MEETING

STATE OF CALIFORNIA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

BOARD OF ADMINISTRATION

PENSION & HEALTH BENEFITS COMMITTEE

CALPERS AUDITORIUM

LINCOLN PLAZA NORTH

400 P STREET

SACRAMENTO, CALIFORNIA

WEDNESDAY, SEPTEMBER 21, 2022

9:45 A.M.

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

APPEARANCES

COMMITTEE MEMBERS:

Rob Feckner, Chairperson

Ramon Rubalcava, Vice Chairperson

Lisa Middleton

David Miller

Eraina Ortega

Jose Luis Pacheco

Theresa Taylor

Mullissa Willette

Betty Yee, represented by Lynn Paquin

BOARD MEMBERS:

Gail Willis, PhD

STAFF:

Marcie Frost, Chief Executive Officer

Matt Jacobs, General Counsel

Donald Moulds, PhD, Chief Health Director

Anthony Suine, Deputy Executive Officer

Yesenia Croft, Assistant Chief, Health Account Management Division

Rob Jarzombek, Chief, Health Plan Research and Administration

Julia Logan, MD, MPH, Chief Medical Officer

APPEARANCES CONTINUED

ALSO PRESENT:

Tim Behrens, California State Retirees

Neal Johnson

Paia Levine

William Stewart

Larry Woodson, California State Retirees

INDEX

PAGE

1. Call to Order and Roll Call 1

2. Executive Report - Don Moulds, Anthony Suine 2

3. Action Consent Items - Don Moulds 10
   a. Approval of the June 14, 2022, Pension & Health Benefits Committee Meeting Minutes
   b. Approval of the September 21, 2022, Pension & Health Benefits Committee Meeting Timed Agenda

4. Information Consent Items - Don Moulds 11
   a. Annual Calendar Review
   b. Draft Agenda for the November 15, 2022, Pension & Health Benefits Committee Meeting

5. Action Agenda Items
   a. Proposed Revisions to the Public Employees' Medical and Hospital Care Act (PEMHCA) Regulations: Definition of Parent-Child Relationships - Yesenia Croft 11

6. Information Agenda Items
   a. Preferred Provider Organization Strategic Alignment - Don Moulds, Julia Logan, Rob Jarzombek 16
   b. Summary of Committee Direction - Don Moulds, Anthony Suine 57
   c. Public Comment 58

7. Adjournment of Meeting 68

Reporter's Certificate 69

PROCEEDINGS

CHAIRPERSON FECKNER: We're going to call the Pension and Health Benefits Committee meeting to order. The first order of business will be to call the roll.

COMMITTEE SECRETARY: Rob Feckner?

CHAIRPERSON FECKNER: Good morning.

COMMITTEE SECRETARY: Ramon Rubalcava?

CHAIRPERSON FECKNER: Unmute yourself, Ramon.

VICE CHAIRPERSON RUBALCAVA: Sorry. I'm here. I can't seem to get the big screen up. Yeah, I'm here. Sorry.

COMMITTEE SECRETARY: Lisa Middleton?

COMMITTEE MEMBER MIDDLETON: Present.

COMMITTEE SECRETARY: David Miller?

COMMITTEE MEMBER MILLER: Here.

COMMITTEE SECRETARY: Eraina Ortega?

COMMITTEE MEMBER ORTEGA: Present.

COMMITTEE SECRETARY: Jose Luis Pacheco?

COMMITTEE MEMBER PACHECO: Present.

COMMITTEE SECRETARY: Theresa Taylor?

COMMITTEE MEMBER TAYLOR: Here.

COMMITTEE SECRETARY: Mullissa Willette?

COMMITTEE MEMBER WILLETTE: Here.

COMMITTEE SECRETARY: Lynn Paquin for Betty Yee?

ACTING COMMITTEE MEMBER PAQUIN: Here.

1 CHAIRPERSON FECKNER: Thank you.
2 Agenda item 2, executive report. Mr. Suine.
3 DEPUTY EXECUTIVE OFFICER SUINE: Good Morning,
4 Mr. Chair --
5 CHAIRPERSON FECKNER: Good morning.
6 DEPUTY EXECUTIVE OFFICER SUINE: -- members of
7 the Committee. Anthony Suine, CalPERS team member. And
8 I'm happy to be here today to share a little update from
9 our customer service and support team. As you know, last
10 month, we held a successful return to our first in-person
11 CalPERS Benefit Education Event in Oakland. It's the
12 first in-person event since February of 2020. And I want
13 to thank everyone involved for the phenomenal job that
14 they did putting this together. We had nearly 700 members
15 attend over the two days. And it was great to see them
16 interacting with the team in person. It seemed like they
17 were happy to be back. It was evidenced by out 99 percent
18 satisfaction rating for the overall event and for the
19 classes, which is the highest we've ever had actually.
20 We're now planning our remaining CBEEs for this
21 fiscal year, two virtual events, one in December and one
22 in February, and then we're planning our next in-person
23 event for March in Anaheim.
24 I wanted to share a quick member story from the
25 Oakland CBEE. We han inactive member who separated from

1 his CalPERS employer over 10 years ago, walked into the
2 event. He knew he hadn't maximized his benefit factor and
3 intended to retire in age -- at age 63, which was a year
4 away. But anyway, our counselor escorted him to one of
5 the kiosks and informed him we could run an estimate for
6 him. Knowing that he had been inactive, we decided to run
7 an estimate as of that day that he attended. The member
8 was happy to see the amount that it was, but he still was
9 interested in potentially waiting for another year. So we
10 ran the estimate for a year out and the difference was a
11 mere $3.
12 (Laughter)
13 DEPUTY EXECUTIVE OFFICER SUINE: So we helped him
14 submit the retirement application right there online at
15 the event and he left the event retired and extremely
16 happy as you can imagine. So great event.
17 (Applause).
18 DEPUTY EXECUTIVE OFFICER SUINE: Great results.
19 CHAIRPERSON FECKNER: Excellent.
20 DEPUTY EXECUTIVE OFFICER SUINE: So speaking of
21 retirements, I wanted to give an update on how retirements
22 from the 21-22 fiscal year compared to the 20-21 fiscal
23 year. So overall, our retirements were down 7.6 percent
24 compared to the prior year. The State was down about 17
25 percent, public agencies down about six percent, and

1 schools were fairly steady down just half a percent.
2 Looking at just safety retirements, they were
3 down about 17 percent overall and 25 percent decrease in
4 State safety retirements.
5 Interestingly enough, the decrease of about eight
6 percent from this fiscal year -- or last fiscal year to
7 the previous year was almost identical to the increase we
8 had from the year before that, so when you look over the
9 last three fiscal years, it's -- it's pretty stable
10 overall.
11 I also wanted to acknowledge that this week
12 begins our health open enrollment period for our
13 employers, active members, and retirees. And this is
14 traditionally the busiest time of year for our Contact
15 Center. But last year, we were able to reduce caller wait
16 times by 78 percent and increase the number of calls we
17 answered by 34 percent. So this year we're doing
18 everything we can to sustain that and continuous smooth
19 experience. And I want to thank our agents and support
20 teams for their extra hard work during this busiest time
21 of the year.
22 Since we last met, there have been several
23 environmental events that have impacted our retirees. As
24 I mentioned before, our teams continuously monitor
25 disasters year-round, reaching out to members who receive

1 paper checks and may be impacted by mail deliveries. So
2 far this season, there have been 50 fires and even a flood
3 back in Kentucky that we have been monitoring. We've made
4 calls to nearly 100 impacted members who have paper checks
5 and impacted postal service delivery.
6 Most are okay with the mail being redirected or
7 waiting for their checks to be delivered, but we were able
8 to switch seven of those members to direct -- direct
9 deposit, which is our ultimate goal.
10 Just a little bit about the limited duration regs
11 after -- as you're aware, we're working to define the term
12 "limited duration" as it applies to retired annuitants and
13 temporary upgrade pay appointments. And the public
14 comment period ended August 1st for those regulations.
15 We're working on reviewing those comments, preparing
16 responses, and making modifications to the proposed
17 language. And we'll bring those revised regulations back
18 to the Committee in November. If you receive any -- any
19 questions from your constituents in the meantime, I'm
20 happy to be a resource, so please reach out.
21 Lastly, yesterday, you heard a presentation from
22 the CEM Benchmarking group. And it was stated that
23 CalPERS is the most complex system in the 500 plus pan --
24 plans that participate in CEM. I just wanted to let you
25 know that this complexity makes it that much more

1 difficult for our team to always deliver timely benefits
2 and superior customer service, but they always seem to
3 come through.
4 So I just wanted to thank our teams for their
5 continued hard work and dedication. And that concludes my
6 update and I'm happy to take any questions.
7 CHAIRPERSON FECKNER: Very good. Thank you for
8 your report and thank your team for constantly doing good
9 work on our members' behalf. I do have a question for
10 you, Anthony. On some of these Zooms that I do, I often
11 get questions about people saying, how do I get my
12 retirement money if I retire and leave the country? Is
13 there a way that we could post -- because I know we can
14 send checks, but there is a limit of where we can do
15 direct deposits, correct?
16 DEPUTY EXECUTIVE OFFICER SUINE: (Nods head).
17 CHAIRPERSON FECKNER: Is there a way that that
18 could be put on the website somewhere, that list of
19 countries where we can't send direct deposit?
20 DEPUTY EXECUTIVE OFFICER SUINE: Yeah. There --
21 there's certain banks that have connections with the
22 foreign countries that are able to do --
23 CHAIRPERSON FECKNER: Okay.
24 DEPUTY EXECUTIVE OFFICER SUINE: -- the direct
25 deposit approved transfers and there's others that don't

1 allow that. So let me take that back and I can look into,
2 you know, if there's any more information we can provide
3 on that and do that.
4 CHAIRPERSON FECKNER: That would great. And even
5 if we could give a list of the banks --
6 DEPUTY EXECUTIVE OFFICER SUINE: Yeah.
7 CHAIRPERSON FECKNER: -- that they can use in
8 another country, that might help off -- stave off some
9 questions in the future.
10 DEPUTY EXECUTIVE OFFICER SUINE: Sure.
11 CHAIRPERSON FECKNER: Great. Thank you.
12 Seeing no other requests, thank you.
13 Mr. Moulds.
14 CHIEF HEALTH DIRECTOR MOULDS: Good Morning, Mr.
15 Chair, members of the Committee. Don Moulds Chief Health
16 Director.
17 Before we get to the agenda, I want to provide a
18 few updates. As Anthony mentioned, open enrollment
19 started this past Monday, September 19th. It runs through
20 October 14th. This is the annual time of year our members
21 can enroll in and make changes to their health plans and
22 add or remove dependents. All of the information a member
23 needs to research plan choices and the 2023 premiums and
24 benefits are available online in myCalPERS and our website
25 on the open enrollment pages.

1 Next, at past Committee min -- meetings, you've
2 heard public comment from our retiree stakeholders about
3 the Medicare ACO REACH Model. I want to let you know
4 we'll be holding an education session on ACO REACH in
5 January at Board education day. We'll have a panel of
6 speakers offering various views and dive into the program
7 so we can better understand it. My goal is to have a
8 clear direction -- have clear direction from the Board
9 that we can use to engage CMS and others in D.C. This is
10 an important topic. I look forward to delivering an
11 informative session for everyone in January.
12 Next, I want to update the Committee on the
13 long-term care, managed care solicitation that we've
14 discussed in the past and also earlier this year. By way
15 of reminder, the managed care solicitation is our attempt
16 to bring new benefit designs that we believe can reduce
17 costs for CalPERS and our long-term care policyholders by
18 helping them stay in their homes longer. As we've
19 discussed in the past, we also see helping our
20 policyholders stay in their homes longer as a significant
21 potential program improvement, since staying in their
22 homes as long as possible is what all -- our policyholders
23 consistently tell us is what they want out of the program.
24 I'm pleased to report we have an intent to award
25 in place with a bidding vendor for that would-be program,

1 pending successful contract negotiations. If we're
2 successful, we'll communicate to you and to policyholders
3 the details of the program likely in early 2023. I should
4 caution that we still have a lot of work to do before we
5 reach terms, specifically we won't be able to move forward
6 with a contract unless there are strong performance
7 guarantees in place that minimize any potential risks to
8 the Long-Term Care Program.

9 Next, I want to quickly highlight some of the
10 great work by the team. One area of focus this past year
11 has been telehealth, where we wanted to better understand
12 the quality of our services our members receive and how we
13 can improve them. Our Health Innovation Team led work in
14 this area in collaboration with Rand to better understand
15 how telehealth services measure up. I'm pleased to report
16 that our study and its findings will be published in the
17 journal Health Affairs in December.

18 In November, we'll have the opportunity to share
19 the CalPERS journey on health equity. We're one of only a
20 few purchasers leading the way in collecting demographic
21 information that includes key data on race, ethnicity,
22 language preference, sexual orientation, and gender
23 identify. We'll be presenting our health equity
24 initiative at the National Committee for Quality Assurance
25 annual meeting in Washington D.C. this November.

1 And speaking of health equity, starting this
2 Saturday, September 24th, health subscribers will receive
3 a $10 gift card from their plan by completing their health
4 demographic profile either in myCalPERS or through the
5 link available on our website. We're excited to partner
6 with our plans and offer this incentive because gathering
7 this information is vital to our health equity work.
8 We've said in the past, understanding the demographic
9 information of our members has the power to reveal
10 important trends and help us and our health plans identify
11 whether changes need to be made in the way care and
12 treatment is provided to ensure it's equitable for all of
13 our members.
14 We'll be community -- communicating this gift
15 card incentive to our subscribers throughout open
16 enrollment and over the next couple of months and will
17 come back to you with how we did.
18 That concludes my remarks. Happy to answer any
19 questions.
20 CHAIRPERSON FECKNER: Seeing no requests, thank
21 you very much.
22 Moving on to Item 3, action consent items. We
23 have 3A, the June 14th Committee meeting minutes, 3B is
24 today's timed agenda. What's the pleasure of the
25 Committee?

1 COMMITTEE MEMBER PACHECO: Move approval.
2 COMMITTEE MEMBER TAYLOR: Move approval.
3 CHAIRPERSON FECKNER: Moved by Taylor, seconded
4 by Pacheco.
5 CHAIRPERSON FECKNER: Any discussion on the
6 motion?
7 Seeing none.
8 All in favor say aye?
9 (Ayes.)
10 CHAIRPERSON FECKNER: Opposed, no?
11 Motion carries.
12 Item 4, information consent items. Having no
13 request to pull anything off, we move to Agenda Item 5,
14 action agenda items, proposed revisions to PEMHCA.
15 Mr. Moulds.
16 CHIEF HEALTH DIRECTOR MOULDS: Yeah. And I will
17 turn things over to Yesenia Croft from the Health Account
18 Management Division.
19 CHAIRPERSON FECKNER: VERY good. Good morning.
20 Not yet.
21 There you go.
22 HEALTH ACCOUNT MANAGEMENT ASSISTANT DIVISION
23 CHIEF CROFT: Thank you.
24 Good morning, Mr. Chair, members of the
25 Committee. Yesenia Croft, CalPERS team member.

1 Today, I bring forward an action item to approve
2 revised proposed amendments to the Public Employees'
3 Medical and Hospital Care Act regulation section 599.500
4 subdivision (o), definition of parent-child relationship,
5 so that it may be released for an additional 15-day public
6 comment period.
7 On March 16th, 2022 the Board approved the formal
8 process to amend the regulation to clarify a dependent's
9 eligibility in a parent-child relationship. On June 3rd,
10 2022, we submitted the public notice package to the Office
11 of Administrative Law commencing the 45-day public comment
12 period, which formally closed on July 18th, 2022.
13 CalPERS received two public comments during the
14 45-day public comment period. Public comments pertain
15 primarily to children who are not yet school age and those
16 who are new to the program. Concerns were expressed as to
17 whether the documentation requirements for these
18 individuals were too burdensome. One commenter felt that
19 the added specificity in the proposed regulation was
20 overly narrowing.
21 However, the intent of the proposed regulation
22 changes is to add clarifying language as to the types of
23 primary and secondary supporting documentation required to
24 certify the financial dependency of more than 50 percent
25 of an employee or an annuitant's support.

1 In addition, the current regulation provides
2 multiple alternative ways to demonstrate a dependent's
3 eligibility as a parent-child relationship. For example,
4 for dependents under the age of 19, a copy of the first
5 page of the employee or annuitant's income tax return from
6 the previous tax year listing the child as a tax dependent
7 is required. However, to address the newly acquired
8 dependents in a parent-child relationship for a time not
9 to exceed one tax filing year, the employer annuitant may
10 submit other documents that substantiates the child's
11 financial dependence.
12 For children who are not yet school age, school
13 records may also include pre-school, and day care records
14 showing the employer annuitant as having legal parental
15 status or guardianship over the child.
16 In addition, other verifiable documentation is
17 acceptable, such as medical bills or proof of medical and
18 dental insurance. Secondary supporting documentation may
19 also include day care or pre-school payments, proof of
20 payment by the employee or annuitant for activities such
21 as sports registration fees, music lessons, or swimming
22 lessons, et cetera.
23 In the instance where an employee or annuitant is
24 unable to comply with the parent-child relationship
25 requirements and certify financial responsibility for the

1 dependent child within the required time frame, they may
2 request enrollment or a subsequent qualifying event such
3 as open enrollment or as a late enrollment request
4 providing them additional time to secure the required
5 documentation.
6 Public comments also indicated concern with the
7 requirement that supporting documentation not be older
8 than 60 calendar days from the date of signature of the
9 affidavit of parent-child relationship. As some of the
10 documents are likely to be outside of the 60 days due to
11 the nature of the document type. To remedy this issue, we
12 updated the proposed language to include an exception to
13 the 60 calendar day requirement for legal judgments, court
14 documents, child driver's license or State identification,
15 or vehicle registrations. All other supporting
16 documentation will maintain the 60 calendar day
17 requirement.
18 Another public comment included a recommendation
19 to add regulatory language to provide an employee or
20 annuitant one year from date of death of their spouse or
21 domestic partner to certify the child or children of the
22 deceased spouse or domestic partner as a parent-child
23 relationship. However, this recommendation is not
24 necessary as existing law provides that step-children and
25 domestic partner children remain eligible for CalPERS

1 health benefits as a dependent, and may remain enrolled on
2 the employee or annuitant's account until they turn 26 or
3 until the employer annuitant remarries or registers a new
4 domestic partnership. CalPERS will clarify this in future
5 guidance to employers.
6 With Committee approval of these changes, we will
7 move to submit our public notice package to Office of
8 Administrative Law for an additional 15-day comment
9 period. We also seek approval to submit the final
10 rulemaking package to the Office of Administrative Law
11 upon conclusion of the comment period if no additional
12 comments are received. This concludes my presentation and
13 I'm happy to take questions.
14 CHAIRPERSON FECKNER: Very well. Let's see, I
15 have no questions at this time.
16 This is an action item. What's the pleasure of
17 the Committee?
18 COMMITTEE MEMBER PACHECO: Move approval.
19 COMMITTEE MEMBER MILLER: Second.
20 CHAIRPERSON FECKNER: Moved by Pacheco, seconded
21 by Miller.
22 Any discussion on the motion?
23 Seeing none.
24 All in favor say aye?
25 (Ayes.)

1 CHAIRPERSON FECKNER: Opposed, no?
2 Motion carries. Thank you.
3 HEALTH ACCOUNT MANAGEMENT ASSISTANT DIVISION
4 CHIEF CROFT: Thank you.
5 CHAIRPERSON FECKNER: That brings us to Agenda
6 Item 6A, PPO strategic alignment.
7 Mr. Moulds.
8 (Thereupon a slide presentation.)
9 CHIEF HEALTH DIRECTOR MOULDS: Good morning, Mr.
10 Chair, members of the Committee. Don Moulds, CalPERS team
11 member.
12 I'm here with Rob Jarzombek and Julia Logan to
13 present an update to our PPO strategic alignment effort
14 and I'll pass it to them shortly, but I want to start with
15 some background.
16 --o0o--
17 CHIEF HEALTH DIRECTOR MOULDS: So at the June
18 2022 Pension and Health Benefits Committee meeting, we
19 shared some challenges facing the Basic PPO program. As a
20 reminder, the Basic PPO plans have experienced premium
21 increases and volatility over the last few years. In
22 2021, they saw higher than expected medical and pharmacy
23 costs, as well as investment-related losses. Both of
24 these contributed to a large reserve deficit.
25 To address the deficit, you approved a five-year

1 surcharge to the basic PPO premiums to replenish reserves
2 starting with the 2023 plan year. In June, we also
3 informed you of concerns the health team had about
4 possible near-term and longer-term affordability
5 challenges facing the PPO. At the time, we were
6 particularly concerned about the PPO Gold product. In
7 July, we shared with you that the team had begun
8 additional financial analysis of both PPO products and
9 that we were exploring options to help address some of the
10 challenges facing the PPO. We're here today to present
11 our initial findings and to start to lay out some of the
12 options we may bring you in November for consideration.
13 There are several key goals of the work that's
14 currently underway. These include ensuring that pricing
15 for the CalPERS Basic Gold product stays in line with the
16 pricing of our low cost HMO products and identifying
17 potential interventions that could help curb near and
18 longer-term costs both for products. There are also
19 non-cost related goals as well.
20 One is ensuring that both PPO Basic plans are
21 aligned with our strategic goals and that the PPO quality
22 measures and health plan requirements are consistent with
23 those in the HMO solicitation which is currently underway.
24 A second is integrated lessons learned into other CalPERS
25 plan offerings, and the last is developing the foundation

1 for upcoming PPO contract solicitation for calendar year
2 2025 through 2029. I know that seems like a lifetime from
3 now, but it really isn't.
4 As you'll see, this effort has highlighted the
5 need to assess how the PPOs are structured, as well as the
6 financial arrangements we have with our third-party
7 administrator Anthem. As you know, we have a range of
8 financial, contractual, and policy considerations that
9 impact premiums that do not inherently relate to the
10 underlying care delivery. They include the nature of the
11 funding for the PPO program, so self-funded versus
12 insured, and how risk between populations is managed.
13 We also seek financial arrangements with our
14 contracted health plans and our third-party administrator
15 that ensure members get the highest quality care.
16 Mechanisms include CalPERS supporting administrative
17 functions related to administering the PPO at risk for --
18 sorry, administering the PPO at risk for outcomes and
19 having strong quality incentives. As CalPERS plans its
20 solicitation for the 2025 PPO contract, we'll review
21 options to encourage both lower cost and higher quality
22 care.
23 I'm going to pass the baton to Rob in just a
24 second. But before I do, I want to update you on a
25 concern I raised earlier in the summer. When you approved

1 2023 rates in July, the health team was worried that cost
2 growth in the PPbasic plans was significantly outpacing
3 cost growth in our HMO products. And that the rate of
4 growth coupled with member responses to those changes
5 could create profound challenges to the PPO, particularly
6 the Gold product as early as in 2024. Our analysis has
7 identified several areas where PPO costs need to be
8 improved, but it also shows that generally the underlying
9 medical and pharmacy cost growth in the PPO is in line
10 with that of our HMO products. This is largely good news,
11 because it tells us that the PPO is not facing and
12 imminent sustainability crisis.
13 The message of the presentation today is that we
14 have a lot of work to do to improve the cost of our
15 Platinum and Gold PPO products. We aren't facing an
16 immediate sustainability crisis though.
17 Rob and Julia are going to go into all of the
18 details, but I thought I would start by sharing that
19 largely positive news for the context on the work we're
20 doing. I'll turn it over to Rob now to share more details
21 about the work that took place over the summer and that's
22 being conducted now. He and Julia are also going to share
23 several initial findings.
24 So, Rob.
25 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF

1 JARZOMBEK: All right. Thank you, Don. And good morning,
2 Mr. Chair and members of the Committee. Rob Jarzombek,
3 CalPERS team member. To research all the items Don just
4 described, we assembled a team and engaged our third-party
5 actuarial firm, Milliman, to help us better understand our
6 data. We were also fortunate to engage Peter Lee, former
7 director of Covered California, to help inform and guide
8 our research. With both Milliman's and Peter's knowledge
9 and expertise, we were analyzing current and historical
10 health care cost and utilization trends in our PPO and HMO
11 basic plans.
12 --o0o--
13 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
14 JARZOMBEK: We continue to work closely with Anthem to
15 lower costs, while ensuring members have access to high
16 quality care. We are also researching other models, so we
17 can begin conducting an informed and thoughtful PPO
18 procurement in 2023. In the same spirit, we're looking at
19 other structural changes to the PPO program as well.
20 --o0o--
21 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
22 JARZOMBEK: So let's first start with industry engagement.
23 With Anthem, we are looking at the PPO cost relative to
24 the cost in the HMOs and learning more about what
25 additional tools they may have to improve costs and

1 outcomes for our members. We are discussing network
2 design, quality, and management options. This will be a
3 major focus as it has the potential to save money and
4 improve outcomes for members.
5 As we engage with Anthem, we are focused on
6 interventions we can implement in the short-term as well
7 as next -- as the next plan year, which starts in 2024,
8 but we are also looking at longer term interventions that
9 will likely make more sent -- more sense as part of our
10 next TPA contract, which will be in place starting in
11 January of 2025.
12 Next, we are collecting independent data and held
13 detailed inquiries with entities serving large purchasers.
14 These are entities that provide member navigation and
15 advocacy programs, which you might know as navigator
16 systems or assistance. Others provide virtual care
17 options and somehow programs that target individuals with
18 particular conditions.
19 Lastly, and as part of our normal course of
20 business, we're engaging with other large purchasers and
21 purchaser groups. With them, we're exploring new models
22 that may allow us to better serve our members. As we
23 approach the end of our five-year PPO contract and prepare
24 for the next solicitation, this research and engagement is
25 helping us better understand some of the innovative and

1 value-add services we might consider for our members in
2 CalPERS PPO plans.
3 Before I turn things over to Dr. Logan, who will
4 be talking about what we are seeing in some of our data, I
5 want to spend a little time unpacking the various cost
6 drivers in the PPO.
7 --o0o--
8 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
9 JARZOMBEK: So let's start with the 2023 Basic PPO
10 premiums. The blue bar on the right shows we had -- as
11 the blue bar on the right shows, we had an overall
12 increase of 15.76 percent. When we break things down, we
13 see that health care cost increases account for 8.5
14 percent, 4.9 percent of this was medical, 2.6 pharmacy,
15 and one percent was other. So this category includes
16 several components, but combined together had a net impact
17 of a one percent increase.
18 There was an un -- underprojection for 2022,
19 which accounted for two percent of that premium increase.
20 This underprojection is combined in the medical increase
21 in the chart. So two percent of the medical's green bar
22 of 6.8 percent was this underprojection.
23 And lastly, structural adjustments made up 5.3
24 percent, 2.6 came from a snapback from buying down the
25 2022 premiums, and 2.7 percent is to rebuild reserves.

1 So the underprojection and structural adjustments
2 are responsible for almost half of this year's PPO rate
3 increase.
4 --o0o--
5 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
6 JARZOMBEK: As you know, this rate increase is
7 significantly higher than the average HMO increase of 4.35
8 percent. However, it's important to take a multi-year
9 view when looking at premiums and not just focus on a
10 single year. This chart shows the average Basic PPO and
11 HMO premium increases since 2018. Comparing the 2018 and
12 2023 premiums, the overall average annual increases are
13 similar for Basic HMO and PPO.
14 The six-year average premium increase for P --
15 HMOs is 3.2 percent and it is 4.2 percent for PPOs. You
16 can see that the PPO rate changes have shown more
17 volatility with a rate decrease in 2018 and then a high
18 increase in 2023, but much of the premium volatility in
19 the PPO is driven by structural issues rather than
20 underlying health care costs.
21 For example, we had the premium buydown, which
22 artificially lowers premiums for the -- for the year and
23 causes a snapback if the same amount of money is not
24 applied to those premiums again in the subsequent year.
25 And we also had a premium surcharge for the 2023 basic

1 plans to start rebuilding reserves.
2 Finally, this chart shows the weighted average
3 Basic PPO and HMO premiums for the same time frame.
4 So going to slide 8 --
5 --o0o--
6 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
7 JARZOMBEK: -- you can see that they are relatively
8 similar despite the volatility and the increases and
9 decreases we just saw on the previous slide. The premiums
10 for the HMO and PPO are similar in 2018 and 2019, but
11 diverged in 2023. This highlights Don's comments that
12 while we need to continuously look at how to improve the
13 value in the PPO program, in the short-term, the PPO does
14 not appear to be in jeopardy of being unsustainable.
15 --o0o--
16 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
17 JARZOMBEK: Let's talk about more about the exploratory
18 analysis that we've done so far. CalPERS has engaged
19 Milliman to perform an in-depth data analysis to identify
20 potential areas for improvement within the Basic PPO
21 program. The analysis involved direct comparisons of the
22 Basic PPO to non-Kaiser HMOs based on medical and pharmacy
23 data from 2017 to 2021. We also did indirect comparisons
24 to Kaiser.
25 Some of the early findings include that PPO cost

growth is not increasing at a faster pace than HMO cost growth. The same cost trend exists for medical and pharmacy, and we'll see this on the next chart.

--o0o--

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Utilization is similar between PPO and HMO products. Said differently, in general, PPO members are not going to the doctors more often than their HMO counterparts. We've identified the top contributors to the increased cost in the PPOs and these are unit costs related to hospital outpatient services, chemotherapy, specialist care, outpatient labs, and imaging. Julia will talk about these in a moment.

Finally, as with health care spending in general, a small percentage of individuals account for a large proportion of the expenditures. Julia will also explain what these conditions are and the members who comprise this group.

As part of our analysis, we have looked at all members in the PPO, and because the PPO has a higher proportion of early retirees and individuals in rural areas, we looked at the distribution of members -- member costs among active members and members in urban areas. The cost differences are consistent amongst these two groups. So the main take home is that the difference in

1 cost between the PPO and HMO plans is not driven by one
2 thing, but there are several key drivers.
3 So this slide shows the historical, medical, and
4 hospital -- historical pharmacy and medical cost trend
5 between PPO and HMO from 2017 to 2021. Other than in
6 2020, which was a unique year, because it was the height
7 of the COVID pandemic, the historical trend for PPO costs
8 is in line with the HMOs at around three to four percent
9 on an annual basis.
10 While cost growth in the PPOs is not higher than
11 in the HMOs, costs continue to be higher. And it appears
12 that a major driver of this difference is that unit costs
13 in the PPOs are higher than those in the HMOs, rather than
14 the members in the PPOs using more services.
15 So as encouraging as it is to know that the PPO
16 is not increasing at a faster pace than the HMOs, the fact
17 that unit costs are significantly higher is a problem.
18 Our main objective moving forward is to better understand
19 why this is, so we can reverse that difference.
20 The last thing I'd like to draw your attention to
21 is the 2021 column on this chart. The PPO costs were 766
22 and the HMO costs were 664, which is reflected here as a
23 -- as a $103 difference due to rounding. I'm going to
24 turn it over to Julia to help us understand this $103
25 difference or so.

1 CHIEF MEDICAL OFFICER LOGAN: Thanks, Rob.
2 --o0o--
3 CHIEF MEDICAL OFFICER LOGAN: Good morning.
4 Julia Logan, CalPERS team member.
5 To help understand the drivers of the cost
6 differences, we looked at all major service areas and
7 assessed the extent to which the higher costs in the PPO
8 program are driven by using more services or higher unit
9 costs. This slide that you see shows the top eight
10 service areas out of over 140 to give you a flavor of that
11 variation and costs per member per month. The table is
12 sorted base on how much the service category contributes
13 to higher costs in the PPOs than in the MHOs. Let's look
14 at that top row as an example, which is specialty drugs.
15 In 2021, the per member per month cost for
16 specialty drugs was $16.78 higher in the PPO plans than in
17 the HMOs. Now, let's dig into that 16.78 a little bit
18 more using the two columns the right. There are two
19 components of health care costs, the utilization and the
20 unit cost. Higher unit costs in the PPOs than the HMOs
21 account for $11.03 of the 16.78 cost difference for
22 speciality drugs. The other 5.75 comes from higher
23 utilization in the PPOs.
24 The second row of the table says surgery-hospital
25 outpatient tells a different story. The PPO utilization

1 is actually lower for that service category, but the unit
2 costs are so much higher than the overall PPO costs,
3 making the overall difference $9.37 higher in the PPOs
4 than the HMOs. So as you can see moving to the bottom row
5 of the -- in black, the total, of the $102 difference PMPM
6 between the PPO and the HMO, the difference is
7 overwhelmingly driven by higher unit costs. And as you
8 heard earlier, this difference in health care costs has
9 been pretty consistent over the past five years. And
10 also, as Rob mentioned just now, utilization doesn't
11 appear to be the big driver of that cost difference,
12 rather there is a somewhat lower utilization, meaning that
13 the -- if the PPO costs per service were the same as the
14 HMO, the program would actually cost about $29 per month
15 per month less.
16 The driver is higher unit costs. Those higher
17 costs are particularly striking in some areas and deserve
18 more attention, such as outpatient surgery, and radiology,
19 and labs, which will come up later when we discuss some of
20 the intervention options we're exploring. But the key
21 story is that the details matter and we have been rolling
22 up our sleeves to look at issues, such as how the
23 variation in costs are impacted by where members live, are
24 there different utilization and cost patterns in northern
25 versus Southern California, and how much, if at all, are

1 higher unit costs driven by out-of-network utilization,
2 and could higher costs be driven by higher severity of
3 illness of members receiving care.
4 --o0o--
5 CHIEF MEDICAL OFFICER LOGAN: Studies on health
6 care spending generally find that a small percentage of
7 individuals account for a large proportion of
8 expenditures. And CalPERS, as it turns out, is no
9 exception. What we see here is that the most expensive
10 one percent of our PPO members, those at the top of the
11 pyramid in that lighter orange, accounted for almost 40
12 percent of the costs in 2021. In contrast, the least
13 expensive 44 percent of members at the bottom of the
14 pyramid in darker blue accounted for less than two percent
15 of the costs. Almost half of our PPO members incur annual
16 health care costs of less than a thousand dollars, while
17 one percent of our PPO members incur more than $100,000 in
18 health care costs every year, and the six percent with
19 costs over $25,000 account for over two-thirds of our
20 spending.
21 And this is really more than an exercise in
22 divvying up our data in interesting ways. It really helps
23 us delve further into who those at the top -- higher cost
24 members are, what's driving these costs, and really start
25 to explore the answers to questions, like how can care be

1 managed better for those high-cost, high-needs members.
2 On the next two slides, you'll see that --
3 CHAIRPERSON FECKNER: Dr. Logan, before you go
4 on, do you want to take questions as we go or wait till
5 you're done?
6 CHIEF MEDICAL OFFICER LOGAN: Should we --
7 CHIEF HEALTH DIRECTOR MOULDS: It's your
8 prerogative. I think it might be easier to do them
9 afterwards, but if you have question and you think it's --
10 CHAIRPERSON FECKNER: I don't, but I have a
11 couple of Board members that do, so -- you can wait?
12 All right. We'll wait then.
13 Continue on.
14 CHIEF MEDICAL OFFICER LOGAN: Okay. Thank you.
15 We'll go on. On the next two slides, you --
16 you'll see that we've taken a deeper look at members with
17 complex health conditions.
18 --o0o--
19 CHIEF MEDICAL OFFICER LOGAN: This slide focuses
20 on some of the members at the top of the pyramid, the
21 members who are highest cost with highest medical needs.
22 On this slide, we're looking specifically at those members
23 with a cancer diagnosis, because this is where we saw some
24 really high costs and some large differences between the
25 PPOs and the HMOs. You'll notice that the prevalence, or

1 number of cancer cases as a percentage of all members, is
2 consistent between the HMOs and PPOs. For example, about
3 eight-tenths of one percent of PPO members and
4 seven-tenths of one percent of HMO members have had breast
5 cancer in 2021, a little less than one in 100. And the
6 percentage of members with lung cancer is 0.1 percent or
7 about one in a thousand in both the PPOs and the HMOs. We
8 do, however, see large differences in the cost of care for
9 each diagnosis. The average cost of lung cancer care in
10 the PPOs is over $84,000 and in the HMOs it's about
11 50,000.
12 Among CalPERS PPO Basic members only one and a
13 half percent of them have one of these five cancers noted,
14 but they have spending of over $189 million. And as you
15 can see, while the rates of cancer are very similar, the
16 costs of care for these individuals often appears to be
17 far higher in the PPO than the HMO. We're digging into
18 this to see how we can be sure our members with cancer get
19 the best care possible.
20 --o0o--
21 CHIEF MEDICAL OFFICER LOGAN: This next slide
22 continues to look at our higher cost, high needs members
23 and this time takes a deeper look at chronic conditions.
24 In the case of chronic conditions, we see that in general
25 both the prevalence of the condition and the average cost

1 to treat each person with a diagnosis is very similar
2 between the HMOs and PPOs. The notable exception here is
3 depression, where the prevalence of depression is somewhat
4 higher in PPO members as is their average treatment costs.
5 This data puts the spotlight on how important it is for
6 both HMO and PPO members to focus on quality and getting
7 appropriate care for our members with chronic conditions.
8 Many members with chronic conditions have annual
9 costs ranging from $4,700 for diabetes to almost 14,000
10 for substance use disorder, and there are thousands of
11 members with these conditions. We're trying to ensure
12 that our PPO members with chronic conditions are being
13 well served and investigating how we can intervene on
14 improving value and the coordination of care for these PPO
15 members.
16 --o0o--
17 CHIEF MEDICAL OFFICER LOGAN: Excuse me.
18 And this is where our interventions come in.
19 Based on the data analysis that we just reviewed and the
20 industry engagement that Rob discussed a few minutes ago,
21 we're developing and refining a menu of potential
22 interventions to address the underlying quality,
23 experience, and affordability of the care provided through
24 or PPO program. In addition, we realize that some of our
25 members need more of a hands-on approach to their care

1 than others, especially those with higher needs. You will
2 see that theme throughout each of the categories on this
3 slide. Research of in this area indicates that members
4 who receive a effective care management have a better
5 experience and better outcomes. And in my experience as a
6 clini -- clinician too has told me this time and time
7 again.
8 First, I'll start with network design,
9 composition, and structure. High quality provider
10 networks that are accessible to our members are an
11 absolutely crucial part of being able to achieve our
12 strategic objectives. The team is doubling down on our
13 work to investigate the network design differences between
14 PERS Gold and PERS Platinum, and how those networks relate
15 to the offerings available through our CalPERS HMO and EPO
16 products, to inform potential network changes to improve
17 quality, cost, equity, and access.
18 Next, behavioral health. As we've discussed
19 together as recently as the July off-site, access to high
20 quality behavioral health is essential to effective high
21 quality health care, but the challenges, as you know, are
22 many. Additionally, our data analysis shows that most
23 behavioral health services, inpatient/outpatient mental
24 health, and substance use services, both utilization and
25 costs, are higher in our PPO plans.

1 Part of what we will be doing between now and
2 when we next meet together in November is to better
3 understand why this is. It may be in part to higher use
4 of out-of-network clinicians, so we will be investigating
5 options to expand in-network availability of behavioral
6 health clinicians, while simultaneously improving
7 coordination for our members with behavioral health needs.
8 Pharmaceutical strategies. Clearly, controlling
9 pharmacy costs is essential for the ongoing success of our
10 program. We have been engaging with Optum on various
11 strategy, including supporting members to use OptumRx home
12 delivery to fill maintenance medications and using
13 industry best practices for enhanced utilization
14 management for some specific specialty drugs to ensure
15 that members receive clinically effective medications in a
16 timely manner.
17 Reference-based pricing. This is a benefit
18 strategy -- designed strategy that aims to address
19 unwarranted price variation and creates an incentive for
20 members to select lower priced care options for the same
21 services. Because our analysis shows outpatient labs as a
22 top driver of per member per month costs, with higher
23 utilization and higher unit costs in the PPOs compared to
24 the HMOs, we will be exploring expanding our existence --
25 existing, excuse me, reference-based pricing programs to

1 include outpatient lab services.
2 Next, I'll touch on both member navigation and
3 condition-specific support together, because they really
4 do hand in hand. We can see from our utilization and cost
5 data that clearly chronic health conditions require a
6 comprehensive approach to care. Currently, PPO members
7 with complex high needs conditions, such as cancer and
8 chronic health conditions, receive support for treatment
9 through various care management programs. We're looking
10 to maximize existing efforts where possible and -- oh, if
11 you can go back to the previous slide. Thank you -- where
12 possible and are engaging with Anthem and potentially
13 others to explore additional programs to better identify
14 members at high risk and emerging risk who could benefit
15 from support and timely access to the best possible
16 specialty care.
17 In tandem with this effort, the team is
18 investigating options to expand in-network availability of
19 clinicians and options related to network's benefit design
20 and alternative delivery models to continue to improve
21 health services, including behavioral health and oncology
22 care.
23 Site of care management. This is a really
24 important aspect of controlling costs in the PPOs, because
25 costs and quality for the same treatment can vary widely

1 depending on where the care is administered. As part of
2 this work, we have identified opportunities to improve the
3 care experience for high complexity members, while
4 lowering overall costs through a centers of excellence
5 program for targeted high-complexity conditions. Such a
6 program would apply lessons from CalPERS, other
7 purchasers, and health plans to potentially build a
8 program to include certain procedures or conditions.
9 And certainly, but not least, primary care. As
10 we've discussed in the past, high quality equital --
11 equitable - excuse me - primary care is the cornerstone of
12 our health care system and our program. CalPERS wants to
13 support members by ensuring access to effective primary
14 care and by ensuring that members with complex health
15 issues are supported by a coordinated team of providers
16 working together to meet each individual's needs.
17 We're investigating in -- innovative primary care
18 models that build on our statewide partnerships, such as
19 the current advanced primary care measurement pilot, and
20 are exploring how primary care, integrated behavioral
21 health, and team based care may be better delivered to our
22 members. PCP matching for our basic members in our PPOs
23 starting in 2023 is an important step in establishing a
24 strong primary care foundation for our PPO members.
25 Now, you can move to that slide.

1 --o0o--

2 CHIEF MEDICAL OFFICER LOGAN: Thank you.

3 And before we move to questions, we wanted to
4 share our project timeline, to give you a sense of where
5 we're going. And as we mentioned, we'll be sharing our
6 proposed interventions for 2024 to you in November, based
7 on your feedback today, and our further research and
8 analysis. And further, we will be incorporating our
9 learnings into the 2025 PPO solicitation.

10 That concludes our presentation. Don, Rob, and I
11 are happy to answer any questions and look forward to the
12 discussion. Thank you.

13 CHAIRPERSON FECKNER: Thank you. Thank you all
14 for the presentation. We do have a few questions.

15 I want to start with one on slide 13, your cancer
16 slide. Since there seems to be such a large disparity
17 between the PPO and the HMO, do we have any list of
18 outcomes? Are the outcomes percentagely higher, better
19 outcomes for the PPO versus the HMO or are they relatively
20 static?

21 CHIEF MEDICAL OFFICER LOGAN: Yeah. That's a
22 really excellent question and one that we've been
23 wondering as well. Often, our claims data doesn't
24 necessarily tell us the whole story, so we have been
25 partnering with Anthem to get at more of the clinical

1 outcomes and what that really means in terms of our
2 members and their care.
3 CHAIRPERSON FECKNER: Great. And, you know,
4 certainly HIPAA falls into that line as well, but it would
5 be nice to be able to have some kind of comparative
6 figures in looking at whether or not it's a big difference
7 for the PPO side versus the HMO side. I mean, if it was a
8 big difference, you might have more people trend to the
9 PPO side, for instance, so -- all right.
10 CHIEF HEALTH DIRECTOR MOULDS: Outcomes --
11 outcomes are the -- and Julia knows this far better than I
12 do, but outcomes are both the hardest thing to get at and
13 the most important thing to get at. And we're been --
14 that's one of -- one of the foci of this whole exercise
15 has been figuring out where we can get a better accounting
16 of outcomes.
17 CHAIRPERSON FECKNER: Great. Thank you. Before
18 I go on to questions, I do want to say that Mr. Rubalcava
19 is joining us remotely. He's attending other meetings.
20 He stepped out before our action item number 5, that's why
21 we did not do a roll call vote. He was no longer on the
22 line. He came back on after action 5, and he now has a
23 question.
24 Mr. Rubalcava.
25 VICE CHAIRPERSON RUBALCAVA: Thank you, Mr.

1 Chair. I had a question for Dr. Logan on slide number 11.
2 I noticed in comparing the outpatient surgery and the
3 inpatient surgery, it seems like counterintuitive that the
4 inpatient survey -- surge -- inpatient surgical --
5 surgery -- I'm sorry, surgery -- surgery will have a
6 number of costs. But I know this is just a difference and
7 it doesn't actually show the actual dollar amount. So is
8 there something that's easily explainable or is there
9 something here that needs nee to be explored further
10 between the cost on hospital outpatient surgery and
11 inpatient surgery? Generally, inpatient surgery, we've
12 been told is more expensive.
13 CHIEF MEDICAL OFFICER LOGAN: Mr. Rubalcava,
14 you're -- I'm -- it was a little hard to hear you, but I
15 think your question was related to the hospital outpatient
16 surgery versus inpatient surgery.
17 VICE CHAIRPERSON RUBALCAVA: Correct. Yes.
18 CHIEF MEDICAL OFFICER LOGAN: So, yes, the -- the
19 utilization for both outpatient surgery and inpatient
20 surgery is lower than the HMOs, but the costs are higher.
21 So we're looking into that more about what those
22 differences really are. Inpatient -- go ahead, Don.
23 CHIEF HEALTH DIRECTOR MOULDS: I was just going
24 to add that inpatient -- so this doesn't capture total
25 costs in either of those categories.

1 VICE CHAIRPERSON RUBALCAVA: That was why I
2 asked. Okay. So its' just -- okay. Good. I was
3 wondering. All right.
4 And then the other question is I think you've
5 already answered it. There was a lot of discussion in the
6 memo and also towards the end, you know, might want to
7 come in -- the staff on this, the data analysis approach.
8 And I wan intrigued if there was going to be some
9 intervention proposals regarding benefit design and more
10 importantly network design. And so I'm looking forward to
11 that in November. So I look forward to the reports.
12 Thank you very much.
13 CHAIRPERSON FECKNER: Thank you, Mr. Rubalcava.
14 I have Ms. Taylor.
15 COMMITTEE MEMBER TAYLOR: Thank you, Chair
16 Feckner.
17 I think I'm mentioned this before. But as we're
18 looking at these costs that are higher than the HMO costs,
19 and I remember being at a off-site where we had brought
20 costs down for urgent care and emergency room services,
21 and then costs went up elsewhere. So I'm afraid once you
22 get this resolved, right, that it's going to go up
23 elsewhere. How do we mitigate these factors of grabbing
24 profit where they can?
25 CHIEF HEALTH DIRECTOR MOULDS: Yeah. So that --

1 that can be a problem when you're dealing with a single
2 entity. So if you're -- if you're an insurer, negotiating
3 with a large medical group, for example, you know, we --
4 we see this all the time in national data and in some data
5 on -- about California, is that you get -- you focus on an
6 area that's high cost, you do a great job of controlling
7 those costs, and you get the whack-a-mole effect and you
8 see them rise somewhere else. So the -- all of the work
9 that was done with Dartmouth Atlas on Medicare, for
10 example, showed that there are all these areas that --
11 that we're doing terrifically well in price and quality on
12 Medicare, come to find three years later that there -- a
13 number of those areas have really high prices on the group
14 side.
15 So here, because we're dealing with -- we're
16 dealing with particular areas across multiple providers,
17 and -- and in a lot of these areas you're dealing with
18 specialists, they don't have the same kind of ability to
19 raise prices in other places, but you're still going to
20 expect that, anyway, because some of them are large
21 multi-specialty provider groups.
22 You know, it's a hard -- it's a hard question to
23 answer, because at the end of the day, you have to keep
24 trying and you have to -- you have to anticipate some of
25 that and you have to do it across the Board, but it's

1 certainly not one that anybody has tackled in its entirety
2 yet.
3 COMMITTEE MEMBER TAYLOR: And so when the
4 insurers. So this is across -- these are unit costs
5 across whatever health care provider, correct?
6 CHIEF HEALTH DIRECTOR MOULDS: Correct. These
7 are for -- and for specific types of treatment. Julia --
8 COMMITTEE MEMBER TAYLOR: Right. And -- and
9 they're higher in the PPO than the HMO.
10 CHIEF HEALTH DIRECTOR MOULDS: Correct.
11 COMMITTEE MEMBER TAYLOR: Which means it could be
12 the same provider.
13 CHIEF HEALTH DIRECTOR MOULDS: Oh, absolutely.
14 COMMITTEE MEMBER TAYLOR: Wow.
15 CHIEF HEALTH DIRECTOR MOULDS: Yeah, absolutely.
16 COMMITTEE MEMBER TAYLOR: That's insane. Okay.
17 CHIEF MEDICAL OFFICER LOGAN: And just to add to
18 that. One thing that we're doing in our work with
19 Milliman and Peter Lee is looking across the continuum of
20 care. So as an example, maternity care, we're looking at
21 pregnancy, so the mom, and then the delivery, and then
22 we're looking at the -- at the newborn care. And so you
23 really look at costs on -- on all ends and across the
24 spectrum to make sure that the -- that whack-a-mole effect
25 doesn't happen.

1 COMMITTEE MEMBER TAYLOR: So the interesting
2 thing then I'm looking at here, which if it's the same
3 providers charging a different price based on the
4 insurance carriers -- not carriers, but the type of
5 insurance --
6 CHIEF HEALTH DIRECTOR MOULDS: I should -- before
7 we get too far, I should -- I should say in some case it's
8 the same provider. It isn't necessarily always the same
9 provider.
10 COMMITTEE MEMBER TAYLOR: Okay.
11 CHIEF HEALTH DIRECTOR MOULDS: Yeah.
12 COMMITTEE MEMBER TAYLOR: Is it more often than
13 not?
14 CHIEF HEALTH DIRECTOR MOULDS: That's a -- that's
15 a great questions. I would venture to guess that it
16 depends on the area. So if you're dealing with a really
17 small area, highly likely that they're going to be
18 contracting with the -- you know, the one HMO in the area
19 and the one -- and the PPO. If it's larger -- a larger
20 county, may be not. I mean, there's -- there's
21 considerable overlap. Happy to get back to you and look
22 at getting -- get you a more specific answer to that
23 question -- but
24 COMMITTEE MEMBER TAYLOR: Because I'm curious to
25 find out why -- we're -- so we -- we seem to have had some

1 trouble with PPOs coming to agreements lately, I think.
2 CHIEF HEALTH DIRECTOR MOULDS: I think that's a
3 fair -- fair comment.
4 COMMITTEE MEMBER TAYLOR: Okay. So that makes me
5 wonder are -- is there some price gouging going on in
6 the contract -- contractual side by the insurance carrier
7 and their -- I don't know.
8 CHIEF HEALTH DIRECTOR MOULDS: Well, so -- so
9 one -- one other important consideration here is not just
10 on the contracted side, but it's -- it's on the
11 non-contracted side. So, you know, some of -- some of
12 this -- some of these differences we would expect. On the
13 utilization side, for example, we would expect that
14 members in the PPO use less care than members in the HMO,
15 partially because of --
16 COMMITTEE MEMBER TAYLOR: It's more expensive.
17 CHIEF HEALTH DIRECTOR MOULDS: -- cost sharing,
18 right? So it's $5 in most cases in the HMO to get a -- to
19 do most things -- many things and it can be 20 percent
20 cost sharing, if you're in a PPO, so utilization we would
21 expect. Some of the price differences, so, you know,
22 people go out of network more often -- rarely go out of
23 network on the HMO side --
24 COMMITTEE MEMBER TAYLOR: Okay.
25 CHIEF HEALTH DIRECTOR MOULDS: -- often -- more

1 often go out of network on the PPO side. So this is a
2 combination of -- you know, these are overall costs. They
3 are contracted prices. They are non-contracted prices.
4 And then the contracted prices will vary depending on the
5 nature of the contract.
6 COMMITTEE MEMBER TAYLOR: Okay. So you really
7 have to dig into the weeds and that's what this whole
8 process is going to b.
9 CHIEF HEALTH DIRECTOR MOULDS: That's exactly
10 what we're doing.
11 COMMITTEE MEMBER TAYLOR: Okay. That's -- I'm
12 just trying to figure it out. It sort of boggles the
13 mind.
14 CHIEF HEALTH DIRECTOR MOULDS: Yeah. I think --
15 I think one really important question that we're grappling
16 wit right now is what -- what is it reasonable -- so
17 knowing that there's going to -- there's -- no matter how
18 good a job we do, there's going to be more out-of-network
19 use in the PPO. What -- what is it reasonable to expect?
20 What's that baseline? So that's one of the questions that
21 we're grappling with right now. We think this difference
22 is too much to be clear.
23 COMMITTEE MEMBER TAYLOR: Yeah.
24 CHIEF HEALTH DIRECTOR MOULDS: But quest --
25 and -- and the variation is -- is particularly telling,

1 that it's in some areas and not in other areas, but what's
2 the right number there. And having that allows us to sort
3 of reorient our expectations on the PPO side.
4 COMMITTEE MEMBER TAYLOR: That can't be the only
5 answer though.
6 CHIEF HEALTH DIRECTOR MOULDS: What is "that",
7 sorry?
8 COMMITTEE MEMBER TAYLOR: Well, I'm just --
9 you're saying that the -- trying to figure out how much of
10 this is out -- out of the --
11 CHIEF HEALTH DIRECTOR MOULDS: Oh, yeah. We
12 agree with you. That is -- that is unlikely to be the
13 only answer.
14 COMMITTEE MEMBER TAYLOR: It's not the only
15 factor.
16 CHIEF HEALTH DIRECTOR MOULDS: Yeah. Yeah.
17 COMMITTEE MEMBER TAYLOR: Okay. I'm just --
18 yeah, I think -- wow.
19 CHIEF HEALTH DIRECTOR MOULDS: Yeah.
20 COMMITTEE MEMBER TAYLOR: It's just amazing to
21 see that, so I appreciate the work you're doing on it.
22 CHAIRPERSON FECKNER: Thank you.
23 Mr. Pacheco.
24 COMMITTEE MEMBER PACHECO: Yes. Thank you, Don,
25 for your -- your report here and thank you, Chairman,

1 Feckner. I just want to -- I want to actually piggyback
2 on what -- on Vice Chairman Rubalcava was talking about
3 regarding the top contributors for the increase in the
4 unit cost, noticing that it's higher in the PPO than the
5 HMO. And the top one is being the hospital -- hospital
6 outpatient service. And I just want to know if in this
7 initial data analysis, have you noticed, are we offering
8 like ambulatory surgical centers options, you know,
9 outside the -- for the hospital outpatient services, offer
10 the active members to -- you know, from what I read, it
11 does help curb costs. And I'm wondering if the data or
12 the claim information can kind -- can kind of give us
13 some -- dive some information into that.
14 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
15 JARZOMBEK: So for some of the -- for some of these here,
16 we do definitely use ambulatory surgery centers, but for
17 these treatments, they don't always fall in line with our
18 reference-based pricing. And so the reference-based
19 pricing has 15 different -- 15 different categories of
20 things, where we have a reference-based price, but those
21 aren't always what we're seeing here as our high outcomes.
22 So we do have a strong Reference Based Pricing Program,
23 and about 90 percent of our members use that, and it saves
24 about $10 million roughly every year.
25 And so, these just are not reference-based price,

1 because they don't really meet the criteria to be good
2 candidates for our reference based pricing program.
3 COMMITTEE MEMBER PACHECO: But currently, because
4 there are -- we do have existing reference-based pricing.
5 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
6 JARZOMBEK: Correct. Correct.
7 COMMITTEE MEMBER PACHECO: However, it could be
8 within the -- within the thought process of the -- of a
9 redesign, we could add those or it could modified, right?
10 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
11 JARZOMBEK: Whether it's reference-based pricing or if
12 it's site of care, or whatever it might be, but the tools
13 to help get it -- the right -- the right services at the
14 right location, where they are at the -- have high quality
15 as well as a high -- a good price. And so this gets at
16 the network comments, as well as making sure members are
17 aware on where to go when they have these certain things.
18 And so it hits a variety of different things on how to try
19 to solve this issue.
20 COMMITTEE MEMBER PACHECO: And actually that
21 brings me to the next question, because this is kind --
22 with regarding the patient -- the member navigational
23 programs. So that would tie in, if we were to have this
24 established -- you know, enhance the -- the reference
25 pricing, they would be -- we would be able to utilize

1 these -- this new novel -- or novel member navigational
2 program, especially for the cancer cases and so forth to
3 help us. Is that -- am I -- am I -- is my thinking
4 correct on this or --
5 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
6 JARZOMBEK: Yes. And so that is something that we've been
7 the detailed increase with a variety of entities that do
8 this, also working with Anthem on how best we can help
9 inform the member when they are in that situation, when
10 they do have that diagnosis on where the best care for
11 them is --
12 COMMITTEE MEMBER PACHECO: Right.
13 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
14 JARZOMBEK: -- so they could be supported in that way as
15 well.
16 COMMITTEE MEMBER PACHECO: And then how would the
17 advanced primary care component delivery help it -- I mean
18 play into this as well?
19 HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF
20 JARZOMBEK: I'll defer to Dr. Logan.
21 CHIEF MEDICAL OFFICER LOGAN: Yeah, I'm happy to
22 answer that. Yeah, as I've mentioned and we've talked
23 about, primary care -- advanced primary care, high quality
24 primary care is really the -- the cornerstone, the
25 keystone of a -- of a effective health care system. So

1 we're working on the measurement pilot with Covered
2 California, the PCP match for our PPO Basic members, and
3 looking into paying for value for primary care, because we
4 realize, as a country, as a system, we don't pay enough
5 for primary care to be as effective as it should be.
6 So -- so that's what we're working on for primary care.
7 However, primary care is necessary for a high
8 quality system, but it's definitely not sufficient. So
9 there are other things that we're working on around
10 population health management, quality improvement
11 programs, health equity for sure, that are supporting this
12 high quality primary care system. And a lot of the --
13 what we're putting into the -- our HMO solicitation around
14 population health and NCQA accreditation for health equity
15 will parlay into our -- our PPO solicitation.
16 COMMITTEE MEMBER PACHECO: And as a side note,
17 with respect to the -- the health demographic profile
18 information that -- would that -- when we start getting
19 more of that data, would that be able to help us, you
20 know -- you know, help us with this advanced primary care?
21 CHIEF MEDICAL OFFICER LOGAN: Absolutely, yes.
22 And that is -- the health demographic profiles are -- are
23 essential to us understanding the diversity and complexity
24 of our membership. So that will only help with the care
25 management with advanced primary care and what we're

1 trying to do.
2 CHIEF HEALTH DIRECTOR MOULDS: Dr. Logan has
3 several questions queued up for when we're able to do the
4 analysis. All of them I think that we've talked about are
5 related to population health and feedback into assessments
6 about -- about the effectiveness of our primary care.
7 COMMITTEE MEMBER PACHECO: I'm a real -- I'm a
8 real strong advocate of population health, so this is
9 quite -- this is quite exciting. So I think -- I think my
10 answers are all there.
11 One last item, I know this is very -- from what I
12 can, this is a very ambitious process and ambitious seeing
13 how -- what is the timeline you guys are thinking on how
14 this could be implemented to try to kind of, you know,
15 curb the cost, but still provide high quality health care
16 for our members?
17 CHIEF HEALTH DIRECTOR MOULDS: If you're talking
18 about the PPO specifically --
19 COMMITTEE MEMBER PACHECO: Yes.
20 CHIEF HEALTH DIRECTOR MOULDS: -- our timeline is
21 to bring you in November, so in a couple of months, a
22 handful of probably of -- of recommended changes. Dr.
23 Logan at a high level talked about the universe in that
24 last slide of interventions that we're looking at,
25 primarily focused at working within our existing contract

1 with Anthem, because we have one more year left on that
2 contract. We've had very -- we've had several
3 interactions with them and outlined in very clear terms
4 what we expect out of the contract, that we think the
5 contract allows for, in terms of getting to the ultimate
6 goal of the, you know, larger transformation of the PPO.
7 So that will be most of the changes that we will be
8 recommending in 2024 -- for 2024, sorry in 2023, will be
9 within that context.
10 The large -- larger potential changes would be
11 part of the -- the solicitation for 2025. So the new
12 contract with -- with either this vendor or a new vendor
13 will take place starting in 2025, so for the following
14 year. And that's where we would envision incorporating
15 larger more systemic changes. And, you know, the goal is
16 partially to mirror a lot of ambitious changes that you
17 see in the HMO solicitation in the PPO, but also to look
18 more broadly about at whether, for example, we might want
19 to be engaging third parties.
20 COMMITTEE MEMBER PACHECO: Exactly.
21 CHIEF HEALTH DIRECTOR MOULDS: Dr. Logan talked
22 about -- about several of these -- of these possibilities,
23 including bringing people in, for example, groups that
24 specialize in -- in care management. Increasingly, there
25 is a lot of focus on how to bring the best parts of an HMO

1 into a PPO, while still maintaining the things that people
2 choose PPOs for, you know, the ability to -- to see a
3 broader array of -- of providers that may not all operate
4 within the same system, but still do things like maintain
5 a single electronic health record in a seamless way, have
6 it be primary care centric so there's a quarterback
7 managing somebody's health and so forth.
8 So that's -- those larger changes, to the extent
9 that they would bring in third parties, would probably be
10 2025. Several of them we think we can take significant
11 steps in -- in the existing contract.
12 COMMITTEE MEMBER PACHECO: But for the -- for
13 the -- for -- having kind of like a test run or a pilot
14 sort of, it would be in 2024. And that's my -- that's my
15 understanding, right, so we can kind of see how this can
16 play out.
17 CHIEF HEALTH DIRECTOR MOULDS: Right.
18 COMMITTEE MEMBER PACHECO: Very good then. Thank
19 you so much. Thank you, Don. Thank you, everyone. Team,
20 thank you.
21 CHAIRPERSON FECKNER: Thank you.
22 Ms. Paquin.
23 ACTING COMMITTEE MEMBER PAQUIN: Thank you, Mr.
24 Chair.
25 Thank you so much for the report this morning. I

1 was just curious what impact, if any, has value-based
2 pricing had on specialist care costs?
3 CHIEF HEALTH DIRECTOR MOULDS: So in terms of our
4 offerings or -- or in the world?
5 ACTING COMMITTEE MEMBER PAQUIN: In terms of, as
6 you're doing this analysis, have you been looking at that
7 lens as well too and the data that you're finding?
8 CHIEF HEALTH DIRECTOR MOULDS: Absolutely. So,
9 you know, we -- we do a -- we do a lot to try to -- to
10 bring more value. It's, you know, sort of why we're here.
11 The -- and we see a number of -- of the interventions that
12 we've made to date being helpful in that regard. You
13 know, the Reference Pricing program is a great example.
14 See lots of data that suggests that -- that the various
15 iterations of that program have led to -- to more of our
16 members going to high quality lower cost sites of care for
17 example.
18 I'm going to steal Dr. Logan's thunder a little
19 bit. I apologize. But our VBID program as we've done
20 analysis, we think there is a lot of room for improvement
21 of the VBID program, but we're seeing some parts of the
22 VBID program as -- as bringing returns. We see much
23 higher use of primary care in the Gold program as a result
24 of the -- of the -- the primary care physician matching
25 that's been in existence for some time there, and the

1 incentives to be working with a primary care provider.
2 And we see it in all sorts of population health measures.
3 So I, you know, don't want to sort of go on to
4 talk about other programs, but, in general, that is where
5 we need to be going. It's where we're focused.
6 ACTING COMMITTEE MEMBER PAQUIN: Um-hmm.
7 CHIEF HEALTH DIRECTOR MOULDS: And we certainly
8 see both better quality resulting in those efforts and
9 certainly a reduction in costs.
10 ACTING COMMITTEE MEMBER PAQUIN: Great. Thank
11 you.
12 CHAIRPERSON FECKNER: All right. I have one
13 request to speak from the audience, Mr. Larry Woodson.
14 Please come up and microphone will be turned on and the
15 clock will start when you do.
16 MR. WOODSON: Good morning.
17 CHAIRPERSON FECKNER: Good morning.
18 MR. WOODSON: Larry Woodson, California State
19 Retirees. Thank you for the opportunity to comment.
20 CSR applauds the staff's efforts to ensure that
21 PPO plans are aligned with the strategic plan goals. We
22 believe the data collection and analysis is a good first
23 step. And we do have some skepticism that -- in a
24 for-profit health care system of vast complexity, that
25 true cost reduction is achievable short of legislation and

1 without costs causing higher out-of-pocket costs for
2 members.
3 CalPERS in the past, a couple years ago, has
4 tried cost reduction efforts such as the value-based
5 insurance design and the Castlight Pilot, which didn't
6 work out that well, but we do support -- support this new
7 effort, and it's very impressive what we've heard.
8 There is a statement in the data analysis section
9 that says quote, "PPO health care costs have exceeded HMO
10 costs for the past five years", end quote. Yet, it gives
11 no numbers regarding total costs. And that statement is
12 inconsistent with the data reported in the last Health
13 Benefits Program annual report.
14 An important means of cost comparison is the per
15 person per year cost between the two categories, which the
16 annual report shows -- stops short of. So I use the
17 reported enrollment and expenditure figures, and found in
18 2020 that HMO plans cost more at 7,121 -- 29 PMPY compared
19 to 6,903 PMPY for the PPO plans, or $225 more. However,
20 by calculating the individual PPO plans, there's a more
21 noteworthy result. PERSCare costs 10,489 PMPY, Choice
22 2,157, and Select 4,520. So Choice and Select were much
23 lower than HMO costs, but Care much higher. And I realize
24 Gold is now a blend of Select and Care.
25 One explanation is that high-risk members who

1 have chronic or serious health conditions select the PPO
2 plan, which costs them half the out-of-pocket expense, 10
3 percent, rather than 20. And another driver is that in 17
4 counties there are no HMOs available, only the PPOs. The
5 alignment write-up effort I didn't see this addressed, and
6 hopefully that will be looked at.
7 There are other parts of the data collection and
8 analysis we find very helpful, such as reporting the
9 high-cost members and high-cost conditions, and other
10 impressive information presented.
11 Lastly, at the stakeholders briefing last
12 Thursday, I expressed concern that any benefit design
13 changes from this effort should not result in the shifting
14 of costs from CalPERS to members. Mr. Jarzombek assured
15 me that this would not be an approach in whatever
16 recommendations they bring forward. And I thanked him and
17 I thank you for your time.
18 CHAIRPERSON FECKNER: Thank you very much.
19 Seeing no other requests on this topic, thank you
20 all for your presentation. Great information. Let's keep
21 holding their feet to the fire and let's make sure we get
22 the information that we need to make educated decisions.
23 So thank that you all.
24 That brings us to Item 6B, summary of Committee
25 direction. Mr. Suine, Mr. Moulds, anything that you

1 picked up on?
2 CHIEF HEALTH DIRECTOR MOULDS: I did not record
3 any specific direction, but if there is direction that I
4 missed.
5 DEPUTY EXECUTIVE OFFICER SUINE: Mr. Chair, I
6 just recorded the review of the foreign country direct
7 deposits for retirees, and options, and communications
8 available.
9 CHAIRPERSON FECKNER: Thank you.
10 Brings us to 6C, public comment. I do have some
11 requests to speak. Mr. Woodson, you stayed in place.
12 Good job.
13 (Laughter).
14 MR. WOODSON: I thought I'd save time.
15 Good morning again. Thank you for the
16 opportunity to comment again. My comments are on the ACO
17 REACH program, which you know CSR opposes. As I reported
18 in my public comments at the June 14th Pension and Health
19 Benefits Committee meeting, and in a report to all Board
20 members, it moves CalPERS retirees out of traditional
21 Medicare and into a plan managed by a for-profit middle
22 man without approval or knowledge of the member.
23 I urge CalPERS to oppose this program and I thank
24 the Board for asking staff to further investigate it and
25 report back. Since then, I do have a couple of updates.

1 First in addition to the originally approved 99 direct
2 contract entities, or DCEs, CMS announced provisional
3 approval of 128 new for-profit entities nationwide, now
4 rebranded ACOs. This more than doubles their original 99
5 and demonstrates an upscaling far beyond what would be
6 needed for a so-called pilot project. I found that 20 of
7 the 128, or 15 percent, are classified as new entrants,
8 meaning little or no experience managing Medicare.
9 As I reported in June, Sutter Health was approved
10 as a GCE starting in January. At two recent CSR meetings,
11 in September, I asked for a show of hands from retirees
12 who were on traditional Medicare who had Sutter primary
13 care providers. About 20 people raised their hands. I
14 then asked how many had received the letters informing
15 them that they're now part of a Sutter DCE and no hands
16 went up.
17 Since all Sutter PCPs are in direct -- Sutter
18 direct as of January, all their patients should have
19 received CMS mandated letters. It appears that nine
20 months later, Sutter hasn't informed members or maybe
21 some, but not -- certainly not all, and they're no longer
22 in traditional Medi -- that they're no longer in
23 traditional Medicare. It also appears CMS is not
24 monitoring well.
25 With some effort, I was able to get Sutter Direct

1 to give me a copy of their letter. It's the boilerplate
2 language from CMS for the same exaggeration and
3 misrepresent -- misrepresentation that I described to you
4 in my report.
5 Lastly, I know that Don Moulds is contracting --
6 contacting subject matter experts for more information and
7 we're very happy about his plans to have a panel of pros
8 and cons I assume on Board education day. I hope this
9 results in a recommendation for the CalPERS Board to
10 oppose ACO REACH. If allowed to continue, it will result
11 in total privatization of original Medicare, allowing
12 private equity tea and large insurers to take it over.
13 Thank you.
14 CHAIRPERSON FECKNER: Thank you.
15 Mr. Tim Behrens.
16 MR. BEHRENS: Chairman Feckner, members of the
17 Committee. Tim Behrens, California State Retirees.
18 I want to start off thanking the CalPERS Health
19 team for coming to the rescue of a 94-year old long-term
20 care man and his daughter was trying to help him maneuver
21 through it. And she sent me about three pages of issues.
22 And this was passed along to the Health Care team at
23 CalPERS and they're on it right now giving assistance to
24 this lady and this gentleman.
25 There was a lot of things that this young lady

1 didn't understand -- I call her young. She's probably
2 70s -- didn't understand, because she didn't know anything
3 about the plan until her father got sick. So I appreciate
4 that.
5 I'm wondering if it's possible in the future, and
6 I think I mentioned this the last time we met, if we could
7 get more choices for out-of-state stakeholders for health
8 care. I've received 14 calls from out-of-state and all of
9 them would like to have more choices. And it seems to me
10 like it's possible for CalPERS, because they are number
11 two biggest guy on the block, to leverage places like
12 Kaiser in other states that can then cover other hospitals
13 in other states under their agreement with CalPERS. Just
14 a thought.
15 I'm really disappointed that we're waiting till
16 January to follow up on the privatization of Medicare.
17 I'm happy we're going to do it. I would urge this Board
18 and CalPERS to do a deep dive on this. Larry gave you the
19 statistical information that we know right now. The
20 California State Retirees has embarked on a phone call to
21 the President and a phone call to our congressman asking
22 them to consider killing this pilot program. And I hope
23 the recommendation from staff to the Board will be to do
24 the same.
25 Thank you.

1 CHAIRPERSON FECKNER: Thank you. And as you
2 know, Mr. Behrens, we don't have meetings in October or
3 December, so it made it a little harder to put this on
4 sooner. So I appreciate your comments, but January seemed
5 to be as quick as we could get there.
6 MR. BEHRENS: We need to have more meetings.
7 CHAIRPERSON FECKNER: You're not going to hear an
8 argument from me.
9 (Laughter)
10 CHAIRPERSON FECKNER: That -- we have one caller
11 on the phone.
12 STAKEHOLDER STRATEGY MANAGER TEYKAERTS: Mr.
13 Chair, we actually have three callers now. I'll begin
14 with the first one. First up we have William Stewart.
15 Mr. Stewart, go ahead.
16 MR. STEWART: Good morning, Mr. Chair and Chair
17 members, are you able to hear me clearly?
18 CHAIRPERSON FECKNER: Good morning. Yes.
19 MR. STEWART: Thank you for this opportunity to
20 provide comment and make an identical request by
21 happenstance and providence that Mr. Behrens just made
22 regarding health insurance for out-of-state retirees.
23 My name is William Stewart. I had no idea what
24 would be discussed at this meeting. I'm a local
25 miscellaneous public agency retiree living in the state of

1 Texas. I have not reached the age of 65, so I do not
2 qualify for Medicare. Since retiring, I have been offered
3 only one health insurance plan option. PERS Platinum PPO
4 was the only plan I was offered last year and it is the
5 only plan offered to me during the current open enrollment
6 period.
7 This is, of course, an excellent health insurance
8 plan. And I'm very thankful that my former employer is
9 paying the majority of my family's monthly premium.
10 However, my premium responsibility will be over $3,991 for
11 the year, which is a significant burden for a retiree.
12 So I would like to know if CalPERS could offer an
13 additional health insurance plan option that would be less
14 expensive for people like me that do not qualify for
15 Medicare.
16 Thank you.
17 CHAIRPERSON FECKNER: Thank you.
18 Mr. Teykaerts.
19 STAKEHOLDER STRATEGY MANAGER TEYKAERTS: Mr.
20 Chair, next up, we have Paia Levine. Go ahead, Ms.
21 Levine.
22 MS. LEVINE: Good morning. I didn't hear anybody
23 mention the time limit for comments. Can you tell me what
24 that is?
25 CHAIRPERSON FECKNER: I didn't understand what

1 you said. I'm sorry.
2 MS. LEVINE: Three minutes.
3 STAKEHOLDER STRATEGY MANAGER TEYKAERTS: It's
4 three minutes. Three minute time limit.
5 CHAIRPERSON FECKNER: Three minutes.
6 MS. LEVINE: Thank you.
7 My name is Paia Levine. And I'm a 35-year member
8 of CalPERS. And I called this morning, because I want to
9 tell you about a situation that our insurers periodically
10 create for the members that has to do with mid-year
11 changes to preferred provider medical groups and what it's
12 like from the member's perspective to go through that.
13 It seems especially relevant today, because we're
14 talking about administering the PPOs. Negotiations with
15 provider groups, they appear to be handled in such a way
16 that when the providers and the insurer reach an impasse,
17 the insurer sends notices to members saying that the
18 provider will no longer be available after a certain date,
19 and it's usually very short notice, on the order of two or
20 three weeks.
21 When that happens, it just pulls the rug out from
22 under the members and the families who have to rely on
23 specific doctors and specialized clinics that are not
24 available in every neighborhood. I, for example, have a
25 chronically ill child with a tough diagnosis and the

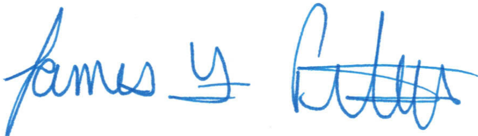
1 abrupt disruption just happened to us. I received a
2 letter on September 7th from Anthem telling me that
3 Stanford is no longer a network provider effective
4 September 1st. It had already happened when I was
5 informed. And I can't explain to you the stress that is
6 caused when your kid's specialized providers are all of a
7 sudden not available.
8 I don't know if the administrators are -- are
9 fully aware, but it can often take years to cobble
10 together the right providers and to get to the top of the
11 waiting lists to be treated by them.
12 Anthem's practice of sudden cancellation is
13 really just not acceptable and we can do better. For
14 completeness, I'll note that Anthem does have a continuity
15 of care process, but please know that it consists of one
16 final appointment, and only when that appointment has been
17 scheduled prior to the change in the contract, which in
18 this case was obviously impossible, because there was zero
19 notice.
20 My request today, as your Committee looks at the
21 larger issues of sustainability with the health plans and
22 performance, are that, one, please keep it front and
23 center that we, CalPERS, are the customers of the
24 insurers. It's not the other way around and I think we
25 can require better more compassionate performance when

1 they're handling disruptions caused by provider
2 negotiations.
3 Second, we sure should not participate in
4 brinkmanship that results in mailed notices of pending
5 loss of care. When contract negotiations are difficult,
6 actually that -- that shouldn't matter, because contract
7 negotiations should be managed so that changes only occur
8 at the end of a contract and before open enrollment, so
9 that medical consumers and families can know what
10 providers are available with what plans. Many of us are
11 completely dependent on those lists of providers, because
12 we have to be treated by certain specialists.
13 CHAIRPERSON FECKNER: Thank you. Your time has
14 expired.
15 MS. LEVINE: A full year should be allowed to --
16 CHAIRPERSON FECKNER: Your time is up. Thank you
17 very much for your comments.
18 MS. LEVINE: Thank you.
19 CHAIRPERSON FECKNER: Mr. Teykaerts.
20 STAKEHOLDER STRATEGY MANAGER TEYKAERTS: Mr.
21 Chair, our last caller Neal Johnson. Go ahead, Neal.
22 MR. JOHNSON: Hello, can you hear me?
23 CHAIRPERSON FECKNER: Hello, Neal. Good morning.
24 MR. JOHNSON: Good morning, Mr. Feckner. It's
25 good to see and hear from you and members of the

1 Committee.
2 I have two comments. One is sort of directed at
3 Don. Last fall, November/December, and earlier this year,
4 some gentleman called in about Medicare and how expensive
5 the PERS plan was, and there were cheaper options
6 available. And Don said he would contact him and I
7 thought was going to report back. I never -- have never
8 heard in public meetings any discussion of what the result
9 of that discussion -- those discussions were.
10 Secondly, this seems more at Mr. Suine and the
11 Contact Center. On August 5th I called the Contact Center
12 because I had received a billing from Mercy Medical Group
13 over a surgery I had in December of 2021, and asking me to
14 essentially pay the entire bill, because it turns out the
15 provider hat not build UnitedHealthcare, who was my
16 insurer at the time. And when I called PERS to mention
17 this, I got summarily cut off and said, you know, this is
18 a problem with the plans, don't bother us essentially.
19 And, yes, you fund plans, so I think you would
20 want to know what problems are arising, et cetera. And I
21 was really sort of shocked at the lady's summarily
22 rejection of my asking questions. I have subsequently
23 contacted United and was able to get an explanation that
24 the doctor had not billed. I got another billing from
25 Mercy last -- end of last month, and again it's -- they

1 hadn't -- either hadn't billed or the billing and the
2 automatic generation of bills weren't in sync, and so --
3 but I've been told both times I would not be responsible
4 for the 16,000 plus dollar bill.
5 Anyway, I just wanted to let you know about those
6 problems and thank you very much.
7 CHAIRPERSON FECKNER: Thank you, Mr. Johnson.
8 Are there any other calls on the line?
9 STAKEHOLDER STRATEGY MANAGER TEYKAERTS: No, Mr.
10 Chair.
11 CHAIRPERSON FECKNER: Very good. Thank you.
12 Seeing no other requests to speak, nothing else
13 on the agenda, we will adjourn the PHBC meeting and we
14 will begin the Board meeting at 11:35. Staff needs some
15 time to get the Zoom Meeting set up, et cetera. So we'll
16 see you in about 21 minutes.
17 Thank you, all.
18 (Thereupon California Public Employees'
19 Retirement System, Pension and Health Benefits
20 Committee meeting adjourned at 11:14 a.m.)
21
22
23
24
25

1 CERTIFICATE OF REPORTER

2 I, JAMES F. PETERS, a Certified Shorthand
3 Reporter of the State of California, do hereby certify:
4 That I am a disinterested person herein; that the
5 foregoing California Public Employees' Retirement System,
6 Board of Administration, Pension and Health Benefits
7 Committee meeting was reported in shorthand by me, James
8 F. Peters, a Certified Shorthand Reporter of the State of
9 California, and was thereafter transcribed, under my
10 direction, by computer-assisted transcription;
11 I further certify that I am not of counsel or
12 attorney for any of the parties to said meeting nor in any
13 way interested in the outcome of said meeting.
14 IN WITNESS WHEREOF, I have hereunto set my hand
15 this 21st day of June, 2022.
16
17
18
19

20
21
22 JAMES F. PETERS, CSR
23 Certified Shorthand Reporter
24 License No. 10063
25