 Can members obtain clear information during open
8 enrollment? Can members reach a knowledgeable
9 representative? Can they maintain important physician
10 relationships? Will an existing authorization or active
11 treatment plan continue without unnecessary interruption?
12 Can members with complex or behavioral health needs
13 receive additional transition support?

14 Those are the standards by which we are
15 evaluating our work. On behalf of Aparna, Dr. Bixler, and
16 the entire Sutter Health Plan team, I want to thank you
17 for the opportunity to share our approach and progress.
18 We appreciate the collaboration and continue coordination
19 occurring with the entire CalPERS team. They've been
20 great to work with in this transition.

21 Sutter Health Plan looks forward to serving
22 CalPERS members and earning their confidence through
23 accessible care, responsible service, and disciplined
24 execution. We would be pleased to answer any questions
25 you have for us.

1 CHAIR RUBALCAVA: Thank you very much. I'll now
2 entertain questions from the Committee. We'll start with
3 Vice Chair Kevin Palkki.

4 VICE CHAIR PALKKI: Thank you for the
5 presentation and welcome. Thank you for showing up and
6 presenting. Every time we have these spotlights, I always
7 ask a couple questions, so hopefully I don't off-put you
8 or anything. But as we all know, the cost of health care
9 is constantly rising. And in the past, we were -- AI was
10 the hot topic and AI was going to reduce our costs and
11 things of that sort. Obviously, we now know what AI is
12 capable of doing and what it's not capable of doing.

13 So what is Sutter doing to contain costs,
14 especially when we see like those national averages at
15 eight percent and the cost of living adjustments at
16 roughly like two percent. Like how do you guys contain
17 those costs, so that the effects are minimized on the
18 membership?

19 APARNA ABBURI: Mr. Vice Chair, I'll -- happy to
20 kick off and look to my partners to jump in. You're
21 right, you know, employers are bearing -- employers and
22 payers, such as CalPERS, are bearing the highest cost in,
23 what, two decades -- nearly two decades. So it's a
24 really, really important matter that we are working on.

25 You know, when we really think about the

1 breakdown of the cost inflation, the double digit trends,
2 pharmacy pharmaceuticals is a big issue, as you all very
3 well know. I think chronic care and cancer treatments are
4 some of the things that we believe are -- where we're
5 seeing significant trends.

6 Dr. Bixler talked about our care management
7 model. You know, this is not just about making sure that
8 the patients are going to see the care -- going to see
9 their doctor at the right time, right, that the condition
10 doesn't get worse. So for us access is a really important
11 measure in not just about having the right level of
12 physicians and providers available, but making sure that
13 there's timely access to those appointments. And the care
14 that we want to bring into the mix from a total cost of
15 care standpoint is ensuring that we're not -- we're there
16 for the patient when they're outside the four walls of the
17 doctor's office, or four walls of the clinic, or four
18 walls of the hospital.

19 So the whole care management and surrounding them
20 with services that you heard about the interdisciplinary
21 team and the tools like Compass Rose, which is truly
22 dictated into their oral EMR is really how we're making
23 sure that the patients are getting the right care, at the
24 right time, into the right setting, with the right
25 provider. So, maybe you can add a few more thoughts.

1 DR. ROBERT BIXLER: Yeah. Thanks, Aparna.

2 You know as I'm sitting here just jotting a
3 couple quick notes down thinking, oh, man, we've got a lot
4 of things going on and we do. At Sutter Health, we've
5 made a lot of big changes. You know, Aparna already
6 mentioned pharmacy. We have a phenomenal VP of pharmacy
7 who is really digging in deep to find out where we can
8 actually contain costs, but still maintain the same
9 quality of care. That's a big, big deal. As you know,
10 pharmacy costs have driven the growth in health care
11 costs. And so having that partnership and being able to
12 really dive in, not just with our pharmacy benefit
13 manager, but sometimes it's even going to the pharmacy --
14 or the pharmaceutical manager themselves to try to hold
15 their feet to the fire.

16 Another piece that we've been working on really
17 heavily is around site of service, making sure that we're
18 providing the appropriate care, but doing those at an
19 ambulatory center, rather than in a hospital setting,
20 which has a higher cost. That's a situation where we're
21 literally just throwing money away, when we can be doing
22 this much better and providing care to many more people.

23 Consistency is a big thing for me as a physician.
24 And one of the things that we've done at Sutter Health is,
25 in the last couple years, we've created a new clinical

1 service line structure. So we have service lines that
2 oversee, for instance, orthopedics. And so that way we
3 can get consistency in the care that we're providing, so
4 we don't have an outlier doing things that are overly
5 expensive or unnecessary, so we're making sure we're
6 providing the right care, at the right place, for the
7 right patient.

8 And the last piece I'll put in here is something
9 that we've talked a lot about in recent retreats is with
10 Sutter Health, we are truly on a journey for value-based
11 care. And so we're trying to reteach our organization how
12 to look at health care in a way that is really looking at
13 those outcomes, and making sure -- or making sure that
14 what we are putting our resources behind are things that
15 really make a difference for the patient or make a
16 difference to contain the cost of care.

17 CHAIR RUBALCAVA: Thank you.

18 VICE CHAIR PALKKI: Just one more question,
19 please. And then obviously, a lot of our members -- and
20 maybe this is an industry thing that is being seen by the
21 end user, where you're assigned a primary care physician.
22 And there's a large turnover of those primary care
23 physicians. And then the ability to see another one is
24 another six months down the road. And if that, person die
25 is it leave, then it's like how do you get the care that

1 you need within a timely manner, right? So what is Sutter
2 doing to sort of address that issue of the turnover of
3 primary care physicians, so that members can maintain the
4 constant care that the need.

5 DR. ROBERT BIXLER: Yeah. Fantastic. What I'll
6 tell you is one of the biggest things we've done last
7 career and a half, almost two years, massive hiring.
8 We've hired a lot of clinicians. I'm a member of Sutter
9 Medical Group here in the Sac/Sierra region. The medical
10 group hired as many physicians last year as existed in the
11 medical group completely when I joined 2008. That's a lot
12 of hiring.

13 The other piece that we're -- that what we're
14 working on now -- actually, I shouldn't say we're working
15 on. We've implemented now is we've created a care center
16 mentality. So just because you see Dr. Bixler, and Dr.
17 Bixler isn't there today. Guess what, Dr. Bixler has
18 other partners in his office. And that's the model that
19 we're really pushing is to making sure -- to make sure
20 that we have those care centers that look at providing
21 care as a team effort. I keep pressing again and again in
22 multiple venues that medicine is a team sport. We need to
23 have the right people involved and we need to be willing
24 to kind of hand the ball off sometimes. If one provider
25 is not available, we've got others.

1 And we're looking to be able to expand that even
2 broader. So let's just say you're visiting family in San
3 Francisco and something happens. I can't tell you we have
4 this nailed right now, but this is what we're working on.
5 So that when you say, hey, I have something that's very
6 primary care oriented, that one of our San Francisco
7 partners would say, great. Come on in. I'll take care of
8 you since you're here visiting family.

9 That's the expansion we're looking for, but I
10 could tell you what we have right now is a really
11 efficient system, as far as being able to make sure you're
12 working with, not just your PCP, but the entire care team.

13 APARNA ABBURI: I would just add two more
14 thoughts to that. I think the point I want to underscore
15 is we say, you know, you're not practicing solely in a
16 group practice. We don't want that, right? You know,
17 this -- really this notion of a team concept is something
18 we're really aggressively pushing. Our retention rates
19 and our physician engagement rates are almost industry
20 best practice, over 90 percent. And this has been over
21 the last three or four years. So that is really important
22 when we think about attention.

23 The other thing I want to call out is their GME,
24 graduate medical education. We are almost doubling our
25 residents that we're graduating from our various programs.

1 But what's really important is how we're able to retain
2 them to join our medical groups. So that is also another
3 important pipeline. And again, keeping that access to
4 primary care is a really important aspect continuing the
5 continuity of care.

6 VICE CHAIR PALKKI: Thank you. And again,
7 welcome, and I look forward to what the future holds.

8 So that concludes my questions. Thank you.

9 CHAIR RUBALCAVA: Any more questions from
10 committee?

11 Obviously, this is a very impressive -- very
12 impressive presentation. And we're looking forward to
13 having Sutter Plan in our menu.

14 If I could just follow up a little bit on your
15 care management program. Your presentation mentioned
16 predictive modeling and a program called Compass Rose.
17 Can you explain a little bit more about that and what
18 particular point of entry, how do you say it's a
19 first-time user not sure whether to go to urgent care or
20 emergency room? And say it's somebody that has a chronic
21 disease. How do you manage it so they're -- or they're
22 just released from the hospital, so there's less
23 readmissions, there -- we don't want to get -- we want to
24 get people -- you talked about outcomes. How do we ensure
25 that a successful outcome, the people who are chronic

1 stay, with compliance with their medicine, and don't get
2 worse, and vice versa, they can improve even better? Just
3 general question so I can give you an opportunity to
4 explain your care management model.

5 DR. ROBERT BIXLER: Yeah, absolutely. Thank you.
6 Compass Rose is actually a platform within Epic, which is
7 our health record. And it allows our teams to be able to
8 hand off care between team members, which is a big benefit
9 in and of itself. As far as their predictive modeling,
10 this is something that's pretty exciting. What has been
11 created is composite score. It takes 1,500 different data
12 points to come up with a predictive model as to who is
13 most likely to require care that could change their
14 outcome. If we could capture someone before they have an
15 event, that's winning the game, and that's what we're
16 really trying to do here.

17 And to the question is how can they access?
18 There's multiple points of access, the points of access
19 could be they inadvertently ended up in the emergency room
20 for some reason. And so an emergency room is going to be
21 one trigger for a case management team to get involved.
22 Another trigger point would be a PCP that's seeing a
23 patient that realizes that this individual needs more
24 assistance. And then they're really having a hard time.
25 Maybe it's with complicated medications or a new -- a new

1 chronic diagnosis. And so that's another where -- area
2 where the PCP can say, hey, case management team, I need
3 you to help my patient.

4 But the other piece that I think that really
5 strikes me is as what you mentioned as far as the
6 transitions of care. When people leave hospitals, what
7 we've identified is that is one of the biggest
8 vulnerabilities for a patient. It's also the area that
9 can come with the most unnecessary cost, if we don't do it
10 right. And so with our Transition Care Program, what
11 we're doing is making sure we have a nurse and a navigator
12 that work with that patient. This could be as simple as
13 reviewing the medications. Did you -- were you able to
14 pick up your medications? Were there any problems with
15 the medications? Do you have any questions about the
16 medications?

17 The bottom line is you're creating a connection
18 with that individual to make sure that they understand how
19 they can be successful in their care and recognizing that
20 they have a team member within Sutter who is willing to
21 literally hold their hand through that process.

22 CHAIR RUBALCAVA: Thank you. Just a follow-up
23 question. In your presentation, you mentioned there's
24 like a coordinated -- a team -- I forgot the term you
25 used -- interdisciplinary team. And let's say somebody

1 is -- has been assigned or selected a primary care
2 physician, and they represent with say comorbidities. How
3 does the patient -- how does the physician say there's
4 some underlying behavioral health issue. How do they
5 coordinate and pass on in this team setting?

6 DR. ROBERT BIXLER: Yeah, that's fantastic.
7 Right now in our region right now, where we'll be taking
8 those CalPERS members, we actually have a centralized
9 referral system. So everyone I'm sure is aware of the
10 fact that it used to be when someone had a behavioral
11 health issue, their doctor would say, oh, take your
12 insurance card out, flip it over, look at the number on
13 the back, call that number. They'll give you some phone
14 numbers to call. And then the member is left to start
15 calling numbers to see who is accepting patients. It's a
16 horribly frustrating process for someone who is not having
17 a behavioral health concern.

18 So with our centralized behavioral -- it's called
19 behavioral, or BH Central, it's a centralized referral
20 program. And what that does is it allows our primary care
21 docs to just simply say, I think you need help. I'm
22 putting you referral for behavioral health. Our
23 centralized referral system then is able to pull that
24 patient's insurance and find out who they're contracted
25 with, and it makes for a warm hand off to a behavioral

1 health provider, whether it's for counseling, whether it's
2 for a psychiatrist. Whatever the need might be, that
3 centralized referral system is there to make sure to close
4 the loop. Because as a primary doc, one of the things
5 that always drove me crazy was knowing that I was sending
6 the patient -- it's like I'm pushing them in a boat out to
7 the sea and I'm hoping they get it right. Now, I've got
8 somebody that's actually in that boat with them to make
9 sure they get connected properly.

10 CHAIR RUBALCAVA: Last question, I promise and
11 then we'll go to Mr. Miller. One of the areas where --
12 what I think we sometimes miss is prenatal care. We have
13 the technology, we have the health, but just somehow we --
14 somehow we lost the touch. What is your -- how do you
15 handle prenatal care to ensure that there's safe delivery,
16 and postpartum, and everything else.

17 DR. ROBERT BIXLER: Yeah, it's fantastic that you
18 asked that questions, because I've actually been in a
19 couple calls with our OB chair of our service line. You
20 know, because as a -- we've been going through the
21 contract and making sure that we're able to check all the
22 boxes and provide, you know, the highest level of care,
23 you know, it prompted some questions from a couple of our
24 OB docs all the way up to the service line chair.

25 And so, you know, really they have the same

1 concerns you do. We want to make sure to capture these
2 patients as quick as possible and we want to be able to
3 plug them into the system to make sure they're getting
4 consistent care, whether it's the traditional model of
5 having a traditional OB doc that you're seeing on a
6 regular basis, or delivery, or maybe it's because -- or
7 maybe it's a situation where that patient actually wants
8 to have a doula, someone who can help them out in a
9 slightly different way.

10 That's the big piece here is making sure we have
11 a coordinated model, so that when that member is ready to
12 have their delivery, they're plugged in with their OB and
13 their doula. So we have, you know, good lines of
14 communication between those modalities, but it's something
15 that we take much, much pride in. And I'll tell you that
16 in my conversations with my OB colleagues, you know,
17 they're -- they are just bulldogs when it comes to
18 quality. And that's where they're trying to hold my feet
19 to the fire so say we better do this right. We better do
20 this right. And I'm saying you're preaching to the choir.
21 Let's do this, so we're ready.

22 APARNA ABBURI: Do you want to also touch on
23 Sutter Sync as a program for prenatal care.

24 DR. ROBERT BIXLER: Oh, yeah. Great point. We
25 have a new program. It's not live just yet, but it will

1 be very soon within the next few months. And it's a --
2 it's an app based program that also has clinician
3 involvement called Sutter Sync. What it allows us to do
4 is, for instance, at a certain point in the pregnancy,
5 moms are encouraged to do what's called a kick count, to
6 count how many times you felt the baby kick in a
7 particular amount of time. This app gives a reminder to
8 that mom and say, hey, remember sometime this week you've
9 got to do a kick count. And when you do, you'll pull up
10 the app. They get to sit somewhere relaxed nice and easy.
11 And every time the baby kicks, they just push the button.
12 And guess what, after they've done that exercise on that
13 app, it gets sent to their OB doc.

14 Along with other measuring parameters that happen
15 during the pregnancy, it allows a seamless and wireless
16 connection to their OB doc, so that way their OB doc is
17 aware of things that are going on with their pregnancy and
18 also the first to know if there's a significant change in
19 the status of that pregnancy.

20 APARNA ABBURI: What's unique about the program -
21 sorry - is it actually integrates into their Epic medical
22 record. So the physician is able to see it and it's also
23 in their -- in the phone in the app. It's the first time
24 Epic coordinator --

25 CHAIR RUBALCAVA: Very good and very innovative.

1 Thank you.

2 We have some more Committee members with
3 questions. We'll start with Trustee David Miller, please.

4 COMMITTEE MEMBER MILLER: Thank you. And thank
5 you for the presentation. I think Chairman Rubalcava kind
6 of touched on the questions I had relating to the
7 behavioral health stuff. And I'll just preface it by
8 saying usually I'm kind of eating up on some of our guests
9 here when -- on the subject of behavioral health. But
10 Sutter, and this may be just anecdotal, has a reputation
11 in this area of actually being kind of a provider of
12 choice for a lot of our members who are dealing with
13 behavioral health issues. Particularly when they're
14 comorbid with other regular kind of health care issues, it
15 requires specialty care.

16 But one of the things that I'd like to hear your
17 thoughts on, especially since Sutter seems to be doing a
18 little better job with this is from the primary care
19 physician standpoint, it usually seems pretty clear and
20 obvious the direction to go with referrals to an
21 endocrinologist or a cardiologist and the people don't end
22 up referred off to a social worker with some special
23 training, or a nurse practitioner when -- versus
24 behavioral health where we often -- I often hear from
25 members who are really frustrated that they can't see a

1 psychiatrist for months and they get shuffled off to
2 someone who wants to pull out a pamphlet and do some
3 canned behavioral therapy thing that they learned in a
4 six-week program that's an add-on to their scope of
5 practice, which is completely, you know, a matter of
6 resources and availability.

7 I don't hear that kind of concerns as much with
8 the members who are at Sutter. And so, how have you
9 approached that and how is that becoming more of something
10 we can hope to see more of and better in the future,
11 because it seems the behavioral health stuff has really
12 come to the fore in a big way since -- especially since
13 the pandemic?

14 DR. ROBERT BIXLER: Yeah. One big way that we've
15 stepped up in that space is we've done a -- again, a lot
16 of hiring. Sutter Medical Group in particular, again this
17 region where we're sitting now, has hired a large number
18 of psychiatrists, social workers, a really big cadre of
19 behavioral health specialists, not just in the hospital
20 setting. These are for outpatient care as well. It's
21 that something Sutter Health and the different medical
22 groups are seeing as -- we're at a point now where we
23 realize the calvary is not coming. Behavioral health is
24 such an issue for access. And if we just continue to go
25 the status quo with the different behavioral health

1 vendors that out there, again the cavalry is not coming.
2 We have to do it ourselves.

3 And so Sutter Health in most of the medical group
4 has made a concerted effort to hire our own behavioral
5 health specialists to try to fill those gaps. You know,
6 and additionally, one of the pieces all throughout here as
7 well, is, you know, Sutter Health also wants to be at the
8 cutting edge of that care. One area to point out is
9 Sutter Center for Psychiatry, you know, here in Sacramento
10 providing cutting edge care for major depression by using
11 a new -- a new device called the TMS SAINT. And this is
12 rapid cycle protocol that's transcranial magnetic
13 stimulation with very, just mind-blowing rates of
14 remission for patients with depression.

15 In perspective, you start a medication for a
16 patient with major depression, you're looking for
17 improvement within four to six weeks. With this TMS SAINT
18 Protocol, you're seeing patients with signs of remission
19 within five days. It's mind-blowing. And we're doing
20 that here in Sacramento with our own providers.

21 So part of it is just the pride of being Sutter
22 and knowing that we can do it better, but it's also
23 recognizing that this big care gap we have, access in
24 behavioral health, was not going to fix itself, so we had
25 to step as an organization and start hiring our own

1 clinicians to make sure that they were filling those gaps
2 in network.

3 APARNA ABBURI: I just want to add to that. I
4 think it's a commitment from the Board at Sutter Health.
5 Last couple years, we established a service line. There's
6 leadership over it now. We've very targeted in hiring.
7 We actually just got approved for -- next year will be the
8 first class to start a psychiatric GME program. So this
9 is our way of, you know, calling the calvary. Like we're
10 investing in this, because it is a priority.

11 COMMITTEE MEMBER MILLER: Thank you.

12 CHAIR RUBALCAVA: Thank you, Mr. Miller. Thank
13 you.

14 President Theresa Taylor next.

15 COMMITTEE MEMBER TAYLOR: Thank you, Mr.
16 Rubalcava. So everything I'm hearing and reading here on
17 your presentation is amazing. And I'm very happy to --
18 that you have joined us and are helping our members. I
19 ran into a couple of questions that I wouldn't have talked
20 otherwise. Somebody brought it up to my head and I was
21 like oh, I better ask that question. So in prenatal care
22 and OB care, are we looking at making sure there's equity
23 in that care, because women of color have worse outcomes
24 than -- okay. So, can you give me --

25 DR. ROBERT BIXLER: Absolutely. Absolutely. In

1 fact, I'll tell you my last couple weeks I've been working
2 with a number of our clinicians and experts within Sutter
3 Health in the equity space. And so what I'm looking at is
4 collaborating with them to learn from their expertise as
5 to how we can better understand the data and how we can
6 more effectively come up with interventions around the
7 data that we're looking at. Sometimes when we look at
8 that data, the raw number isn't a large enough data. And
9 so when you have a small in, some folks just put their
10 hands in the air and say, well, we can't do anything with
11 that. Don't have enough data.

12 Well, there are methods to do this. And so
13 that's what I've been doing the last couple weeks is
14 working with some of these experts in that field to help
15 me understand how we can better make sense of that data,
16 so that we can thereby create An effective program, so we
17 can see some of those health disparities decrease. We
18 want -- I mean, this is -- this is the United States of
19 American in 2026. We should be having much better health
20 outcomes on the maternity side than we have.

21 COMMITTEE MEMBER TAYLOR: I agree. And thank you
22 very much. I think there was an article I read that
23 talked about -- and gosh, I don't remember, because I'm
24 not a doctor -- a specific thing that women of color have
25 that white women don't, but it gets measured incorrectly.

1 And for the life of me, I can't remember what it was. But
2 I guess it Gets measured against whatever white women
3 normally have. And it's just assumed that women of color
4 have this. And this is an indicator of a difficulty in
5 pregnancy. And I don't know if that's -- but I just want
6 to make sure that we're -- it's a holistic picture. It's
7 not just the disparit -- the health disparities, but also
8 are there medical teachings that you guys go by that
9 have -- aren't correct and are they being corrected?

10 DR. ROBERT BIXLER: Yeah. And that's actually
11 the beautiful of having -- beautiful thing about having
12 graduate medical education within Sutter. That's where --
13 that's where that cutting edge -- those cutting edge, you
14 know, discussions are happening and identifying that, hey,
15 that data point does not work for this population. What
16 should -- what else should we be using, like the age old
17 conversation around just using simply BMI --

18 COMMITTEE MEMBER TAYLOR: Right.

19 DR. ROBERT BIXLER: -- for level of health. You
20 know, we should be using other measures. And so that's
21 the beautiful thing with our just robust GME offerings is
22 we're in those conversations and we're trying to change
23 the way people look at health care. And I can't -- I
24 don't know exactly which metric you're talking about on
25 the delivery part of it.

1 COMMITTEE MEMBER TAYLOR: I can't remember. I
2 think it was in New York times or something.

3 DR. ROBERT BIXLER: But I will look it up. I'm
4 very interested to see exactly what that one is.

5 COMMITTEE MEMBER TAYLOR: And then lastly, I want
6 to congratulate you on this integration of your behavioral
7 health where you're actually reaching out to the patient
8 and saying we've connected you with this person, because
9 for myself and my husband, it was a nightmare, because
10 half of that list -- more than half that list was not even
11 applicable. It was like child behavioral health and it
12 was just awful, so that's excellent. So I want to -- wow.

13 And then you said at the very end of the last --
14 when David I think was done talking that you are really
15 dialing in on the behavioral health and you're dog a lot
16 of hiring. I was always under the impression, there was a
17 shortage because of pay.

18 DR. ROBERT BIXLER: Well, there is and that's
19 always a challenge. And, you know, and honestly I can't
20 tell you in the weeds what those numbers look like on
21 Sutter Health, but what I can tell you is we've been
22 successful. And so we have certainly been able to hire a
23 number of social workers and psychiatrists. I did get a
24 little bit of an earful recently from one of the
25 psychiatrists that's an outside psychiatrist, about, you

1 know, pay and kind of what those contracts look like.

2 But what I do is I continue to encourage them, to
3 keep negotiating with, you know, what they -- you know,
4 what they're working on as far as those contracts, but
5 also just encouraging them to, you know, consider Sutter
6 Health because this is somebody who's doing an independent
7 practice. And those clinicians that we're hiring them and
8 talking about are Sutter Medical Group clinicians now,
9 they are part of the medical group.

10 COMMITTEE MEMBER TAYLOR: So they're not like
11 outsourced like a lot of places do.

12 DR. ROBERT BIXLER: Correct. Those are my
13 colleagues, my partners, and my medical group, Sutter
14 Medical Group.

15 COMMITTEE MEMBER TAYLOR: Excellent.

16 DR. ROBERT BIXLER: It's a big change and it's an
17 exciting change.

18 COMMITTEE MEMBER TAYLOR: All right. Thank you
19 very much.

20 CHAIR RUBALCAVA: Thank you.

21 Trustee Monica Erickson, please.

22 COMMITTEE MEMBER ERICKSON: Good afternoon.
23 Thank you so much for being here today. I really
24 appreciate your presentation. Question for you how about
25 any changes to any geriatric care.

1 DR. ROBERT BIXLER: Yeah.

2 APARNA ABBURI: Yeah. Let me jump in. I know
3 you all know the stats, around 11,000 people aging across
4 the country every day. Within our own Sutter Health
5 Panel, we have almost 4,000 every month. So this is a
6 really -- and we believe in continuity of care, just
7 because the aged in and began Medicare, we don't want them
8 to go have to shop for another primary care. So this is a
9 really important strategic priority for us. We actually
10 currently operate two senior care clinics, in addition to
11 a PACE program actually right here in Sacramento. And
12 we're in the process of standing up four more that will be
13 opening up ahead of the DAP.

14 And we have more -- again, we're investing over a
15 hundred million dollars in this program. And that
16 includes not just the programmatic way in how we create
17 the clinics, but what is inside the clinic, how we're
18 staffing the clinics. And that also includes the
19 geriatrician hiring. And really very different staffing
20 model, different programs. You know, there's more of that
21 hope person health addressing the loneliness issue. So
22 that's been a really important strategic priority for us.
23 And you'll hear more about this in the coming months.

24 COMMITTEE MEMBER ERICKSON: Thank you.

25 APARNA ABBURI: Yeah.

1 CHAIR RUBALCAVA: Thank you very much. I think
2 that concludes our comments and questions from the
3 Committee. I want to thank you for your excellent
4 presentation. And I'm sure you'll hear from Don and Rob,
5 but we're looking forward to work -- engaging with you
6 into our CalPERS menu -- health menu. Thank you very
7 much.

8 APARNA ABBURI: Thank you.

9 CHAIR RUBALCAVA: So now, I'm going to -- we have
10 public comment on this item. So first, we'll start with
11 somebody on the phone.

12 CALPERS STAFF: Yes. Chair Rubalcava, we have
13 Joe Heim to comment on 5a. Joe Heim, you are now live and
14 can proceed with your comment.

15 JOE HEIM: Hi. Good afternoon. My name is Joe.
16 Can you hear me?

17 CHAIR RUBALCAVA: Yes. Please continue.

18 JOE HEIM: All right. So my name is Joe Heim.
19 I'm work for the City of Los Banos, which is Merced
20 County. My family is covered through the CalPERS Gold
21 plan. Last year, my wife's water broke at 11 o'clock at
22 night. We went directly to Memoranda Hospital, which is
23 Sutter, in Los Banos here. It's our local hospital. She
24 was admitted through the emergency room. Eighteen hours
25 of labor later, she ended up needing a C-section after

1 all, which we went to Sutter, because it was 11 o'clock at
2 night. And that's our near -- that's -- it's about two
3 blocks from my house. And the next nearest hospital is in
4 the next town over about 40 minutes away.

5 Memorial Hospital Sutter Health is out of
6 network, under PERS Gold. And because it's being billed
7 as out of network, rather than emergency delivery, we're
8 getting charged more than 24,000 hospital bill. So I've
9 been going through that for the last year and trying to
10 get somebody to actually review that as emergency care.
11 So part of my comment is about Included Health and part of
12 it is about sutter health.

13 Included Health appealed the claim specifically
14 as an emergency C-section, requested the emergency
15 services exception. Blue Shield still denied that based
16 purely on it being -- the hospital being out of network.
17 And I'm going through administrative review with CalPERS,
18 so I won't go too far with that. But Included Health has
19 been unable to provide me a record of the appeal process.
20 Appeal documents and my care history don't exist. They
21 weren't able to let me know a canceled, restarted, or the
22 current status of those appeals, and just generally
23 speaking weren't able to really be an advocate for us.

24 It's -- this is all concerning to me, because
25 again it's something that -- you know, obviously the

1 easiest system for me would be to go to a Sutter Health.
2 And it's a little frustrating that Medi-Cal, for example,
3 I'd be able to do that, but PERS Gold, I can't as a public
4 employee. Now, during open enrollment it looks like
5 Sutter Health has been added as an option that I can see
6 as far as open enrollment. However, this is only
7 available as an HMO and our local Sutter Hospital does not
8 accept HMOs. So again, it kind of leaves me in the same
9 spot.

10 My family has kind of gone through quite a bit.
11 Now, we're looking at maybe having another baby in the
12 future. This would most likely be a planned C-section
13 this time, which means that we would need to do it out of
14 town. For us, that's a concern. We really like our
15 doctor. My wife's sister nine years ago passed away
16 during child birth complications -- due to complications
17 during child birth. And so, you know, it's just something
18 that's Obviously very serious to us as a family. And I
19 guess just generally speaking, I just have questions for
20 CalPERS, and PERS Gold, and relating to Sutter Health
21 which is, you know, is this something that CalPERS looks
22 at, as far as a local issue? Is CalPERS unable to
23 leverage anything with Sutter to be able to get them
24 in-network? Is this a Sutter issue or is this a CalPERS
25 issue?

1 And then, of course, going back to my comments on
2 Included Health, you know, they call themselves the claim
3 advocate, but their -- and to their credit, I don't think
4 they're -- according to them they're not able to, but
5 it's -- there's not really much advocacy going on there.
6 They're not able to provide a record of appeal. They're
7 not able to reliably tell when appeals are canceled, or
8 restarted, or anything along those -- any sort of updates
9 at all, and whatnot. So thank you. Sorry

10 CHAIR RUBALCAVA: Thank you, Joe. You ended just
11 at the right time. Thank you for sharing your experience.
12 They are concerning. We have a policy of not commenting,
13 but I will ask our Health staff to get back to you,
14 please. Okay. So make sure somebody gets your number.
15 Thank you very much.

16 Next, we have Sara Granda.

17 SARA GRANDA: Can I get the mic?

18 CHAIR RUBALCAVA: Okay. Please hold.

19 SARA GRANDA: I can respond to the caller. I
20 should -- it is a CalPERS issue.

21 CHAIR RUBALCAVA: While we get the mic to you, I
22 just want to remind the public and yourself that public
23 comment will have to be on this item, which is Sutter
24 Health Plan or else we can -- you can wait till the
25 regular public comment.

1 SARA GRANDA: I'm trying. Sorry, I'm really
2 trying to like contain myself. This is a pretty like
3 incredulous discussion about, you know, Sutter, because I
4 was a former medical surge worker for Sutter and I don't
5 think anything that you're discussing actually happens.
6 And I think you have a patient that's -- phoned a
7 beneficiary who's trying to tell you, screaming out loud,
8 there's a problem. But regardless, I guess I'll talk
9 about my piece and I'll cork it, but...

10 So Chair Rubalcava and members of the Committee,
11 my name is Sara Granda. So before beginning I renew my
12 unanswered request for six minutes as disability
13 accommodation. Please allow the pauses of physical
14 assistance I need to communicate.

15 So you are discussing -- sorry -- vulnerability
16 during transitions in care. I want to explain what that
17 means inside my home, right? I have a high level spinal
18 cord injury. I depend on a ventilator and have no
19 functional use of my hands, right? I'm also an attorney
20 and a former medical social worker. My knowledge helps me
21 describe what is missing. It does not allow me to perform
22 my own nursing or physically replace an absent nurse,
23 okay?

24 On the night of September 13th, September 14th,
25 no nurse was initially scheduled. For the 12-hour

1 overnight shift. The night was eventually divided among
2 different nurses. One nurse extended her day until
3 midnight. Thanks. And the next arrived approximately
4 12:18 a.m. and remained until 4 a.m. A registered nurse
5 then covered 4 p.m. to 7 p.m. I remained awake while
6 unfinished care was addressed and we tried to determine
7 what could be -- excuse me -- what could be completed
8 before the next day shift, okay.

9 The next morning, I reported that the schedule
10 nurse was ill. And I was again trying to find replacement
11 assistance and help accessing the court case, because as
12 you guys know we're all in a court case about, I think you
13 know, my whole situation for the last, I don't know, five
14 years, right?

15 There's another vulnerability that needs to be
16 understood, okay? Whenever a request for necessary care
17 leads to conflict, I cannot stand up and leave, okay? I
18 cannot safely displace several without a competent
19 replacement. Sorry. I mean I depend on the same person
20 for immediate physical assistance. I need a way to obtain
21 help that does not depend entirely on the person whose
22 contact concerns me. This was a domestic.

23 CHAIR RUBALCAVA: Ms. Granda, let me interrupt
24 you. We must speak to -- public comment must speak to the
25 item, which is Sutter Health. I will give you six

1 minutes, but at the general public comment, which is after
2 the summary of Committee direction. So we have two more
3 items, and then we can get back to you, and I will grant
4 you six minutes.

5 SARA GRANDA: Well, I think Christina I thought
6 told me just now that I could speak on 5a. So I mean I'm
7 not -- I guess I'm confused. The only reason I have
8 this --

9 CHAIR RUBALCAVA: We'll give -- I will give you
10 an additional six minutes in general public comment.

11 SARA GRANDA: Yeah, it's the --

12 CHAIR RUBALCAVA: You'll just have to wait two
13 more items.

14 SARA GRANDA: Yeah, it's the -- it's my
15 accommodation that I've had for the State Bar and --

16 CHAIR RUBALCAVA: No. No. I'll grant you
17 accommodation of six more minutes, but our rules are
18 public comment has to be to the item on the agenda, which
19 is Sutter Health Plan. So I'm asking you to please wait
20 two more items and I will grant you six minutes.

21 SARA GRANDA: Okay.

22 CHAIR RUBALCAVA: Thank you.

23 So that concludes the item on health spotlight.
24 Thank you Sutter Health Plan for your presentation.

25 Now, we'll move on to Item 5b, contracting agency

1 health regions.

2 CHIEF HEALTH DIRECTOR MOULDS: Thank you, Mr.
3 Chair. I'm going to turn it over to Yesenia Croft whose
4 been -- and to Emily Zhong who've been leading our efforts
5 on the region's conversation.

6 CHAIR RUBALCAVA: Thank you, Mr. Moulds. I mean,
7 thank you, Don.

8 Please proceed, Ms. Croft.

9 (Slide presentation).

10 CHAIR RUBALCAVA: And Emily.

11 HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF CROFT:

12 Good afternoon, Mr. Chair and members of the
13 Committee. Yesenia Croft, CalPERS team member.

14 This information item is a continuation of our
15 discussion of CalPERS regions for our public agency and
16 school district employers. As a reminder, CalPERS uses
17 regional pricing to keep our premiums competitive in local
18 markets. And when CalPERS regions accurately reflect
19 regional price variation, CalPERS can be competitive in
20 every market in California. And when they don't, CalPERS
21 is only competitive in select markets, typically those
22 that are high cost. This imbalance impacts our
23 recruitment and retention efforts.

24 And in July, we presented you with three
25 potential scenarios for regions. And today, we will share

1 refined options based on updated data.

2 [SLIDE CHANGE]

3 HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF CROFT:

4 I'm going to start with a brief overview, as well
5 as some key takeaways from our recent employer outreach.
6 Emily Zhong from the Actuarial Office is going to share
7 updates to county cost data and present two potential
8 options for new regions. I'll conclude with next steps.
9 And as a reminder, we'll bring you a recommendation for
10 action in November. And the new regions will take effect
11 in 2028.

12 [SLIDE CHANGE]

13 HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF CROFT:

14 So let's start with an overview. As a reminder,
15 regions are a grouping of counties in a geographic area
16 where health care costs are comparable. There are three
17 regions today that have been in place since 2020. And
18 under today's model, there is only 46 percent alignment
19 with the actual cost of care, meaning that 46 percent of
20 public agency and school members are paying within five
21 percent of the actual cost in their county. This
22 misalignment makes CalPERS premiums more appealing in high
23 cost areas of the state and less competitive in low cost
24 areas. And over time, this causes the premiums to go up
25 for everyone. And untouched over a very long time, it

1 creates serious sustainability issues.

2 Let's look at where our public agency and school
3 employers are concentrated. We showed you the map on the
4 left in July. It shows Region 1 is home to over 600
5 public agency and school employers, more than Region 2 and
6 3 combined. The map on the right shows the concentration
7 of where our members are located and it reflects the same
8 story. What this tells us is most of our employers and
9 members are located in Region 1, our most costly region.

10 [SLIDE CHANGE]

11 HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF CROFT:

12 I want to next highlight some of our recent
13 employer outreach and feedback opportunities. In August,
14 we held an employer webinar on regions where we had strong
15 engagement and answered employer questions. During the
16 webinar, we presented the same three scenarios you saw in
17 July, along with a discussion on the current regional
18 challenges, county health care costs, and the model used
19 to develop the scenario maps.

20 We knew it would be a lot of information to
21 absorb on a webinar, so following the event, we emailed
22 the recording, along with the slide presentation, to all
23 our employers and invited them to submit their feedback to
24 a dedicated mailbox. And in addition, as the employer
25 leadership dialogues have continued at the regional

1 offices, we presented the scenarios and all encouraged
2 them to email their feedback to us.

3 The employer feedback has reflected a mix of
4 support, concern, and in small cases opposition.
5 Employers located in counties with expected premium
6 decreases, express general support for seven regions, and
7 acknowledged the need to better align premiums with the
8 actual cost of care. Some employers in counties where
9 members could expect premium increases raised concerns
10 about the potential cost burden on their members or
11 opposed their placement in a high cost region.

12 Regarding the administrative complexity, some
13 employers noted that supporting employers across multiple
14 regions would create ongoing administrative challenges,
15 though some said this arrangement already occurs today and
16 could be managed without issue. We also received several
17 operational questions with employers emphasizing the need
18 for timely communication, so they can prepare for
19 implementation ahead of open enrollment in September of
20 2027.

21 [SLIDE CHANGE]

22 HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF CROFT:

23 So we said in July that we would update the
24 county health care cost data in the model to analyze the
25 refine scenarios. In here, we show the components of that

1 updated data. The previous modeling from the scenarios
2 you saw in July was based on the three-year 2022 through
3 2024 health care cost data. We now have a more complete
4 2025 claims data. And the Actuarial team has updated the
5 county -- the county cost index and the heatmap with the
6 most recent three-year data.

7 Along with the most recent cost data, the updated
8 model also has factored in the 2027 health plan premiums
9 and the estimated member migration assumptions. The team
10 used this to determine the estimated premium impacts under
11 each regional scenario.

12 And I'll now turn it over to Emily to go over the
13 updated heatmap and the refined scenarios.

14 SUPERVISING HEALTH ACTUARY ZHONG: Thanks,
15 Yesenia.

16 [SLIDE CHANGE]

17 SUPERVISING HEALTH ACTUARY ZHONG: Good
18 afternoon, Mr. Chair and members of the Committee. Emily
19 Zhong, CalPERS team from the Actuarial Office.

20 Here, we show the updated heatmap and the
21 associated county cost index as a visual to identify the
22 county cost and variation throughout the state. Using the
23 most recent three years of data from 2023 to 2025 for our
24 analysis, the county cost index have changed slightly at
25 the county level. The most expensive dark red county has

1 a county cost index of 1.46. That means its health care
2 cost is 46 percent higher than the statewide average,
3 while the lowest cost, the dark blue county, has a county
4 cost index of 0.78 and its cost is 22 percent below the
5 statewide average.

6 And also, the spread between the highest and the
7 lowest cost remain nearly the same as what we share in
8 July. We took your feedback along with employer input and
9 run it through our updated model to refine the scenario.
10 The two options I'm about to show you delivered the best
11 result of balancing cost alignment related to
12 administrative complexity and member impacts. I also want
13 to note that after analyzing some six region option, we
14 are not recommending those as they did not do enough to
15 address the current cost misalignment.

16 [SLIDE CHANGE]

17 SUPERVISING HEALTH ACTUARY ZHONG: Let's start
18 with Option 1. This is a new seven region model based
19 strictly on cost. We showed you in July a six-region
20 cost-only model. We updated it, because the seven region
21 version generate a higher cost alignment, based on our
22 latest data. Let's go through the information on the
23 slide on the left. You see the map where the county color
24 indicated regional assignment. As a reminder, the regions
25 are numbered geographically from north to south and from

1 left to right. And we include maps in the appendix that
2 list the county in each region. Because this model is
3 purely cost based, so it is highly non-contiguous.

4 On the right, the gauge show how costly this
5 scenario aligned with the actual cost of care. In this
6 case, it's 97 percent. Right below the gauge is the
7 percentage a member estimated should have increases or
8 decreases in premium in this scenario.

9 I'll also call your attention at the note at the
10 bottom, which indicate the administrative complexity
11 level, which is high for this option due to the highly
12 non-contiguous nature for this scenario.

13 As Yesenia just mentioned, we heard concern from
14 our employer that the cost-only model would be difficult
15 to administer and for member to understand when choosing
16 health plans. We also believe this option would be
17 challenging for the prospective agency to understand and
18 administer should they choose to join CalPERS.

19 [SLIDE CHANGE]

20 SUPERVISING HEALTH ACTUARY ZHONG: To help our
21 employer understand how this scenario would impact
22 premium, we model the estimated average premium impact by
23 county for each option. Here are the estimated premium
24 increases and decreases under Option 1, the cost-based
25 scenario. The county in dark and medium red where a

1 member may see average premium increases rather than 15
2 percent, and then between 5 and 15 percent.

3 On the flip side, in the counties shaded in light
4 and dark blue reflect premium decreases up to five percent
5 or up to 15 percent respectively.

6 Let's move on to Option 2.

7 [SLIDE CHANGE]

8 SUPERVISING HEALTH ACTUARY ZHONG: This is a
9 mostly contiguous seven-region model and is very similar
10 to the seven region Scenario C we presented to you in
11 July. The overall cost alignment is 85 percent. It has a
12 similar level have member impact to option 1, as well as
13 the previous scenario presented.

14 The administrative complexity is run as medium,
15 because it has more than three region today, but it is
16 also highly contiguous. As you can see, Santa Barbara
17 remain a non-contiguous county. However, it's now grouped
18 in Region 3. In the updated modeling, aligning is cost
19 more costly to the county in that region.

20 We analyzed several other option, including
21 grouping Santa Barbara with its neighboring county, or
22 making it its own region. Grouping Santa Barbara with
23 neighboring county in Region 6 would undermine the cost
24 alignment and negatively impact more member in those
25 county.

1 [SLIDE CHANGE]

2 SUPERVISING HEALTH ACTUARY ZHONG: This map
3 displaced the estimated average premium impact by county
4 for Option 2. Similarly, the shade of red indicate the
5 county where a member may have estimated premium
6 increases. The blue colored county reflect is estimated
7 decrease. Increases are happening in those county where
8 we often discuss as being high cost county in the state,
9 where most area, it's either like the provider
10 competition, also high cost medical group in hospital.

11 While this factor are mostly outside of our
12 control, so we do -- we do see our member and worker live
13 there and work there as well. So what we must solve for
14 within regions is this misalignment. We believe seven is
15 the right number of region, and Option 2 is the best path
16 forward, because it increases the cost of health care
17 alignment from 46 to 85 percent. It is the option that
18 reflects the least member impact and is highly contiguous
19 model with lower administrative burden and member
20 confusion.

21 Now, I'm going to turn it back to Yesenia to talk
22 through the next step and looking forward to answer any
23 questions.

24 [SLIDE CHANGE]

25 HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF CROFT:

1 Thanks, Emily. For next steps, we will
2 incorporate your feedback from today and finalize our
3 recommended scenario and bring it to you to the -- in
4 November as an action item. Any new region model you
5 approve will take effect January 1 of 2028 and will
6 therefore be factored into the 2028 rate development
7 process and the 2027 open enrollment. And as a reminder,
8 the maps with the counties are provided in the appendix.
9 This concludes our presentation and we look forward to
10 your feedback and questions.

11 CHAIR RUBALCAVA: Thank you very much. We do
12 have some questions here. We'll start with Board Member
13 Troy Johnson, please.

14 COMMITTEE MEMBER JOHNSON: Thank you for the
15 presentation. We have received, and I know that guys have
16 as well, received several letters from several different
17 counties, either proposing 1 or 2, and -- but one of the
18 things that I have seen in looking at overall these
19 letters is there is some proposals that are the same in
20 each of those letters, either in one or two, and that is
21 about adding Yolo into proposed Region 2, moving Butte
22 County into Region 1. Have you guys taken a look at that
23 and does that change -- does that change things?

24 SUPERVISING HEALTH ACTUARY ZHONG: Let me -- let
25 me go ahead and answer this question. Before getting to

1 the Yolo and Sacramento situation, I just want to
2 emphasize this modeling and analysis is very data driven.
3 So there are many, many way to group county into region.
4 The team has been more -- we literally looked through more
5 than 8,000 different scenario and option. So I'm sure
6 Yolo County is one of those.

7 So all of those, we pick out the top option. So
8 Option 1 basically based strictly on cost. And Option 2,
9 we show you today, so it's a really best balance of --
10 well, considering the cost of health care alignment,
11 member impact, and the administrative complexities. So
12 now back to the Yolo-Sacramento situation. When we look
13 at those cost, the county cost for Yolo, they're very
14 different compared to Region 2, which is a part of
15 Sacramento at this point. So the cost spreads is roughly
16 10 percent.

17 So based on our updated modeling, we really think
18 like grouping Yolo with Region 3, it's better -- it's a
19 better compared to Region 2. So we also did a test in the
20 modeling. Okay. So what about if we put Yolo next to
21 Sacramento? We basically -- we will put in pricing
22 pressure -- like upward pressure to all Region 2 members.
23 So this is -- this is the trade off and then all the
24 testing that we've done at this point.

25 COMMITTEE MEMBER JOHNSON: Great. Thank you.

1 CHAIR RUBALCAVA: Thank you. Now, we'll go to
2 Trustee Mullissa Willette, please.

3 COMMITTEE MEMBER WILLETTE: Thank you. Thank you
4 for the presentation. I think you've answered this in
5 July, but I'm going to ask again so I can be clear, if a
6 members lives and works in different regions, they do have
7 the option of then choosing which region they will enroll
8 in, is that right?

9 HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF CROFT:

10 Correct. So an employer -- or a member can
11 utilize their home residential zip code or their employer
12 zip code. And there's time periods when they can do that.
13 They can do that during open enrollment, at initial
14 enrollment, or due to a qualifying event like a move,
15 yeah.

16 COMMITTEE MEMBER WILLETTE: Excellent. Thank
17 you. And then just ballpark, about how many of the
18 employers participated in the maybe webinar or at least
19 the conversation?

20 HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF CROFT:

21 We've -- during the webinar, I believe we had
22 about over 400 that tuned in live. And then it's been
23 posted on our YouTube channel and we've had a lot more
24 folks view it since then, and then they've been submitting
25 comments to our dedicated mailbox.

1 COMMITTEE MEMBER WILLETTE: Are we targeting
2 conversations with like some large employers and employers
3 that would be more in the red affected?

4 HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF CROFT:

5 I've been having, yeah, direct conversations with
6 employers that have reached out.

7 COMMITTEE MEMBER WILLETTE: Okay. Thank you.

8 HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF CROFT:

9 Yep.

10 CHAIR RUBALCAVA: Thank you, Ms. Willette.

11 Thank you for the presentation. I noticed
12 that -- I mean, the whole focus here is to align with
13 cost, of course, but there's two criteria we're using,
14 which is to minimize the impact on employers and members,
15 and the other one is minimizing administrative complexity.
16 On administrative complexity, can you explain what that
17 does mean -- what does that mean and what is the
18 difference between medium and high between Region 2 and
19 1 -- Option 2 and 1? What does high administrative
20 complexity mean as compared to medium administrative
21 complexity?

22 HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF CROFT:

23 The high under Option 1 means that an employer
24 could have members living in more than one region, so --
25 versus medium, there -- you know, you might not have your

1 employees spread out so -- across so many multiple
2 regions.

3 And as far as the administrative complexity, from
4 what we've heard from our employers is the complexity with
5 having to update their systems to account for how many
6 different regions their employees live in, the different
7 rate structure for all those different regions, having to
8 negotiate their bargaining memorandum of understandings
9 for multiple regional rate structures because of it,
10 because they're so spread out across multiple regions,
11 those are a few of the comments that we've received so
12 far.

13 CHAIR RUBALCAVA: Thank you for clarifying about
14 the MOUs. I hadn't thought about that.

15 HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF CROFT:
16 Um-hmm.

17 CHAIR RUBALCAVA: But on the let's say open
18 enrollment, who handles that? Is it the employer, or is
19 it CalPERS, and how does that work on the complexity side?

20 HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF CROFT:

21 So it could be different. Some employers
22 utilize -- many of our employers utilize our myCalPERS
23 system, and we would update our system with the different
24 regions and the different rates. Some employers use their
25 own system and they have to build that out themselves each

1 year and update it each year.

2 CHAIR RUBALCAVA: In some of those letters, that
3 it was mentioned some employers saying that they can't
4 deal with the complexity. I'm assuming those are the ones
5 that CalPERS does the enrollment for them or does it --

6 HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF CROFT:

7 It could be a mixture. It could be a mixture of
8 they use their own system or they use ours.

9 CHAIR RUBALCAVA: So would it be fair to say that
10 the bigger the employer, the more members, the more
11 complexity, I mean, given -- if there's more than one
12 county involved?

13 HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF CROFT:

14 Possible. We've received some comments from our
15 smaller employers saying that it would be difficult for
16 them, because they use their own system and they'd have to
17 update it. And being smaller, that it seems that it would
18 be more difficult for them.

19 CHIEF HEALTH DIRECTOR MOULDS: The other -- the
20 other challenge is that -- so some of the larger employers
21 also have more resources to navigate some of these and the
22 smaller employers don't. So even though they might have
23 multiple different or in -- under the second scenario a
24 couple of different rates, they're in a better position to
25 manage them, because they have staff or systems that can

1 do that.

2 CHAIR RUBALCAVA: Thank you for the presentation
3 and thank you for answering the Committee's questions.

4 Any more comments or questions from the Committee
5 members?

6 We look forward to your final recommendation in
7 November. Thank you.

8 HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF CROFT:
9 Thank you.

10 CHAIR RUBALCAVA: Now, we'll have public comment
11 on this item. And again, this item is the regions for
12 contract -- for contract agency health premiums.

13 We'll start with Ariana Adame City of West
14 Sacramento. Please come up here and then Stacey Peterson
15 come up here.

16 ARIANA ADAME: Good afternoon, Mr. Chair, members
17 of the Committee. My name is Ariana Adame. I'm the
18 Assistant City Manager of Community Services for the City
19 of West Sacramento. I'm here to speak on behalf of our
20 employees. I'm here to request that the Committee
21 reconsider its placement of Yolo County, in a region
22 separate from Sacramento County for the regional
23 realignment effective in 2028. Yolo County is -- Yolo
24 County is part of the Sacramento metropolitan area. And
25 its major population centers Davis, Woodland, West

1 Sacramento sit roughly 30 minutes of Sacramento County.
2 Other state and federal designations including Caltrans,
3 the National Weather Service, and Covered California also
4 treat Yolo County as part of the Sacramento region.

5 Yolo County wages and housing costs are closely
6 aligned to Sacramento, not the Bay Area or Central Valley.
7 Our Yolo County employees are part of medical plans with
8 doctors and hospitals in the Sacramento region, and it is
9 not fair that what is being proposed that they pay for
10 health care premiums depends on which side of the river
11 they live.

12 I would like to highlight two important factors
13 in this request, what this costs are employees in real
14 dollars and where our employees actually live and receive
15 care. The last CalPERS priced the Sacramento area and Bay
16 Area separately in 2019, Kaiser premiums were 11.67
17 percent higher in the Bay Area. Using a similar
18 percentage difference among the regions using today's
19 rates, an employee living and working in Yolo County would
20 pay \$80 to \$209 ore each month than a Sacramento resident
21 working that same Yolo County job, same plan, same Kaiser
22 doctors, same network. Nothing changes except the
23 address.

24 However, the actual dollar amount will be far
25 greater, given that Sacramento County will expect to see a

1 five to 15 percent premium decrease and Yolo County will
2 expect a five percent increase. So Yolo County's
3 premiums -- premium amounts may be almost 20 percent
4 higher than Sacramento County's. Yolo County's own cost
5 of care index has actually decreased over the past year.
6 That's the opposite of what you'd expect if Yolo belonged
7 in a higher cost region. Across our 470 benefits-eligible
8 employees, 64 percent live in the counties CalPERS is
9 grouped into the Sacramento aligned region, 35 percent
10 live in a proposed Region 3 county, and of those, 81
11 percent live in Yolo County itself, getting their care in
12 Sacramento County.

13 Looking at the 328 employees on our health plans,
14 84 percent see providers in the Sacramento area network
15 and another 10 percent get that same Sacramento area care
16 locally in Yolo County. Ninety-five percent of our
17 workforce already served by Sacramento area providers, but
18 yet 35 percent of them would be forced to pay a premium
19 almost 20 percent higher than their coworkers who live on
20 the other side of the river.

21 Thank you for your time.

22 CHAIR RUBALCAVA: Thank you for your comments.
23 Stacey.

24 STACEY PETERSON: Okay. Good afternoon, Chair
25 Rubalcava and Committee Members. I want to first of all

1 thank the CalPERS staff for doing this analysis, because I
2 do understand it's very complex and we appreciate them
3 looking at the competitive regions with health care. Our
4 goal is to advocate for the Sacramento Placer region,
5 because we do have competitive health care in our region.
6 And definitely the increased costs we've experienced with
7 Region 1 being -- including the Bay Area counties and the
8 Northern California counties has significantly increased.

9 Our costs, our rates definitely should be lower.
10 I'm going to give you a little history going back to 2014.
11 CalPERS considered adding, at that time, Sacramento into
12 what I call the Bay Area influenced counties, which are
13 those kind of to the west of us and south of us, where
14 they have higher cost of living. And at that time, it was
15 estimated that it would increase our costs in the
16 Sacramento/Placer region by 12 to 13 percent. And, at
17 that time, Yolo County was also being considered to be put
18 into that Bay Area region. And the CalPERS Board did not
19 decide to do that, because of those significant impacts to
20 the Sacramento/Placer region. They did, however, include
21 Yolo County into that Sacramento/Placer region.

22 Historically, actually Yolo County has been part
23 of the Sacramento/Placer region since 2009 till 2020, when
24 we had the full region change. I'm not exactly sure what
25 the cost increase was to our region with this larger

1 Region 1 that we currently have, but I would estimate it
2 was over 12 percent because of the numbers we saw before,
3 and probably much higher with the higher costs of care in
4 the Northern California counties.

5 So I'm here to advocate for Option 1. That one
6 truly is based on getting agencies and counties closer to
7 their cost of care, which CalPERS staff has reported that
8 97 percent would be within about five percent of their
9 actual cost of care. I do recognize that staff have
10 identified that there are administrative complexities. I
11 did talk to my staff about that and what that would
12 entail. City of Roseville is a larger employer.

13 And I'm sorry if I didn't fully introduce. I'm
14 the HR Director for the City of Roseville.

15 And we definitely -- it would require more
16 education to our employees. As CalPERS staff identified,
17 employees who do live in counties that are near Sacramento
18 and Placer, they would be able to receive the lower rates,
19 because they would be able to use the employer zip code.
20 I also do believe that technology would significantly
21 support us. It's not the same as it used to be. And so,
22 we certainly also receive great education pamphlets or
23 fliers from CalPERS that identify if you're in this region
24 or if you're in this county, you're in this region, and
25 that's always been something. Even with the contiguous

1 counties, we have to rely on those communications for
2 staff, because not all staff live in the county we work
3 in.

4 CHAIR RUBALCAVA: Ms. Peterson, can you wrap it
5 up?

6 STACEY PETERSON: Okay. With that, I just want
7 to also indicate for Option 2 if the Committee does favor
8 that, certainly I do advocate, like I said, for the
9 history of Yolo to remain with Sacramento County, but that
10 is with removing Butte. Your question was very on point.
11 When you look at the cost, the heat index that staff have
12 identified, Butte County has a higher cost than Yolo
13 County. So that very targeted change would be helpful.

14 CHAIR RUBALCAVA: Thank you, Ms. Peterson. Your
15 time has expired.

16 STACEY PETERSON: So thank you for your
17 consideration.

18 CHAIR RUBALCAVA: We heard you. Thank you very
19 much.

20 Now, we'll go into a Summary of Committee
21 Direction.

22 CHIEF HEALTH DIRECTOR MOULDS: I have one item
23 which is to reach out to the caller from Amador County and
24 see if we can help him through all of the things that he
25 was articulating.

1 CHAIR RUBALCAVA: Thank you very much for doing
2 that. Do you have something?

3 Okay. Merced, I think it was. Merced.

4 CHIEF HEALTH DIRECTOR MOULDS: I don't know why I
5 heard Amador. Apologies to the caller.

6 CHAIR RUBALCAVA: Thank you for that
7 clarification.

8 Now, we'll go into general public comment. We'll
9 start with Sara Granda. And I did grant you the
10 six-minute accommodation. And then it will be followed by
11 Frank Ruffino.

12 SARA GRANDA: Thanks, Ramon. And Don Moulds, can
13 you like respond to mine too, because that would be
14 helpful, because I'm just trying to get to, you know,
15 truth in the response.

16 So anyway, sorry, that it's uncomfortable. I
17 want to tell you I think it should be uncomfortable,
18 because it's just the reality, right? I'm coming --

19 Down. Down.

20 So I was going to just try to secure
21 coordination, because care coordination must connect the
22 shifts in care with current orders, patient-specific
23 preparation, shared records and hand off equipment
24 supplies, replacement staffing, and clinician who can
25 respond when something the missed, right?

1 Each function needs someone who has accepted
2 responsibility and has time and funding to perform it.
3 Since September 1, I have been seeking restoration of
4 several funded care coordination providers who previously
5 performed that work, report that they can no longer bill
6 for it. The work continues to be necessary. Much of the
7 effort to make it happen continued returning to me.

8 I have a prospective provider in Washington that
9 has accepted and proposed a more organized service
10 assessment, authorization agreement, staffing, and a start
11 date still need to be established. Meanwhile, I continue
12 needing care in California every hour. Processing a
13 future arrangement leaves me -- leaves immediate questions
14 about who is caring for me now.

15 Today, I also emailed for an accommodation and
16 tried to complete the paper public comment request. I
17 have been struggling to reach this Committee while
18 listening to the very services I need being discussed.
19 Please identify who at CalPERS can respond to that current
20 coordination gap. Work with the administrators and
21 willing providers and tell me what funded assistance will
22 actually begin, when and who provides that gap. Please
23 arrange direct follow-up with me today and preserve my
24 unanswered accommodation requests in the meeting access
25 records.

1 I do it because I have to. I do all of this
2 because I have to, but not because I can, right? My
3 continued efforts to not establish that the missing
4 service has been delivered. I need an answer the
5 resulting care reaching me. So, I mean, I don't even need
6 to be here any more if you guys would just do what you
7 already promised. And I think that's all in public
8 record. That's all before the courts. And I just missed
9 another court deadline, so I would have liked to have
10 finished before, but I mean that's where we are now.

11 And I also live in Yolo County so -- by the way.
12 Okay. Got to go. Bye.

13 CHAIR RUBALCAVA: Thank you for your comment.

14 Okay. Now, we'll proceed with Mr. Frank Ruffino.

15 FRANK RUFFINO: Good afternoon, Mr. Chair,
16 members of the Committee. Frank Ruffino, California State
17 Retirees. I would like to share an experience that I
18 recently had, and more importantly with the Committee, but
19 more importantly with staff, so that they can perhaps do a
20 follow-up.

21 So you Probably received, just like I did, this
22 beautiful postcard from CVS Caremark and -- which
23 announces obviously that -- the open enrollment. And then
24 in the back I quote it says, "To explore your pharmacy
25 benefits. The 2027 evidence of coverage booklets are

1 available on the CalPERS website..." -- it gives the
2 website -- "...or, you can call 1(833)291-3649...", which
3 is the number for them, "...to have a copy mailed to you."
4 So I want to repeat it. "Or you can call to have a copy
5 mailed to you."

6 So some of our members called, because as you
7 know, some of our members do not have a computer or a
8 printer, to try to obtain a copy. And unfortunately, they
9 could not get a copy, because there was not -- the system
10 was not set up for them to get a copy. They didn't even
11 know what -- so I says, well, that's impossible. It says
12 it right on the postcard. They have to have a way. Did
13 you talk to a supervisor? No worries. He reminded me my
14 work when I was a delegate for the Treasurer's Office.
15 And I felt, okay, well, I'll take care of it. I'll try to
16 call and find out and get to the bomb of it.

17 So on September the 8th, I called and spent an
18 hour and 55 minutes on the phone, which is good. You
19 know, we got a lot going on. We have a lot to try to
20 figure it out.

21 And I want to be clear, the customer service
22 representative was excellent. He tried everything and
23 anything that he could to try to help and to try to get me
24 a printed copy. But unfortunately, he says -- he talked
25 to some other folks. That's why it took so long, because

1 he put me on hold. He tried everything he could under his
2 power. He says we are not -- were given that kind of
3 instruction. We don't how to do it. So sorry.

4 At the end of the day, if we need to tell our
5 members, we've got to send a postcard and telling them
6 that they have that option, it's good. You know, they
7 should be prepared or they should make sure that they do
8 good on their promise. So I just -- I'm sure it's an easy
9 fix and I'm sure our staff will be on top of it, would
10 make a secondary call and we'll take care of it. And --
11 but to the -- to benefit other callers, be patience, give
12 the system -- just in case you require a copy or you would
13 like to request a copy, give them some time until they fix
14 this little SNAFU.

15 Thank you for your attention and thank you,
16 staff, for following it up.

17 CHAIR RUBALCAVA: Thank you. That concludes
18 public comment and that concludes today's meeting of the
19 Pension and Health Benefits Committee.

20 So this meeting is adjourned.

21 (Thereupon California Public Employees'
22 Retirement System, Pension and Health Benefits
23 Committee open session meeting adjourned
24 at 4:23 p.m.)
25

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

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

That I am a disinterested person herein; that the foregoing California Public Employees' Retirement System, Board of Administration, Pension 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 September, 2026.



JAMES F. PETERS, CSR
Certified Shorthand Reporter
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