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

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SACRAMENTO, CALIFORNIA

TUESDAY, MARCH 19, 2024

9:00 A.M.

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

APPEARANCES

COMMITTEE MEMBERS:

Ramón Rubalcava, Chair

Kevin Palkki, Vice Chair

Malia Cohen, represented by Deborah Gallegos

David Miller

Eraina Ortega

Jose Luis Pacheco

Theresa Taylor

Mullissa Willette

BOARD MEMBERS:

Fiona Ma, represented by Frank Ruffino

STAFF:

Marcie Frost, Chief Executive Officer

Matt Jacobs, General Counsel

Kim Malm, Deputy Executive Officer

Donald Moulds, PhD, Chief Health Director

Kelli Aoki, Chief, Policy Research and Data Analytics Division

Rob Jarzombek, Chief, Health Plan Research and Administration

Kimberlee Pulido, Chief, Retirement Benefit Services Division

APPEARANCES CONTINUED

ALSO PRESENT:

Khuram Arif, MD, Western Health Advantage

Margherita Brown

Michael Byrd, Sharp Health Plan

Brano Goluza

Melissa Hayden, Sharp Health Plan

Garry Maisel, Western Health Advantage

Cary Shames, MD, Sharp Health Plan

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PROCEEDINGS

CHAIR RUBALCAVA: Good morning, everybody. We're going to call to order the Pension & Health Benefits Committee.

And the first order of business is roll call.

Thank you.

BOARD CLERK ANDERSON: Ramon Rubalcava?

CHAIR RUBALCAVA: Present.

BOARD CLERK ANDERSON: Kevin Palkki?

VICE CHAIR PALKKI: Good morning.

BOARD CLERK ANDERSON: Deborah Gallegos for Malia Cohen?

ACTING COMMITTEE MEMBER GALLEGOS: Here.

BOARD CLERK ANDERSON: David Miller?

COMMITTEE MEMBER MILLER: Here.

BOARD CLERK ANDERSON: Eraina Ortega?

COMMITTEE MEMBER ORTEGA: Here.

BOARD CLERK ANDERSON: Jose Luis Pacheco?

COMMITTEE MEMBER PACHECO: Present.

BOARD CLERK ANDERSON: Theresa Taylor?

COMMITTEE MEMBER TAYLOR: Here.

BOARD CLERK ANDERSON: Yvonne Walker?

CHAIR RUBALCAVA: Excused.

BOARD CLERK ANDERSON: Mullissa Willette?

COMMITTEE MEMBER WILLETTE: Here.

CHAIR RUBALCAVA: Thank you, everybody. Now we have to -- we're going to recess to go into closed session. I apologize folks but we will be back within 2 hours.

Thank you, everybody.

(Off record: 9:00 a.m.)

(Thereupon the meeting recessed into closed session.)

(Thereupon the meeting reconvened open session.)

(On record: 10:44 a.m.)

CHAIR RUBALCAVA: Good morning, everybody. We're back in open session, and we will continue with the remainder of the open session agenda.

Our next item is the Executive Report.

Mr. Moulds an Ms. Malm.

DEPUTY EXECUTIVE OFFICER MALM: Good morning. Kim Malm, CalPERS team member. I wanted to share a few things with you today.

First, our next CBEE will be held virtually on April 10th and 11th. We're also planning one for June 7th and 8th in San Luis Obispo at the Embassy Suites. It's now posted on our website, and registration will open in early May.

Next, we're preparing to begin another benefit

verification cycle. This is one step we can take prior to utilizing Socure. This isn't a new process. We perform benefit verifications regularly. In fact, the last one was in 2022.

Through this cycle we are focusing on reducing risks to the fund and overpayments that result when members' deaths go unreported.

The process includes sending a letter to the identified benefit recipient requesting documentation to certify their eligibility to continue receiving benefits.

At CalPERS, all CalPERS payees may be subject to receiving this letter at some point while receiving ongoing monthly benefit from us. But the upcoming cycle we will reach out to approximately 8,000 retired members or approximately 1 percent of our retiree population.

We spent considerable time and thought determining the high risk individuals in our system. Some of those include the last time they met with their health care providers, the last contact they had with CalPERS, if they live in a state that doesn't share death reporting and the amount of the death benefit payment.

Another factor is age. We have approximately 1200 benefit recipients over a hundred years old. And in fact there are 102 benefit recipients that are over 104 years old.

The kind of documentation that is required is a Certification of Eligibility for Payment form that is notarized; a letter from the member, or a letter from the member's physician on their letterhead stating the member is in their care, or a letter from the care facility that the member resides in on their facility letterhead stating that the member lives in their facility, or completion of this acknowledgment section of the certification form by a bank representative.

And of course if members have challenges providing proper documentation, or they have questions, we'll work with them before any benefit payments are held.

Members can contact our contact center or send secure messages for assistance.

Before I move on, let me emphasize why this is so important. In the 16-month period when we utilized a death verification service, we received almost 26,000 reported deaths from that service. We knew about 15,000 of them. So we processed 11,000 of them that we were unaware of. The average monthly warrant for those -- just those 11,000 was $2,173 per month. And that's just for the 11,000 population we were unaware of.

This has a significant impact to the fund. Taking the average monthly warrant times the 11,000 people is over $23 million for the 16-month period, or almost 1.5

million per month of reduced overpayments. And this represents just one month of overpayment. In some instances, the death may go unreported for multiple months. And again as you're aware, it's very difficult to collect the money after it's been paid unless there's an ongoing payment to a beneficiary.

I briefed the stakeholders this month on March 14th about these upcoming letters, and we'll start sending these letters after this March's meeting.

Finally, in closing, as in typical fashion, I thought I would give you an update on the retiree warrant project. To date, almost 3400 individuals -- or sorry, retirees have successfully used our IVR or phone system since it rolled on you in October. And the on-line link has launched on January 20th - so about two months ago - has been successfully used almost 21,000 times. I know there's a lot of interest in the retiree warrant information so I thought I'd just continue sharing their utilization.

And that concludes my comments. And I can turn it over to Mr. Moulds.

CHAIR RUBALCAVA: Thank you, Kim.

CHIEF HEALTH DIRECTOR MOULDS: Great. Good morning, Mr. Chair, members of the Committee. Don Moulds, Chief Health Director. I have a few updates this morning.

First I want to share this -- that this year open enrollment will be held September 16th through October 11th. These dates are consistent with prior years. And I like to announce them in March so that they can be added to calendars for planning. The preparation for open enrollment is already underway.

Next I'm pleased to share that CalPERS has received a Moonshot Award for our Biosimilars First pharmacy program. The award is given annually by the purchaser or business group on health to member organizations that are reimagining the status quo with innovations that improve health care quality, affordability and equity.

Dr. Logan's talked with you in the past about the Biosimilars First program. We launched it a couple of years back in our PPO basic plans requiring the use of biosimilars for new prescriptions where biosimilars are available and clinically appropriate.

The program includes all of the drugs that have an available biosimilar and it has achieved widespread patient and clinical acceptance. Biosimilars play an important role towards working to lower health care costs while offering the same efficacy and safety as the original biologic drug.

Next I want to share that we held our first

health policy roundtable earlier this month on the topic of specialty pharmacy. The roundtable featured presentations from two terrific outside experts and a really good discussion. I want to particularly thank Mr. Palkki and Mr. Walker for participating. It was helpful to have them there.

Our team is crafting a summary of the notes on the roundtable that we'll share with the Board and post on our website. We'll let you and the stakeholders know when they're available.

Mentioning the roundtable discussion is timely because I want to share that we're preparing for a Pharmacy Benefit Manager solicitation for later on this year. As you know, we currently contract with OptumRx for pharmacy services, and for our PPO plans and the HMO plans outside of Kaiser Permanente and Blue Shield. You've heard me say before that we've negotiated breast market pricing with OptumRx through our acquisition-price-based contract. But I think we all agree that we con -- that we continue to spend too much on pharmaceuticals. My team looks forward to working with the Board this year to secure the strongest contract possible.

The new PBM contract would take effect January 1st, 2026.

Last I want to make an announcement that I'm very

excited about in our Long-Term Care Program. Starting April 1st we'll be launching our Long-Term Care Aging in Place Program which invests in pre-claim interventions that help our policyholders stay in their homes longer. As we've talked about in the past, the vast majority of our policyholders want to remain in their homes as long as they can do so safely. This program will help them do that; and by avoiding costly institutionalization, it also saves precious premium dollars that are used to fund the program.

Moving to our agenda today. We're continuing our Health Plan Spotlight series with leadership teams from Western Health Advantage and Sharp Health Plan, who are both joining us today.

I know you're looking forward to another great discussion and the opportunities to learn more about these plans and how they are supporting our members and our strategic goals.

So I'll stop there, and happy to answer any questions.

CHAIR RUBALCAVA: Thank you Mr. -- Don.

Now we'll proceed to the Action Consent Items. I do have public oral testimony requested.

Margherita Brown, please.

MARGHERITA BROWN: Is this the right spot?

CHAIR RUBALCAVA: Yes, please.

On 3c. Sorry. Yes.

MARGHERITA BROWN: Thank you.

My name is Margherita Brown and I see under its delegations that this Committee has responsibility to oversee the cost and quality of the Long-Term Care Program.

Is this Committee also responsible for assessing the viability of the Fund, and if necessary, determining the need for long-term care rate increases, ensuring a fair distribution of increases across policyholder groups, and providing timely and transparent information to CalPERS members on these decisions?

If yes, has the Committee begun consideration of premium increases for later this year?

CHAIR RUBALCAVA: It's not our practice really to always respond to public comment. But I'm sure staff will be happy to talk to you afterwards.

MARGHERITA BROWN: Thank you.

CHAIR RUBALCAVA: Thank you.

So I'm assuming we can go forward with -- into an inform -- oh, we need a motion to accept.

VICE CHAIR PALKKI: Move to approve.

CHAIR RUBALCAVA: Second by Mr. Pacheco.

Need roll call.

All those in favor?

(Ayes.)

CHAIR RUBALCAVA: So the motion passes. Thank you very much.

Now we'll move to information consent items.

We have one request to pull Item 4c, Health Open Enrollment Results.

And I see Rob's pulling up front.

So should I start with my question or you present?

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Please, go ahead.

CHAIR RUBALCAVA: I noticed we had a lot of activity during open enrollment. And I would believe it's because we did communicate to our members, because of the double digit increase in some of the plans, particularly Kaiser, that there were other options. And we asked people to shop around. And we noted that Kaiser actually had a net loss of over -- almost 22,000 members; total loss was about 26,000.

And so I do want to commend the staff for the communication, and members for shopping around and making changes. And I know we have the Health Plan Spotlight under -- later today. Our first inaugural was Kaiser and we definitely had a good discussion where we laid out our

expectation that this double digit increase is harmful to our members, harmful to the plan and we're hope -- we're really hopeful that we work together to make sure that does not happen again.

Rob, do you have any comments on the open enrollment?

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Oh, yeah. So thank you for your interest in this item.

So, yes, what we did see from Kaiser was a large migration out of their program. It was about 3.5 percent overall when you combine Basic and Medicare. But more specifically, on the Basic side it was about 4 percent of their members left that plan.

This was in line with what we anticipated the projected loss to be, and also in line with what Kaiser has anticipating also.

I'd also like to highlight some of the gaining plans, because there was definitely those plans who are competitive out there that our members made the choice to move to.

So the largest gaining plan was Blue Shield Access+. They gained about 20,000 lives or 21 percent.

Trio was next with gaining 10,000 lives or 31 percent. So definitely making an increase there.

Next was UHC Alliance. They gained about 4500 members, or just about 6 and a half percent.

And then finally UHC Harmony had the largest percentage increase. They gained about 2200 members, and just over 46 percent growth for them.

Lastly I'll also mention that Western Health Advantage also saw a significant increase of about 25 percent or about 4200 members.

So what does show that members were paying attention even more this year. Thanks for efforts that we in the health team and with your direction sent out letters about the significant rate increases. So members definitely are looking -- using our tools and shopping around more than they have before.

CHAIR RUBALCAVA: Thank you, Rob. Appreciate it.

Any more comments from the Committee?

I don't see any.

So now we'll move into the Action Agenda Item Number 5, Proposed Amendment to Regulation: Definition and Reporting of Full-Time Employment.

Ms. Kim Malm and Kelli Aoki.

DEPUTY EXECUTIVE OFFICER MALM: Good morning. Kim Malm, CalPERS team member.

We have one action item before you today. This is the proposed amendments to the definition and reporting

of full-time equivalent, or FTE, school pay rates. This is just the clarification of current regulations. We spent time the last couple of months working with our school stakeholders on this clarification. In addition, we sent out a circular letter to our school employers on Friday, March 8th. That was reviewed by the stakeholders sharing this information with the school employer community.

Kelli Aoki, the Division Chief of Policy Research and Data Analytics, will be presenting this item.

We also have Brad Hanson, who's Acting Division Chief for Employer and Account Management Division here in case you have some additional specific questions.

So I will turn it the over to Kelli.

POLICY RESEARCH AND DATA ANALYTICS DIVISION CHIEF AOKI: Thank you, Kim.

Good morning, Mr. Chair and members of the Committee. Kelli Aoki, CalPERS team member.

This agenda item is an action item requesting approval to amend California Code of Regulations section 574 to describe how a classified school member's full-time pay rate shall be reported to CalPERS; followed by submission of the final rulemaking package to the Office of Administrative Law upon conclusion of the 45-day public comment period provided no public comments are received.

This proposed amendment only applies to classified school members and school employers.

In 2000 the Legislature enacted Government Code section 20636.1, to standardize full-time employment for classified school members as 40 hours per week. Prior to this statute school employers had the discretion to establish how many hours were considered full-time employment for their classified school members, resulting in inconsistent retirement benefits among classified school members across school districts.

In 2019, CalPERS promulgated California Code of Regulations section 574 to define full-time employment for purposes of determining CalPERS membership eligibility reporting overtime positions and determining compensation earnable and pensionable compensation.

School employers are required to report full-time pay rates to CalPERS. A common payroll reporting error we see is some school employers report earnings as pay rate when earnings aren't based on a 40-hour workweek. This -- these noncompliant pay rates lead to inaccurate final compensation and service credit earned, which ultimately results in inaccurate retirement benefits.

Please refer to the table on page 3 of the agenda item.

In this example, there are three employees and

they're all earning $5,000 per month. Only Employee C's earnings and pay rate -- full-time pay rate should be the same, at $5,000 per month, because Employee C is working full-time.

Employee A and B's full-time equivalent pay rates are higher than the five-thousand-dollar earnings because their earnings aren't based on full-time employment.

Consistent with current training and education we provide school employers, and to ensure accurate payroll reporting, the proposed amendment describes how hourly, daily and monthly full-time equivalent pay rates are determined when earnings aren't based on a 40-hour workweek.

To assist school employers with conducting these calculations, we have a full-time equivalent pay rate calculator available on our website that will provide the hourly, daily and monthly full-time equivalent pay rates using the same methodology as the proposed amendment.

Over the past few months we have worked with members of our school stakeholder communities and have received support of this proposed amendment. Following approval of this agenda item, CalPERS will submit the proposed amendment to the Office of Administrative Law to initiate the 45-day public comment period. Following the conclusion of the public comment period, if there are no

comments received, we will submit the final rulemaking package to the Office of Administrative Law.

If comments are received we will bring this proposed amendment back to this Committee with the comments received, our responses to those comments and any amendments deemed necessary in the fall for final approval.

Due to the regulatory process, the earliest this proposed amendment is expected to be effective would be January 2025. But it's more realistic that it will be April or July of 2025.

We understand that some employers may need time to update their payroll system and MOUs. We provided guidance in the circular letter that was issued on March 8th, and we encourage school employers to reach out to us now and begin making those changes.

This concludes my presentation, and I can answer any questions you may have.

Thank you.

CHAIR RUBALCAVA: Thank you.

Does the Committee have any questions?

Mr. Palkki.

VICE CHAIR PALKKI: Thank you, Chair. Thank you. You know, I've received numerous phone calls expressing their frustration on their numbers not matching

up. And I've read through this multiple times, talked to contingency groups to hear. And obviously, thank you for reaching out to those employers as well too. But I think the more that we can do to create that -- the clarity and so that when they log into their myCalPERS, the numbers match up and they can truly see what their retirement looks like is really beneficial to the school employees. So thank you for that.

CHAIR RUBALCAVA: Thank you.

Any more questions from the Committee?

Mr. Pacheco.

Hold on, please.

COMMITTEE MEMBER PACHECO: Yes. Thank you.

First of all, I want to say thank you for the presentation on this important topic. As a fellow -- as a classified school employee, I do appreciate this. This is very, very important.

I'd like to know, how would you be able to -- with respect to the circular letter, this upcoming Education Forum, will there be any workshops for the folks there as well?

POLICY RESEARCH AND DATA ANALYTICS DIVISION CHIEF AOKI: Thank you for that question. And that is something that we will be making sure is added to the Employer Education Forum this year. It is to provide education to

the employers on the calculations and determining the full-time equivalent pay rates.

COMMITTEE MEMBER PACHECO: So education on the new calculator as well and so forth?

POLICY RESEARCH AND DATA ANALYTICS DIVISION CHIEF AOKI: Yes.

COMMITTEE MEMBER PACHECO: Well, excellent then.

Thank you very much. Those are my questions.

POLICY RESEARCH AND DATA ANALYTICS DIVISION CHIEF AOKI: Thank you.

CHAIR RUBALCAVA: Thank you.

Now I think that's it. Thank you for your presentation.

I need now a motion to --

COMMITTEE MEMBER PACHECO: I'll make it.

CHAIR RUBALCAVA: Mr. Pacheco makes a motion.

VICE CHAIR PALKKI: Second.

CHAIR RUBALCAVA: Seconded by Mr. Palkki. Any discussion?

I see none.

So we'll call for the vote. All those in favor?

(Ayes.)

CHAIR RUBALCAVA: The motion passes.

Thank you.

And now we'll move on, proceed to the next agenda

item, which is information agenda items. And it's a --

VICE CHAIR PALKKI: You have to ask for opposed and abstains.

CHAIR RUBALCAVA: Oh, I'm sorry. Thank you.

Okay. So we had the ayes.

Any opposed?

Any abstains?

Thank you.

So now the item has been disposed of or adopted.

And staff has work to do on that one.

And now we'll move to Information Agenda Item 6a, Retiree Cost to Living Adjustment.

Ms. Malm.

(Thereupon a slide presentation).

DEPUTY EXECUTIVE OFFICER MALM: Thank you.

The next agenda item is an information item.

The Cost of Living Adjustment - or COLA - agenda item will be presented by Kimberly Pulido, Division Chief of our Retirement Benefit Services Division. And I'll turn it over to her.

RETIREMENT BENEFIT SERVICES DIVISION CHIEF PULIDO: Thank you, Kim.

Good morning, Mr. Chair and members of the Committee. Kimberly Pulido, CalPERS team member.

Agenda item 6a is a fan favorite. It's an

information item on the retiree cost of living adjustments, or COLA.

[SLIDE CHANGE]

RETIREMENT BENEFIT SERVICES DIVISION CHIEF PULIDO: As background, our retirement law provides for the payment of an annual COLA each May to all eligible retirees based on the rate of inflation as measured by the Consumer Price Index for all urban consumers, or the CPI-U.

For Year 2023 the rate of inflation was 4.12 percent. And this figure is what was used to compute the annual COLA this year.

All retirees become eligible for COLA in the second calendar year of retirement. So therefore members that retired in 2022 are eligible or prior eligible for a COLA this year.

COLA adjustments will appear on the May 1st retirement checks.

[SLIDE CHANGE]

RETIREMENT BENEFIT SERVICES DIVISION CHIEF PULIDO: In addition, we have -- there are instances where COLAs do not adequately keep up with inflation over time. We generally experience this with our retirees that have been retired for 35-plus years. The Purchasing Power Protection Allowance, or PPPA, works in conjunction with

COLA to ensure that our members retain a purchasing power in alignment with what their employer contracted.

This year about 18,000 retirees will receive a PPPA benefit in addition to their COLA. The PPPA adjustment is also payable on the May 1st warrant.

[SLIDE CHANGE]

RETIREMENT BENEFIT SERVICES DIVISION CHIEF PULIDO: To illustrate the impacts to the COLA and PPPA this year, we've included in the agenda item charts showing the allowance increases by each retirement year.

The majority of our retirees, nearly 96 percent or over 750,000, are contracted for a 2 percent COLA. A little over 33,000 of our retirees do have a 3, 4 or 5 percent COLA provision depending on what their employer contracted.

In the chart in the agenda item or up on the screen, you'll notice that retirees with a 2 percent contracted COLA will receive between 2 percent and 4.12 percent this year, depending on what year they retired.

And let me explain further, the COLA for each retirement year is calculated based on the lesser of either the compounded COLA or compounded CPI-U or inflation since their year of retirement. So in years where inflation exceeds the contracted COLA provision, retirees are capped at the contracted COLA amount. And

any excesses applied in future years I think we've explained this as banking in the past.

The banked amount can be paid out in years where compounded inflation is more than the compounded COLA. And you'll see an example in the chart under the retirement year 2008. Retirees in this group will receive 2.0 percent increase instead of just the 2 percent to finish catching them up this year.

We do get questions from retirees why they don't get the CPI-U, so I thought I would add a little extra context there.

[SLIDE CHANGE]

RETIREMENT BENEFIT SERVICES DIVISION CHIEF PULIDO: And since this is a fan favor, we do have a lot of retirees looking for information, and we do do a lot of communication. So our best way to communicate through these channels we'll have an article in our spring newsletter, updates on our COLA website, and then also in various social media platforms and then also retirees can log into their MSS account and see that May 1st warrant and they'll be able to see the increase there.

That's my little plug to hopefully encourage people to sign up for MSS if they haven't already.

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

CHAIR RUBALCAVA: Thank you.

Any questions from the Committee? Nobody?

I don't have anybody.

Did you?

COMMITTEE MEMBER TAYLOR: (Shakes head)

CHAIR RUBALCAVA: So there's no questions then from the Committee. So thank you very much.

So now we'll move into our Information Agenda Item 6b, which is our guest speakers from Western Health Advantage and Sharp Health Plan.

CHIEF HEALTH DIRECTOR MOULDS: Ready to go?

CHAIR RUBALCAVA: Yes, please.

CHIEF HEALTH DIRECTOR MOULDS: Great.

So, Mr. Chair, this is the second of our Health Plan Spotlight items in the second and third plans that we're spotlighting. As a reminder, we are taking a pause on these until you approve rates in July. But the series will pick up again then.

Western Health Advantage is a low cost HMO serving Northern California based here in Sacramento. Representing WHA are its President and CEO Garry Maisel and its Chief Medical and Operating Officer Khuram Arif.

Western Health Advantage has been a great partner in our efforts to bring low cost to HMO options to members living in counties where historically access has been

limited to the PPO.

Sharp is a fully integrated health plan serving San Diego County. Representing Sharp Health Plan are President and CEO Melissa Hayden Cook; Chief Business Officer Michael Byrd; and Chief Medical Officer Cary Shames.

Sharp delivers exceptionally high quality care while maintaining extremely competitive premiums. We only wish they were available in more counties than just San Diego.

We're going to start with Western Health Advantage. So, Gary, why don't I go ahead and turn it over to you. And welcome.

GARRY MAISEL: Good morning, everybody. I'm very pleased to be here today. Dr. Arif is to my right. And it's nice that we can spend a few minutes with you today talking about one of our favorite subjects, which is Western health Advantage.

I'm going to take just a few minutes of your time and talk about some of the fundamentals of Western Health that make us who we are. And then Dr. Arif is going to take the bulk of the time to talk about our clinical initiatives which follow directly in line with and help support CalPERS strategies.

So first of all, the beginning. Western Health

was launched in 1997. So we are the youngest of the plans -- CalPERS benefit plan partners. Sharp is not much older than us. But we've been in business 27 years.

I was the first employee of WHA. I went to work for the company before we had our Knox-Keene license. So I've been there 28 years. I was much younger; I had a lot more hair.

(Laughter).

GARRY MAISEL: And it was certainly a lot browner than it is today.

So it's been an incredible wonderful 27 years.

Western Health is a 501(c)(4) organized organization.

Can we flip to the next slide, please. And then we're just going to freeze it there for awhile.

[SLIDE CHANGE]

GARRY MAISEL: Our two nonprofits health care sponsors are Common Spirit, better known here in California as Dignity Health; and North Bay Health Care, which is the health care system which operates predominantly in Solano County.

Initially, we launched in three counties way back in 1997. We now operate in 10 counties 27 years later. I'm going to say a little bit about our expansion further in a moment.

From day one we have always operated as a fully capitated, fully delegated health plan. And when you flip back to 1997, that was an anomaly. Folks thought that we were crazy for starting Western Health Advantage in 1997 in a health plan field that was crowded. All the health plans that are here today were in existence, plus there's a number of them I could rattle off that have long since gone out of business. We knew we had to do things differently, and that's where the capitated delegated model comes in.

So -- and delegation's important. Because our health plan partners, our -- on the professional side our medical groups and on the hospital side our hospitals, conduct all first level medical decisions, any authorizations or medical reviews. Western Health does not insert itself into that first line medical care. And that's one of the beauties of our model. We remove the plan from that. And we all know that when you go to see your physician and he says you need an MRI, generally for most health plans that's got to go to the health plan for authorization. That is not the way it works at Western Health Advantage. The medical group in which your primary care physician operates makes those decisions.

So the goal from the start was to remove the health plan from the most -- as much as possible from the

relationship between the patient and their physician, to get them out of that.

So just to be clear though, we do not delegate quality improvement, we do not delegate final appeals or grievances. That remains at the health plan level. That is very important. We are always there for our members in the end to make things right.

We're licensed as an HMO. We don't always behave like an HMO. And I'll give you one example: Our advantage referral program, which has been in existence since the very beginning. Normally, if you have a primary care doctor in an HMO model, your care has to be rendered within that primary care doctor's medical group, unless they can't provide that care. That's not the way we operate.

If your primary care doctor, for example, says that you need to see a cardiologist, certainly you can stay within your primary care doctor's medical group, but you have the right as a member to refer yourself to any cardiologist in the Western Health Advantage network. Very different. We call it breaking down the walls between our medical groups or a medical group without walls. And we're very proud about that.

A couple financial facts you can see up on the screen there. Our medical cost target is 90.25 percent,

our administrative cost target is a little over 9 percent.

Let me say something about the word "cost," by the way. We do not use the word "loss ratio." A lot of times you'll see that expressed as the medical loss ratio. We prefer to call it a cost ratio or a care ratio. I've always found it interesting that health plans are in the business of providing care to members. And then when they spend money to do that, a lot of our competitors say that's a loss. I've never quite understood that, because we are here to take care of our members. Certainly it's a cost just like our salaries are a cost, our lease expense is a cost. But it's certainly not a loss to the organization. So we do not like to use the term MLR.

When you add those two together, you can see that that nearly is a hundred percent. So we purposely operate the plan at a very low margin. Our profit margin generally bounces around a half a percent or less. And we do that not because we're poor managers of care, but that 90.25 percent medical cost target is contractually set with our providers. So that's the target. I have been accused in the past of being a very bad HMO president because why is your cost target so high? You guys must not know how to manage care.

The answer is no. We are not here to make money at the plan level. We are here to return as much of the

premium dollar as possible to the providers of the care; to keep our admin low and our profit margin skinny. That translates into our ability to being one of your most affordable health plans. I think in our region we are the most affordable health plan. That's all set by plan. That's not because we're poor managers of care. That's the way we do business.

So before I hand it over to Dr. Arif, I'll say we're very pleased to be a CalPERS partner. We were excited by growing over 4,000 lives this last open enrollment. Remember, we are only licensed in 10 counties. So we're not a statewide plan. So we were pleased by that amount of growth. We're now at a little over 21,000 lives with CalPERS. We want to continue to grow in the future, and we hope we do.

One last comment back to our growth from three counties to 10 counties. We are interested in expansion. But we will only look at areas where our proposed provider partners can manage capitation and can do a good job of accepting delegation. That is the model, and it's been the model since 1997. So we will not expand into a county unless the providers are able to manage capitation and can do that first-line delegated activity. Because that's our method of operation because that brings -- that structure brings a relatively high level of satisfaction to our

members rather than a fee-for-service environment.

So with that I'm going to hand it over to Dr. Arif, who's going to talk more about our clinical initiatives which support the CalPERS strategic plan.

DR. KHURAM ARIF: Good morning, distinguished members of the Board. It's a pleasure to be here today.

I believe we've set out the next few slides is basically to talk about CalPERS strategic initiatives and how Western Health Advantage supports those initiatives.

[SLIDE CHANGE]

DR. KHURAM ARIF: So I think if you go to the next slide you'll see that, you know, what's top of mind for our providers for ourselves as a plan and I'm sure for CalPERS members is access, being able to get in to see a doctor when you need to see a doctor.

We know that the shortage in primary care is a national shortage. And there are not enough people in the world to sort of recruit your way out of that shortage issue.

In that environment, how does one then keep access open and think of new ways of improving access? This is the strength of Western Health Advantage is working with our providers. Because we are a provider-sponsored plan we are very closely integrated with our providers.

We have led the charge working with our providers in terms of redesigning the way simple things, like appointment availability and the way the schedules work and when somebody calls that front desk at the office, how do they get to the right level of care without having to necessarily see the physician every time? Can certain kinds of care be provided asynchronously? Is the way that we operated 10, 15 years ago in the medical office, is that really relevant to today? And how can we think outside the box? And so we have the privilege of working closely with the various medical boards or for medical partners, being involved in helping them with practice redesign and looking at their ideas and refining them by balancing them against the needs of our members.

So access redesign as you know is imperative. And the solutions have to be creative. And access is not just getting care by going into the doctor's office. I mean so many of us I think learned during the pandemic how strong we are, how folks can become self-sufficient if they have the right tools. And so that's where the fact that we were lucky enough to have a significant change in culture - it was a survival matter - but it also helped us change the culture of care delivery. And so patients realized that they could actually take care of themselves if they have the right tools. And physicians realized

that you could provide a lot of care through the virtual medium. And so that has become part and parcel of our access, is making sure that our members and our providers are able to match each other both in the virtual space as well as in person.

On the health plan side, what we can do to support this work is bring in more and more electronic, you know, smart, remote type of tools that members can use, and get rid of some of those barriers to access. We know that financial barriers are big, copays are big, getting the prior authorization referrals from the doctor. All of these are various barriers to access. So besides constantly working with our providers to help them with supporting their recruitment efforts, and pointing them to areas where there may be a shortage in the network and, you know, where there's a need, we've also done things on the plan side such as introduce various kinds of programs. And I'll get to them in the next few slides.

And then, you know, really empowering the patient, creating a lot of awareness with the patient, with the member about how much ability they have to drive their own care by making tools that are available. For example, if your member can look at their blood glucose levels in the morning and correlate that with what they ate last night, and put all of that in the -- even -- have

all of that presented to them in the form of a simple application that presents all the information smartly, and then give pointers and advice on what to do now that your blood -- now that your blood sugar is so high in the morning, perhaps drink a glass of water, because you're obviously pretty hemo-concentrated in the morning.

So those types of simple things is how we can get members care that they need without leaving the member dependent on always having to get in to see the doctor's office to answer these kind of simple self-care tools and techniques.

On to the next slide.

[SLIDE CHANGE]

DR. KHURAM ARIF: So we talked about access a little bit. And I'm going to draw a line between access and quality. We know that if a member is not able to get to care when they need to get to care, when they need that care, the quality of their health is going to suffer. That member may end up in the emergency room or seeking care, you know, too late to be able to change the course of where their disease is bringing them.

And so one of the things that we -- that we've worked hard on the last several years now is really shining a light on the blind spots. Those members who are not coming into care, we need to be aware of who they are

and what their care issues are or what their care gaps are; and be able to get to those members to let them know, you know, you haven't had your blood pressure checked. Now, we know that you have high blood pressure. Here is a tool to help you start checking blood pressures by -- and you can get a monitor at home. You don't need a copay for it. You don't need the physician's authorization. And by the way, this tool can record all your blood pressure logs; so when you go in to see your doctor, you know, every two, three months, you've got a nice record there.

That's an example of the kind of tools that we made available to our members, removing barriers around copay and prior authorizations, so that they can take care of themselves; and then also help the physician take care of them in that quality time that they'll get with their doctor.

We've also made incentives available to members to close their care gaps. So for our CalPERS members, for the last year now, in 2023, we launched care gap incentives. Across our broad range of health care metrics, whether it's checking your blood pressure, getting your blood glucose under control, completing childhood vaccinations. We pay an incentive for every single immunization visit that a member has. This is important, right. We realize that the pandemic people

really took a step back in terms of their trust in vaccinations. And unfortunately as a result of that there is a national issue with childhood vaccination rates.

So what can the plan do? The plan can kind of encourage members by providing incentives and reaching out to the members in personalized targeted fashion when we know that they may be missing a care gap.

The value of technology and science is that you can really help to, you know, create avenues for members to get care using intelligent predictive tools. What we now know as AI has been, you know, very well known to the medical industry. We used to call it predictive analytics. Now it's called artificial intelligence. It sounds a lot more interesting with that terminology. But you can predict who the members are, whose care may be suffering or may start to suffer, and reach out to them through tools that intelligently present to the member their various options, and enable them to see themselves based on, you know, how their health is doing and their various, you know, parameters are, how they can make minor doable changes to their day-to-day life to help improve their care.

And so we have programs for helping reversing type 2 diabetes. You never thought that -- when I first heard about the fact that there was something out there

that could reverse type 2 diabetes, I thought this is malarkey, this cannot be real. But in fact you can help members, you know, get on specific diets reduce the carbohydrate levels, and drop their blood glucose; and, in fact, start to de-prescribe some of their diabetes medications.

We have Maven Maternity available which helps members, you know, who are going through pregnancy or recently had their child, and their spouses get care. And, you know, recently with all the focus on doulas through in maternity were able to provide virtual doula services. And we've had this in place with our CalPERS members for during 2023.

Blood pressure, I mentioned. Simple things like, you know, you've had -- you've got back pain or you've got neck pain and you need to see a physical therapist. The issue used to be having to go in to see the physical therapist, taking time off from work and doing all of those things. And just talking back about access, if you can provide physical therapy to a member at home, using the technology in their phone to monitor their exercise and give them some feedback, we've seen some great improvements over just three months of physical therapy at home, and we use this as an interchangeable with in-person versus virtual physical therapy.

So those kinds of innovations, these are the strengths that the plan can provide. You know, our medical groups and our providers in our hospitals are focused on providing that care when the member's in front of them. And the plan can do its job by providing tools to our providers and to our members with respect to all the various disease management support that's needed, and be able to kind of make that available in a ready and easy fashion to access.

[SLIDE CHANGE]

DR. KHURAM ARIF: On the next slide, we'll talk about equity. So equity, again the pandemic, you know, and a lot of events that happened during the pandemic, really shone a spotlight on equity, and we all became aware that different folks of different ethnic backgrounds, different cultural backgrounds experienced care differently. And trying to remove those disparities in care is what we view as equity in care.

So in 2022 we achieved the national -- the medical health care distinction from the NCQA for cultural awareness and training, as well as we now have our -- our members can look on our provider directories and evaluate their physician's race, ethnicity, language background to see if there's a good cultural fit between them and their doctor.

We have -- all of our medical programs are available in Spanish. In fact, as we began talking about equity and hearing about equity, we led the charge at least with our own vendors, and we all stand that if they wanted to be at the table with us working with our members, they had to at least have their programs all available in Spanish.

This year, we've done outreach for Hispanic members for the flu shot along with that campaign this last winter. We send lists every month to our members -- to our providers on patients who are Hispanic who have uncontrolled diabetes, so that we can focus on providing care team members who speak their language being available to those diabetic members.

And every month we send out a social determinants of health report to each of our medical groups which identifies members who are having risk factors around housing insecurity, transportation issues, food insecurity. And we ask our medical groups care coordinators to reach out to these members and enroll them within their care management programs - because we feel that there is a social determinant of health issue here - that care management can help the members, you know, get those resources that they need.

[SLIDE CHANGE]

DR. KHURAM ARIF: Finally, I believe the next slide is going to be talking about just the ali -- the alignment, you know, of our mission and vision of our organizations. We are a -- as Garry was talking about our beginnings. We are very, very close to the practice of medicine and working with our providers and that experience that they have. And so we firmly believe that our job is to be available in the background as support, so that members can get the care that they need from their providers, and providers can get the tools that they need from their plan to help take care of those members.

And we are grateful to be here with you today. Thank you.

CHAIR RUBALCAVA: Thank you.

Don, do you want to -- okay. I was going to ask if we have to take questions now?

CHIEF HEALTH DIRECTOR MOULDS: Why don't you go ahead with questions for Western Health Advantage before we move to Sharp.

CHAIR RUBALCAVA: Thank you.

President Taylor, please.

COMMITTEE MEMBER TAYLOR: Thank you.

Thank you very much for your presentation.

I remember when Western -- I've been with the State since '94. So I remember when you came into us

for -- and then went away for a while for whatever reason. I don't know.

So I had a couple of questions. You have two medical groups that you're working with here in Sacramento, and I forget what they -- I heard in the beginning and I forgot what they were. I'm sorry.

DR. KHURAM ARIF: We have three medical groups - Mercy Medical Group here in Sacramento proper; Hill Physicians, which is an independent physician association down here; as well as Woodland clinic out in Yolo County-Davis area.

COMMITTEE MEMBER TAYLOR: I'm sorry, say that again.

DR. KHURAM ARIF: Woodland Clinic out in the Yolo County-Davis area. So really the Sacramento area.

COMMITTEE MEMBER TAYLOR: Okay. So Hill Physicians is out of Dignity. So you're with Dignity Health?

DR. KHURAM ARIF: Hill Physicians is affiliated with Dignity as a practice partner. They're there own independent physician association. And, yes, we partner with Hill Physicians as one of our groups.

COMMITTEE MEMBER TAYLOR: Okay. And then your provider -- your hospital providers are Dignity and --

DR. KHURAM ARIF: Correct. Here in Sacramento

it's Dignity.

And then we have -- in the other counties we've got North Health Care out in Solano, and then Providence up closer to the coast.

COMMITTEE MEMBER TAYLOR: Okay. That's what I was trying -- that's what I was trying to figure out.

Then I just -- my last question, I really -- I'm just amazed at what you're doing, which is unusual, to say the least, by removing yourselves from the first line. So what made you start this and when did you start it?

GARRY MAISEL: That was one of our differences from the very beginning. Because back in 1997, I don't believe in our market there was any other health plan that operated that way. And as I said, we knew we had to do it differently. It made no sense to bring another vanilla health plan into the Sacramento region back in 1997. It was a very, very crowded field.

And I must say to your question, we were in CalPERS many, many moons ago. When we joined the program I think there were 12 or 13 plans. Then there were 10, then were 9, then there were 8, and then there 3 - Kaiser, Blue Shield and Western Health Advantage.

COMMITTEE MEMBER TAYLOR: I don't think I was on the Board when that happened.

GARRY MAISEL: And we -- let's just say that it

was not our idea but it was -- at the time the CalPERS plan was different. And it didn't appear that there was room in the program at that time with your strategy at that time for a regional health plan. But we're back, stronger than --

COMMITTEE MEMBER TAYLOR: Yes, you are.

GARRY MAISEL: -- ever.

COMMITTEE MEMBER TAYLOR: Yes, you are.

So -- so that's good. I mean I don't -- I don't remember that. But, again, I wasn't here.

GARRY MAISEL: It's a long time ago.

COMMITTEE MEMBER TAYLOR: Yeah.

I think also, I had a question on I guess it was the -- second to last slide, Maven Maternity, what is that?

DR. KHURAM ARIF: So basically Maven Maternity is an application, it's a program, it's run by a company that we worked with not for several years. And it provides virtual services to members who are either going through pregnancy, have just completed their pregnancy, may unfortunately have had a loss during the pregnancy or they're -- as well as their family members. And it provides services from as simple as, you know, lactation consultants, doulas, OB/GYN services, if a member wants potentially some additional opinions outside of the care

that they're getting.

We are -- this is an example of a program that members can actually drive it themselves. No copays, no, you know, referrals needed, et cetera.

And just to go back to your previous question you'd asked is, you know, why did we -- why do we sort of let a lot of those decisions happen at the medical group level. It's all baked in our history. You know, being a provider sponsor plan, we very much understand the angst that providers deal with. And as a former practicing pediatrician, I dealt with as well, trying to get approvals for every single thing that you need. And to allow and to facilitate that initial level of decision making to happen at the medical group makes a lot of sense. It sort of removes that additional barrier to care that can -- that can potentially exist.

COMMITTEE MEMBER TAYLOR: Okay. That's what I missed. I didn't realize you were provider sponsors.

So the providers that put this together, you haven't been able to get other providers to buy into the delegation and the -- the other thing. Hold on. It's in my notes here.

DR. KHURAM ARIF: So we've expanded into counties where we do find willing provider partners and hospitals who want to -- are comfortable operating the capitated

environment and taking that initial level of responsibility around, you know, delegation of care and appeals. And so that's where we sort of limit our geography very carefully. We grow very carefully.

COMMITTEE MEMBER TAYLOR: Okay. I see. So you're very careful of who you actually go out to. So you're not looking to get just more --

GARRY MAISEL: No, we're not looking to grow just for growth sake.

And so we actually -- as Dr. Arif mentioned, in Napa and Sonoma counties we work with Providence Health. In Marin County with Marin Health. So while they are not sponsors or owners of Western Health, they are part of our provider family. And again, they accept capitation. And they are fully delegated for the care that our members receive in those counties.

COMMITTEE MEMBER TAYLOR: I just think it's a great idea. Right. I think we all have that issue where, oh, I still have to wait for my authorization for my x-ray or even -- I think even blood work. I'm not sure. But, yeah, so I appreciate that. Thank you very much.

CHAIR RUBALCAVA: Thank you, President Taylor.

Next we have Jose Luis Pacheco, trustee.

COMMITTEE MEMBER PACHECO: Yes. Thank you. Thank you very much.

First of all, thank you for your presentation. I found this really enlightening and so forth.

My question is with respect to the equity part, and under the -- all the medical programs are available in Spanish, first of all I'd like to know when that started and has it been more -- have you been -- how do you do the outreach to the Latino community and so forth? If you can elaborate more on that.

DR. KHURAM ARIF: Thank you for that question.

So the outreach to the Latino community, you know, it's always about how can you position the message so it's culturally heard. And so as an example, just recently in this last winter, we worked with the National Hispanic Medical Association to design small, you know, comic strips and story telling sort of approach in Spanish to our Latino community around -- messaging around the flu shot.

Your question -- your prior question was also about how long have you been doing it for. Honestly it was during the pandemic that we realized that there is a gap; you know, there's real inequity. And so at that point, as we brought on new disease management programs, all of these programs that we listed as well as legacy programs that we had in place, we began to have some really robust conversations with our vendors on: Here is

we, the client, as the health plan representing our clients, the members, need care in a language other than English. And we need this done in so-and-so time period. And we basically were able to -- we found really willing partners, by the way. I think that the environment was such that everybody relies -- their eyes are open to inequities in care. And so we've been doing stuff for about three years.

We also provide Spanish language translation for various materials as well as in on our website. And that work is not done. There's a lot that needs to be done. And so we remain acutely aware of how much more needs to happen.

COMMITTEE MEMBER PACHECO: This is -- That's wonderful news to hear that.

Although it's very young have you had any -- have you seen any improvements in quality of care and so forth with respect to this new modality?

DR. KHURAM ARIF: We've been finding that in our Hispanic population where diabetes was relatively poorly controlled compared to our Caucasian population of members we're seeing changes. Improvements in the level of engagement.

We are also realizing that as we speak with our providers, they've got a lot of learning and awareness

building, because actually what happened the last three years. And so it's a lot easier now to have the conversation on equity than it was back in, you know, early 2020, for example.

COMMITTEE MEMBER PACHECO: Fantastic. Thank you very much for your comments.

DR. KHURAM ARIF: Thank you.

CHAIR RUBALCAVA: Thank you, Trustee Pacheco.

And thank you for the presentation. I do want to commend you on your NCQA designation for the multiculture health care.

And I want to thank you for expanding to Humboldt County. And we have seen that you have grown significantly recently. And you introduced the new Medicare product MyCare Select Medicare Advantage. And so it's growing. But we definite -- I'd like to know what efforts are you making to expand it, because it's very high ranked and also very affordable.

So what can we learn from you today about your efforts to promoting the program?

GARRY MAISEL: Well, we've been in Medicare -- our first year in the non-employer-based Medicare was 2021. So we launched our Medicare product right smack dab in the middle of the pandemic. It wasn't a great time to launch it.

So we now have overall -- we have about -- after this AEP that happened this last fall, have about 4300 Medicare lives, and we are slowly growing. Medicare, just like commercial, is a highly penetrated market. There are a lot of Medicare plans. We came to market with a zero premium plan thinking we were going to be in our service area on the commercial side, one of the only non -- no monthly premium plans. And at the same year we launched, two others launched with zero premium. So it's a very competitive market.

So we are growing slowly. We wish we were growing faster. We're looking at new ways to outreach to that section of the marketplace. And we hope to be a long-term Medicare Advantage provider.

CHAIR RUBALCAVA: Well, thank you very much. It's been a very nice experience for us, and thank you for being part of the CalPERS menu.

I think that concludes the maybe questions. So now we're ready for Sharp.

Don, have you anything to do with --

CHIEF HEALTH DIRECTOR MOULDS: So I'm going to turn it over to you.

Thank our guests from Western Health Advantage. You can

(Thereupon a slide presentation).

MELISSA HAYDEN COOK: All right. Good morning. Thank you for having us. It's a real pleasure to be here, to come to talk to you about Sharp and Sharp Health Plan and what we've accomplished. And I'm really hoping this time we're having together -- didn't get a chance to really understand the character of our organization and the accomplishments that our people actually have achieved.

Sharp Health Plan is a non-profit, a 501(c)(4). And our health plan has been around for 32 years, so we're five years older I think than WHA. But we've had the distinct privilege of serving the CalPERS members for about 10 years now.

And as a non-profit, we do not have stockholders, we have stakeholders. Right. And for us that's the greater San Diego community. And Sharp Health Plan wholly owned by Sharp HealthCare. And Sharp HealthCare's the largest health care provider in San Diego, touching in excess of a million lives a year, with thousands of physicians and volunteers. And through great compassion and caring that comes from the Sharp experience culture with Sharp.

And I would say as a non-profit, any margin that we do make goes right back into the community, and of course stays in San Diego and in California.

Much like WHA, our medical cost target is right around 90. And we keep our admin expenses slightly below that. We target about a 1 percent margin because, you know, when you're pricing business you can't be sure, you know, how that business will perform. But a very modest margin for us.

At the foundation -- if we can go to the next slide, please.

[SLIDE CHANGE]

MELISSA HAYDEN COOK: At the foundation of Sharp is our mission. And our mission is to improve the health of those we serve with excellence in all that we do. We take it very seriously. This mission's been around for decades. It is shared throughout the entire organization. And particularly our mission has us, you know, setting standards in the community for quality and service; and you'll also notice that "cost-effective" is in the mission and it's been in there, again, for decades.

Affordability for us is critical. You need affordability in order to create access in the community. I would say that there's a tremendous parallel in what you're trying to accomplish here, with your strategic priorities including affordability and quality access and the member experience. So it makes us very good partners.

We deliver on this mission through our vision.

And our vision is to be the best place to work, practice medicine, and receive care.

And it does say up there "Ultimately, the Best Health Care System in the Universe." People do chuckle about that, and they want to know if we benchmark against Pluto, why did we pick "universe"? And we picked the word "universe" very deliberately, because for us this is a journey that never ends. It's a journey of improvement and a journey of progress in transforming health care.

So, we work through our mission, our vision through a foundation of our culture. And we have actually a nationally recognized culture in the Sharp experience. And that culture is really to transform health care every touch every time. And we all take that very seriously. You'll see there's a flame there, and it's purposeful, because the flame represents the spark that's in all of us to us to make a difference in our role in the Sharp experience.

And it's -- people have tried to duplicate it; and it's really -- it's not one thing, it's everything. And it's really that culture, seeking to transform health care, that journey that started 20 years ago from the Sharp experience, that really binds us together as a delivery system. It's that culture and promise to have top decile performance in our 7 Pillars of Excellence:

Quality, safety, service, people, finance, growth, and community. I mean you can't touch a Sharp Health Plan person or even a Sharp delivery system person that doesn't know that commitment to the Sharp experience, the responsibility that that requires of all of us to make a difference in our community, the community that we live and work in. And it's very, very profound.

And Sharp is actually a -- an icon, if you will. It's a community asset. About $570 million a year goes to support the community. It is about one-and-a-half million dollars a day that goes to the community.

So we're really part of the safety net, we're part of the very fabric of the community. And I like to say Sharp's the largest donor to San Diego, if you will. And we wear that as a badge of honor.

And this commitment, this deep commitment to the community was no more evident than during the pandemic. And it wasn't that long ago Sharp Health Plan, our medical groups, our hospitals, our volunteers and our physicians all came together. And what we do is really extraordinary. And before we were ever asked, we eliminated copays and -- related to COVID -- and co-insurance, and created enormous infrastructures for drive-by testing, and worked directly -- our Sharp HealthCare team worked directly with the county. It was

an amazing, amazing experience. And really culminated in Sharp taking the lead in the vaccination in San Diego County in our underserved areas, in our south bay. You know, being there, being there early, bringing our Sharp experience culture to the vaccination sites so that our that communities were comfortable and could have access to this care.

And I tell you this because I think it's our core differentiator. Yet we've accomplished a lot. We're going to talk about that in a minute. But it's that underlying culture, that underlying commitment that keeps driving us every day, and huge differentiation in the insurance industry.

The health plan -- Sharp Health Plan has a very diverse network of providers. That's very purposeful. We have a multi-specialty -- very large multi-specialty medical group with 20 locations. We have a very large multi-specialty IPA, community physicians. And we also have community clinics. And we do this very purposefully because we want to meet our community members where they are. And we have this sort of experience throughout all of our network.

We are provider sponsored. That's where this unification comes from, the sharing of the -- of the culture. And everything we do, our innovations and our

improvements, they're all grounded in the Sharp experience.

You know, as a health plan, I know our team is just very proud to be the best representation of this amazing delivery system. Really, the best expression of managed care, the incredible results that come from that and discipline that comes from that. So -- and you're going to be seeing some of those results in just a minute as we go through this.

We're very tightly knit together. And in doing so -- and we're very committed to the care model as well as the service model. We're able to -- and we're an improvement company, always improving. And so we find breaks early, we fix them, and we systematically fix them so that we can have really the best experience possible.

And our results and our member satisfaction really speak that organizational-wide commitment.

If you go to the next slide.

[SLIDE CHANGE]

MELISSA HAYDEN COOK: All right. Well, this is really a slide from CMS, if you will, really looking about the maturity level of health plans in value-based -- on their value-based journey. We are of course category 4. We have been a value-based organization for 32 years. We started in the delegated model. We have full capitation,

global capitation. We incorporate pay for performance to optimize our quality and our cost. And we believe this drives provider accountability and innovation, and really great success in our clinical and our member outcomes.

I think I know obviously with this structure we have, with that level of integration, we're really uniquely positioned to work with our delivery system, and creating success with our 7 Pillars of Excellence. We're continuously innovating and really removing waste and making financial improvement. You know, coming out of the pandemic we focused on really righting the organization financially, tremendous amount of investments across the delivery system, including the health plan we're made to meet the needs of our community. And I'm really proud of the organization. Sharp pulled about $94.8 million out of health care costs last year. We are slated to pull another $50 million out in '24. And again, affordability is paramount, and we believe that we have to play a strong role in that.

I'd also say technology has played a big role for us. That's the second real big initiative we had last year, was to put in a new infrastructure, a new core admin system for the health plan known as Epic, which is nationally recognized if not recognized throughout the world as one of the best core admin systems in electronic

medical records that we -- that you can use.

This is really critically important for us, because if we're going to continue to improve quality, continue to improve service, and take dollars out of the delivery syst -- you know, the cost of delivering care, we need technology. And so this technology for us is going to allow us to streamline, reduce cost, and perfect the experience which for us is paramount.

We've also embraced wholeheartedly mobile apps because we know that's what our members need and want. And launched arguably one of the best mobile experiences through Sharp Health Plan, an app that was launched in '23. Basically do all your transactions -- your health plan transactions on line.

And in '24, integration will take over as we launch the Sharp delivery system app that's just been launched. And we look to integrate that, right. So we'll have single sign-ons so you can do -- so your health plan transactions, you can go over and do your provider transactions too.

So we're pretty committed to being the most consumer friendly health system in the universe, again a journey really that never ends for us.

Let's go to the next slide, if you will.

[SLIDE CHANGE]

MELISSA HAYDEN COOK: All right. So what are all these -- all the investments we're making, all the programs we're doing? How is that expressing itself in our benchmarking? Because if you are a continuous improvement organization, you're constantly benchmarking. So we are the -- we have been for the last nine years the highest member-rated health plan in San Diego. Eight of those nine years we were the highest rated in California. A small regional health plan eclipsed us. We plan on getting that real soon. We are very competitive and enjoy our status as highest rated in many, many categories.

We are the -- have the most stars of any Medicare health plan in California at 4-and-a-half stars. This is incredible for us, and really a commitment to what it takes to be successful in the -- in our senior community.

We also have the highest rating, a perfect 5 stars in Medicare Advantage for coordination of care, customer service, rating of health care, and rating of the health plan.

And on our commercial population, we have the highest rating in California for coordination of care, customer service of course, also getting care quickly, and rating of the health care and specialists. So a lot of benchmarking for us and a lot of success in these areas based on the many programs we have.

You know, lastly, I would say affordability is critical for us. And our Medical increase over the last 10 years with CalPERS has averaged 2.2 percent. And we're proud of that. Again, affordability is really important to us.

All these results basically we've been rewarded with growth. We are in San Diego, have the largest market share for CalPERS of any product that's offered. And I believe we've been -- have that market share for, what, five years. And it's one of our benchmarking. And we also enjoy that in Covered California as well. And that really speaks to the marketplaces like CalPERS, like what you've committed to in terms of allowing regional health plans like ourselves, like WHA, who are the very fabric of your communities and our communities, to compete on quality and service and affordability. And we let our members in our community really vote with their feet, and we count that as a win as we grow.

And so I want to thank you very much for your support on regional health plans.

And I'll stop there.

CHAIR RUBALCAVA: Thank you, Ms. Hayden.

Question from the Committee?

Okay. We'll start with Vice Chair Mr. Kevin Palkki.

VICE CHAIR PALKKI: Thank you.

Great presentations from both of you. I think I caught a little bit of competition there.

(Laughter).

VICE CHAIR PALKKI: A little bit of north-south maybe.

(Laughter).

MELISSA HAYDEN COOK: We've known each other for a very...

VICE CHAIR PALKKI: If you could elaborate a little bit more into the tools. I'm a big supporter of sort of the pre-diabetic approach and things that we can do to minimize our members moving into that diabetic range.

Can you share how you're utilizing tools, whether it's technology or -- or what is it you're actually using to sort of support these different approaches.

MELISSA HAYDEN COOK: Absolutely. I'm going to have our chief medical officer answer that question too.

DR. CARY SHAMES: Thanks for the question. And this is something that is throughout the way that we provide care to our members. So the tools are integrated into what we call population health model. So that goes from members that are healthy, for which we have specific programs and services that we benchmark and we have goals

for; all the way through to patients at risk, for which pre-diabetics and pre-hypertensives and overweight and smokers. The modifiable risk areas will be included. And each one of those has tools, which is part of Follow My Health, which is our member link. And we have a connection, an integration with our providers; on our clinical team, our medical directors, our case managers coordinate care daily with our medical groups. That separates us from other health plans that may be using our providers.

So the tools are individual for each individual issue. The hypertensive we have remote monitoring. We have telehealth. We have -- it's called the -- the Materials of Things, which is the ability to have wearables, to have other types of devices that we're able to connect with and real-time be able to provide care because we see a problem happening. The best time to be able to identify a problem is before a patient ends up in the emergency room or the hospital, and it become a preventable acute care situation. That's how we improve quality and that's how we reduce total cost of care.

VICE CHAIR PALKKI: Thank you.

CHAIR RUBALCAVA: Thank you, Ms. Palkki.

Any more questions from the Committee?

I think Frank Ruffino has a question.

ACTING BOARD MEMBER RUFFINO: It's not working. Oh, am I on?

CHAIR RUBALCAVA: Not yet. Hold on.

Yes, you are.

ACTING BOARD MEMBER RUFFINO: Thank you, Mr. Chair. I rise for a quick point of personal privilege.

And thank you to both -- you guys obviously -- both plans have a secret sauce that I wish could be shared, you know, with many, many other out there that could use, you know, some of that recipe.

That said, I want to -- I'm from San Diego. I've lived most of my adult life in San Diego. So I'm going to be a little bit -- and I've been with Sharp for a long, long time. So that said, I wanted to thank you, by the way, Ms. Cook for your incredible leadership that you have had in the community and especially for your efforts, you know, to lead that efforts to make high quality health care accessible to all San Diegans and not only to us state workers who are lucky and honored, you know, and privileged to be able to have the plan.

And behalf of all the state workers, by the way, I'm sure you get plenty complaints from us. But today's the day to say thank you on behalf of all the workers. Thank you for what you do. We truly appreciate that effort.

On your -- I'm on Follow My Health. I'm still from the -- wrong page. I got the email that I need to transition. I'm going to try to make the transition. I think in the next couple weeks or the deadline is. So I hope to succeed. But if not, you know, I know that I can count on your tech people to help me through it.

MELISSA HAYDEN COOK: Yes.

ACTING BOARD MEMBER RUFFINO: But I want you to know I've been with my health provider, my doctor for 20 plus years.

So no complaints today, but just a message of gratitude. And please continue and don't forget, you know, that we all need health care regardless --

MELISSA HAYDEN COOK: That's right.

ACTING BOARD MEMBER RUFFINO: -- of status, gender, identity and so on and so forth.

Thank you, Mr. Chair.

CHAIR RUBALCAVA: Than you, Mr. Ruffino.

MELISSA HAYDEN COOK: Thank you so much.

CHAIR RUBALCAVA: Any other questions from the Committee?

Okay. I do have a comment and a question.

Similarly, I -- we are very appreciative of the high quality ratings you've received from NCQA. And also like Western Health Advantage, you have very competitive

rates, premiums, and so we're very -- we applaud you for that and like you to continue that effort.

And similarly like Western Health Advantage, you have recently launched a Medicare program. Sharp Direct Advantage Medicare Plan. And it's growing. So tell us how you're going to make it grow. We want it to grow.

MELISSA HAYDEN COOK: Yes. I think I'll turn it over to Michael Byrd, who's our Chief Business Development Officer, and really kind of our lead executive on Medicare Advantage.

MICHAEL BYRD: Well, thank you for that question. It's a fantastic one.

And if you look at the kind of growth that we've had since we've been added to CalPERS -- and we were actually one of the first Medicare Advantage plans when you decided to expand the offering to have other Medicare Advantage plans. We were the first to be offered back in 2019.

And if you look at -- of the available market, we have captured the lion's share of those people who are either aging in or switching. So in 2023, last year, was about 50 percent -- very close to 50 percent of the available market we were able to capture.

So as you know though, when you've been in a plan for, let's say, five, six years, it's -- most people don't

want to switch. So it will take some time to allow that organic growth to happen.

But if you look at outside of CalPERS how we've been able to perform in San Diego, we're now ranked number 4. And as Gary Maisel mentioned, it's a very impacted market in San Diego. There's 16 carriers. And we've moved up the ranks very, very quickly, largely because of our benefit package, affordability, as well as our high quality.

So I think the focus for us as a local sales team and Mr. Ruffino, we'll actually help you sign up for the new app if you'd like. We'll call you right after this meeting.

(Laughter).

MICHAEL BYRD: That's part of the Sharp experience.

(Laughter).

GARRY MAISEL: We'll move to Sacramento.

(Laughter).

MICHAEL BYRD: And that's what we're really all about. I think that's what makes us stand out.

And so I would expect just given a little bit of time that we'll be able to really grow that Medicare membership to a critical mass.

CHAIR RUBALCAVA: Well, thank you very much.

CHIEF HEALTH DIRECTOR MOULDS: Mr. Rubalcava, I'll just add that, you know, we made this decision to add a handful of Medicare Advantage plans a few years ago, as you probably recall. And driving consideration was continuity of care, which I think we all believe in, and not wanting to have members who age out of basic care in a high quality plan have to go somewhere else, and potentially find a new provider team and so forth. So we are -- we push on both Western Health Advantage and Sharp every day to grow in this space. I think they're taking it very seriously. But we also are aware to their point that when we're likely to see most of the growth is when basic members in these plans age into Medicare.

CHAIR RUBALCAVA: Thank you, Don.

And I want to thank both of you for presenting that. This was very educational, and also more enjoyable than our last health plan spotlight.

(Laughter).

CHAIR RUBALCAVA: So thank you very much. We want to thank you.

And from here we move on to Summary of Committee Direction.

CHIEF HEALTH DIRECTOR MOULDS: Mr. Chair, I did not report any Committee direction.

CHAIR RUBALCAVA: I did not either, but I want to

make sure.

Well, thank you then.

And so we'll move into public comment.

We have somebody on the phone. So why don't we do that one first.

STAFF SERVICES MANAGER I FORRER: Yes, Mr. Chair. We have Brano Goluza.

CHAIR RUBALCAVA: Please proceed.

BRANO GOLUZA: Good morning, and thank you.

I'm speaking to express my deep concern and frustration regarding a recent policy change that has significantly impacted my ability to access necessary medical prescriptions.

I've been a member of CalPERS for more than 15 years and have always appreciated the support and services provided, which is why the recent challenges I have faced have been particularly disheartening.

A few weeks ago, I was informed by my pharmacist that CalPERS no longer allows for the filling of 90-day prescriptions in person; instead requiring mail order prescriptions for this duration. This change has caused significant inconvenience and stress for me as it restricts my access to essential medications prescribed by my doctor.

I immediately began reaching out to CalPERS to

seek clarification and request a reversal of this policy change. But unfortunately my efforts have been met with numerous obstacles and unfulfilled promises.

Over the past week and a half I have made multiple attempts to contact CalPERS, only to encounter rude and unhelpful responses. I was initially assured by a senior staff member that the policy would be reverted back to its previous state, only to be transferred to OptumRx where I was given false information about updating my prescription access.

Despite following their instructions and waiting for hours, there was no change, indicating a lack of integrity and transparency in the communication process.

The decision to limit prescription access to mail order not only to members like myself, but it also raises serious concerns about the safety and reliability of receiving medications via mail. In my neighborhood mailbox theft is a common occurrence; and relying on mail-order prescriptions puts my health at risk due to potential delays or theft of medication.

I urge the Board of Administration to reconsider this policy change and restore the options for members to obtain 90-day prescription in person as it was before.

This change not only disregards the practical challenges faced by members but also demonstrates a lack

of empathy and understanding for their real-world implications of such decisions.

I trust that the Board will take swift and decisive action to address this issue and restore the previous prescription policy for the health benefit of all members.

Thank you for your attention of this matter.

CHAIR RUBALCAVA: Thank you for your public comment, sir. We have received other -- I don't want to say complaints -- other concerns about our new mail-order-preference program. And I think part of the problem was the member communication, and we are working on some resolution. So somebody will get back to you.

Don, did you want to add something --

CHIEF HEALTH DIRECTOR MOULDS: Yeah, I just wanted to say to the caller that, you know, obviously we're going to look into -- one, we will reach out to him directly, and happy talk through more of this. And obviously we'll follow up. We never want to hear stories like that about our experiences. The fact that we don't encounter them very often I think speaks to the high quality and the commitment to provide excellent customer service. So we will look into that one as well.

You know, we made -- the Board made this decision as a savings opportunity. We are projected to save

several million dollars by transitioning to mail order on 90-day fills. Members are still able to fill 30-day prescriptions, so -- it involves more visits to the pharmacy, but at the pharmacy level. And we're committed -- if there are special circumstances with any particular member, we're committed to talking -- working through and figuring out what we need to do to make sure that that person has appropriate access to their medication in any fill size.

So we'll work through that again. Our apologies for the experience. And I just want to add that.

CHAIR RUBALCAVA: Thank you for that explanation, Don.

And thanks again for calling.

Our next speaker is Margherita Brown, please.

MARGHERITA BROWN: Thank you, Mr. Chair.

I apparently talked at the wrong time about long-term care, so I'm back.

Under the terms of the Wedding and CalPERS lawsuit settlement CalPERS is prevented from increasing premiums on long-term care policies until November of this year. I had been advised that this month is the first time the Committee may consider increases. Yet the only item on the agenda for long-term care is a closed session item.

If rate increases for the long-term care program have not been discussed yet because they're not anticipated, great. But if increases are already under consideration, when will this Committee publicly provide CalPERS members the relevant information on the important questions?

As you may know, during the wedding lawsuit settlement, the Court found that CalPERS intentionally targeted premium increases on older policyholders with inflation-protection policies, inducing these older policyholders to abandon their policies while never receiving benefits.

During the settlement agreement -- or the settlement hearing Judge William Highberger described a CalPERS policy as follows: CalPERS engaged in abrupt rate increase for people with inflation protection and lifetime benefits to the very purpose of driving them off and getting the risk off the books. Which is something other than across-the-board rate increase. In particular, the rate increases at that time were in the nature of 85 percent, and did not include rate increases for enrollees who did not buy inflation protection or lifetime benefits.

So you can imagine these policyholders, which include me, are very interested in ensuring that we are not the target for extra premium increases the next time.

CalPERS owes it to us to provide up front information about whether increases are needed, how much it needs to recover, how much of the increases are driven specifically by inflation as that amount should not be charged to those of us with inflation protection policies, and details on how the increases will be distributed across categories of policyholders and why.

Thank you.

CHAIR RUBALCAVA: Thank you.

Do we have any more public comments?

Thank you.

So we will adjourn the meeting of the Pension & Health Benefits Committee.

And we'll break for lunch.

Thank you.

(Thereupon California Public Employees' Retirement System, Pension and Health Benefits Committee open session meeting adjourned at 12:18 p.m.)

CERTIFICATE OF REPORTER

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

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

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

IN WITNESS WHEREOF, I have hereunto set my hand this 27th day of March, 2024.

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